Chapter 6

Involuntary treatment orders—statistics, legislation and reviews

6.1 The first half of this report focuses on indefinite detention within the criminal or forensic mental health system. Part B of this report (Chapters 7–10) will focus on the civil systems which lead to indefinite detention of people with a cognitive or psychiatric impairment. These include involuntary treatment orders under mental health frameworks, as well as orders under guardianship or disability-related legislation.

6.2 A range of evidence has been presented to the committee, and is discussed in the following chapters, which indicates that civil frameworks—mental health, guardianship and disability frameworks—are generally more informal mechanisms than the forensic system. On one side, this often provides greater flexibility in providing tailored solutions for individuals, but can also involve less structured review rights or oversight, leading to unnecessarily prolonged detention.

6.3 Part B of the report will also review the operation of the civil systems used for detaining people to provide involuntary treatment. If recommendations for early intervention and diversion from the forensic system are acted upon, the civil system will be called upon to a greater extent to provide treatment pathways. It is therefore of critical importance to assess the capacity of those civil systems to deliver improved outcomes for patients leaving the forensic system.

Introduction

6.4 There are three key mechanisms for detaining people cognitive or psychiatric impairment within the civil systems: mental health acts, disability acts and guardianship acts.

6.5 Chapter 7 will focus on mental health acts, and will provide an overview of mental health facilities and treatment order review provisions across the jurisdictions.

The mental health pathway to indefinite detention

6.6 A common entry point for a person to be detained indefinitely under a scheduled mental health order, is where a referral to a designated mental health facility or hospital for assessment is made by another party such as a medical practitioner, or a friend or family member.

6.7 However, many referrals are made during an incident attended by a first responder (generally a police or ambulance officer). Often first responders make these referrals under duress and use the act of referral as a form of crisis management to mitigate against a perceived risk of serious harm.[1]

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1 For a longer discussion on first responder mental health referrals, see: Dr Joanne Bradbury, *Submission 63*.

6.8 During an incident attended by a first responder, often an arbitrary decision is made by the first responder as to whether or not a person is immediately diverted to a mental health pathway or charged with a crime and later enters the forensic mental health system. An individual first responder's training and capacity to recognise a mental health situation and assess the likelihood of risk of harm can be the deciding factors as to the pathway that person will be diverted to for treatment.[2]

6.9 For example, in New South Wales (NSW), first responders including police officers and paramedics are empowered to:

> apprehend and transport a person to a declared mental health facility (DMHF) for psychiatric assessment if the officer believes the person: is committing or has recently committed an offence; has recently attempted or is probably going to attempt to kill himself or herself or someone else; or will probably attempt to cause serious physical harm to himself or herself or someone else (s. 22(1)(a)); ***and*** that it would be "beneficial to the person's welfare" to be dealt with under mental health, rather than criminal, legislation (s. 22(1)(b)).[3]

6.10 If a person is assessed by a medical officer within the DMHF and found to be 'mentally disordered' or a 'mentally ill person' then they may be detained in the DHMF for an indefinite period on an involuntary order, outlined in greater detail below. If not detained on an involuntary order, they must be returned to police custody (for possible charges) or released into the community.[4]

Declared mental health facilities

6.11 There are three broad types of specialist mental health care in Australia—*community mental health care* where the person resides in the community, *residential mental health care*, which is mental health care provided on an overnight basis in a domestic-like environment, or *admitted patient care* provided in a specialist psychiatric hospital or psychiatric unit within a hospital.

Community mental health care

6.12 Community mental health care (CMHC) is defined as 'government-funded and -operated specialised mental health care provided by community mental health

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2 NSW Police Force, *NSWPF Mental Health Intervention Team*, http://www.police.nsw.gov.au/community_issues/mental_health (accessed 10 November 2016).

3 Dr Joanne Bradbury, Matt Ireland, Helen Stasa, 'Mental Health emergency transport: the pot-holed road to care, *The Medical Journal of Australia*, 2014, volume 200, number 6, p. 348, https://www.mja.com.au/system/files/issues/200_06_070414/bra10093_fm.pdf (accessed 7 December 2015). Similar provisions exist in other states, although mostly only for police officers.

4 NSW Legal Aid, *The Practice and Procedure Manual for Mental Health Advocacy (Civil and Forensic Work)—2.12 Procedures after admission of involuntary patients*, October 2008, http://www.legalaid.nsw.gov.au/for-lawyers/policyonline/practice,-procedures-and-directions/2.-the-practice-and-procedure-manual-for-mental-health-advocacy-civil-and-forensic-work/2.12.-procedures-after-admission-of-involuntary-patients (accessed 7 December 2015).

care services and hospital-based ambulatory care services, such as outpatient and day clinics'.[5]

6.13 Nearly 14 per cent of the 8.7 million CMHC episodes recorded in 2013–14, were for involuntary patients. However, these people are not held indefinitely and are allowed to return to their place of residence after attending treatment. This inquiry did not investigate involuntary community treatment orders.

Residential mental health care

6.14 Residential mental health care (RMHC) is mental health care that is provided on an overnight basis in a dedicated facility with a domestic-like environment. A residential mental health service is a specialised mental health service that:

- employs mental health trained staff on-site
- provides rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment
- encourages the residents to take responsibility for their daily living activities.

> These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However, all these services employ on-site mental health trained staff for some part of the day.[6]

6.15 In 2013–14, the Australian Institute of Health and Welfare (AIHW) found a national trend of an increase in RMHC episodes of nearly 75per cent over 5 years, but a decrease in the overall percentage of involuntary admissions from 29 per cent (2009-10) to 18 per cent (2013–14). Greater detail on the changing rates of RMHC episodes are provided at the end of this chapter in a section on statistics.

Admitted patient care

6.16 Admitted patient care takes place within a clinical setting such as a psychiatric hospital or a psychiatric unit within a hospital.[7] The AIHW found that:

> In 2014–15, there were 157,104 mental health-related separations with specialised psychiatric care; equivalent to a national rate of 6.8 per 1,000 population.
>
> In 2014–15, there were 48,857 mental health-related separations with specialised psychiatric care where the mental health legal status was 'involuntary'—representing about a third (31.1%) of these separations.[8]

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5 Australian Institute of Health and Welfare (AIHW), *State and territory community mental health care services: Key concepts*, https://mhsa.aihw.gov.au/services/community-care/data-source/#4_cmhc (accessed 1 November 2016).

6 AIHW, *Mental Health Services in Australia: Key concepts*, https://mhsa.aihw.gov.au/key-concepts/#4_cmhc (accessed 8 December 2015).

7 AIHW, *Admitted patient mental health-related care*, https://mhsa.aihw.gov.au/services/admitted-patient/, (accessed 2 November 2016).

Involuntary mental health orders

6.17 Each state and territory in Australia has enacted legislation which allows for the detention of people deemed at risk of harm to themselves or others, to enable the provision of mental health treatment via an involuntary treatment order (involuntary order).

6.18 Table 6.1 below, shows that there were 12 085 people being treated as inpatients and 14 797 as outpatients subject to involuntary orders from the relevant state or territory mental health review board or tribunal.[9]

Table 6.1: Numbers of involuntary mental health detention orders issued in each jurisdictions and the locations of the detention

		Involuntary mental health orders		
State	**Year**	**Inpatient**	**Outpatient**	**TOTAL**
NSW	2014–15	1339	4219[10]	5558
ACT	2014–15	UKn[11]	UKn	921
VIC	2014–15	2324	2588	4912
TAS	2014–15	UKn	UKn	1446[12]
SA	2014–15	1543	7327	8870
WA	2011–12	2626	329	2955
NT	2012–13	235	252	487
QLD	2014–15	4018	82	4100

Source: NSW Mental Health Review Tribunal, *2014/15 Annual Report*; Tasmanian Mental Health Tribunal, *Annual Report 2014–15*; Victorian Mental Health Tribunal, *2014/15 Annual Report*; Queensland Director of Mental Health, *Annual Report 2014–2015;* South Australian Chief Psychiatrist, *Annual Report 2014-15*; Western Australian Mentally Impaired Accused Review Board (MIARB), *2014/15 Annual Report*; Northern Territory Department of Correctional Services, *Annual Statistics 2013–14*, p. 16; Law Council of

8 AIHW, *Specialised care characteristics,* https://mhsa.aihw.gov.au/services/admitted-patient/specialised-patient-characteristics/ (accessed 2 November 2016).

9 A useful discussion of involuntary mental health care can be found at: http://www.aihw.gov.au/publication-detail/?id=60129549463 pp 20–22.

10 This includes those discharged into community mental health supports or moved to voluntary status.

11 UKn is unknown.

12 A treatment order can include detention. These statistics are not broken down into inpatient or outpatient, but it should be noted that Tasmania is more likely to use community based or outpatient care. These statistics also include 552 interim treatment orders which last for up to 10 days.

Australia, *Submission 72*, pp 6–7; Barriers 2 Justice, *Submission 67*; NT Government, *Submission 75*, Appendix A.

6.19 Each Australian state and territory has a mental health review board or tribunal to provide an oversight and review process for all involuntary mental health orders. These boards and tribunals are also empowered to make, renew and vary mental health orders. The Royal Australian New Zealand College of Psychiatrists submitted that there is great divergence between the various state and territory mental health acts as to the criteria that must be applied for involuntary treatment is enacted, and also in the processes that subsequently review compulsory treatment orders.[13]

6.20 Details on these boards and tribunals are provided below.

New South Wales

6.21 The NSW Mental Health Review Tribunal (MHRT) reviews 'involuntary patients in mental health facilities, usually every three or six months, and in appropriate cases, every twelve months, with forensic patients 'usually every six months'.[14]

6.22 In its annual report, the MHRT noted that:

> In 2014/15 of the 22 252 persons taken involuntarily to a mental health facility or reclassified from voluntary to involuntary: 2 701 were not admitted; 2 491 people were admitted as a voluntary patient and 17 060 were detained as either a mentally ill or mentally disordered person - a total of 19 551 admissions (including 1 720 of the 1 940 people who were reclassified from voluntary to involuntary).
>
> There were 6 633 mental health inquiries commenced with 5 558 involuntary patient orders made. Of these only 1 339 patients remained in a mental health facility until the end of the involuntary patient order (which could be made for a maximum of three months) and were reviewed by the Tribunal. This means 4 219 people were discharged from a mental health facility or reclassified to voluntary status prior to the end of their initial involuntary patient order.[15]
>
> [Of the 17 060 involuntary admissions, 12 018 were mentally ill and 5 042 were mentally disordered].[16]

13 Royal Australian New Zealand College of Psychiatrists, *Submission 17*, pp 6–7.

14 NSW Mental Health Review Tribunal, http://www.mhrt.nsw.gov.au/forensic-patients/forensic-procedures.html and http://www.mhrt.nsw.gov.au/the-tribunal/

15 NSW Mental Health Review Tribunal, *2014/15 Annual Report*, p. 46, http://www.mhrt.nsw.gov.au/assets/files/mhrt/pdf/MHRT%20Annual%20Report%202015.pdf (accessed 11 December 2015).

16 Although this is not expressly stated, of the 17 060 involuntary admissions, only 1339 were held as involuntary inpatients for longer than three months (hence subject to a review by the MHRT).

Queensland

6.23 As at 30 June 2015, there were 4100 involuntary order patients in Queensland (QLD) mental health facilities of which 98 per cent were inpatients.[17] In 2014–15, the QLD Mental Health Tribunal (QMHT) reviewed 8165 involuntary orders, of which the vast majority were confirmed (7981). On top of this, nearly 5500 involuntary orders were revoked prior to hearing highlighting 'that clinical assessment and review prior to the scheduled hearing promotes voluntary acceptance of treatment negating the need for further use of involuntary treatment for a significant number of patients. An involuntary order must be reviewed 'within six weeks of the order being made and afterwards of intervals of not more than six months'.[18]

6.24 The Director of Mental Health highlights that 21 per cent of the nearly 24 200 people who have an open patient record at a public mental health facility are involuntary patients.[19] Similar to NSW, involuntary assessment can be initiated by a front line responder (police or ambulance officer) or medical professional (psychiatrist) under an Emergency Examination Order (EEO). Of the 12 487 EEO's made in 2014–15, 44 per cent were made by ambulance officers and 56 per cent by police officers.[20]

Tasmania

6.25 The Tasmanian Mental Health Tribunal (TMHT) may make, vary, renew or review an involuntary order under the *Mental Health Act 2013* (Tas). In the 2014–15 period, the TMHT made 552 interim orders, made 410 new orders, varied 361 and renewed 123. The TMHT also reviewed 777 cases. These treatment orders can only be issued for a period of up to 6 months and must be reviewed within 30 days initially and then every 90 days thereafter. It is not clear whether these are separate cases or contain multiple cases for individuals.[21]

Victoria

6.26 The Victorian Mental Health Tribunal (VMHT) reviews all 'involuntary' mental health patients and made the following involuntary orders in 2014–15:

- 2 324 inpatient treatment orders;
    - 1–6 week (10 per cent)
    - 7–13 week (24 per cent)

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17 Queensland Director of Mental Health, *Annual Report 2014–2015*, pp 19 & 23, http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2015/5515T1884.pdf (accessed 4 January 2016).

18 Queensland Mental Health Tribunal, *Annual Report 2014–15*, pp 11, 19–20.

19 Queensland Director of Mental Health, *Annual Report 2014–2015*, p. 7.

20 Queensland Director of Mental Health, *Annual Report 2014–2015*, pp 14–15.

21 Tasmanian Mental Health Tribunal, *Annual Report 2014–15*, pp 7–9 and 15, http://www.mentalhealthtribunal.tas.gov.au/__data/assets/pdf_file/0008/329462/Annual_Report_Mental_Health_Tribunal_2014-15.pdf (accessed 18 December 2015).

- 14–20 week (7 per cent)
- 21–26 week (59 per cent) [22]

- 417 temporary treatment and permanent treatment orders revoked.

6.27 The maximum duration of an involuntary order in Victoria is six months.[23]

South Australia

6.28 There are two types of involuntary orders used in South Australia, inpatient orders and community orders. An inpatient order allows a 'person to receive compulsory, inpatient treatment for a mental illness'; whereas a community order 'allows a person with a mental illness to receive compulsory, community-based treatment for a mental illness'. At 30 June 2015, there were 8870 mental health treatment orders, of which 1543 were inpatient orders and 7327 were community orders. Overall this was an increase of about 10 per cent from the previous year. These numbers include individuals who receive multiple orders.[24]

6.29 The South Australian Civil and Administrative Tribunal has powers to review and make certain orders relating to the involuntary treatment and detention of people with mental illness. This tribunal's work is quite complex and reflects the fact that there are a number of different inpatient and community orders for different treatment lengths (that is, short, medium and long).[25]

Western Australia

6.30 In Western Australia, the Mental Health Review Board (MHRB) conducts periodic reviews of the status of involuntary patients at least every six months. The MHRB can review more often if they deem it necessary or if a request is made. In 2011–12, there were 2955 involuntary orders commenced with 2626 detained in hospital and 329 on a community order. These numbers are roughly similar over the preceding period. Other relevant orders were 936 orders that were continued with

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22 There were 2588 community orders.

23 Victorian Mental Health Tribunal, *2014/15 Annual Report*, p. 17, http://www.mht.vic.gov.au/wp-content/uploads/2015/10/MHT-2014-2015-Annual-Report.pdf (accessed 18 December 2015). A maximum duration of a community order is 12 months.

24 South Australian Chief Psychiatrist, *Annual Report 2014-15*, p. 21, http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0ahUKEwiCn8iXqI_KAhVjIKYKHZZNC58QFggnMAI&url=http%3A%2F%2Fwww.parliament.sa.gov.au%2FHouseofAssembly%2FBusinessoftheAssembly%2FRecordsandPapers%2FTabledPapersandPetitions%2FPages%2FTabledPapersandPetitions.aspx%3FTPLoadDoc%3Dtrue%26TPDocType%3D0%26TPP%3D53%26TPS%3D2%26TPItemID%3D464%26TPDocName%3DChief%252BPsychiatrist%252BAnnual%252BReport%252B2014-15.pdf&usg=AFQjCNEwQUAL1gKM1LrjtYmEZKd88oScUQ (accessed 4 January 2016). An involuntary order allows a 'person to receive compulsory, inpatient treatment for a mental illness'; whereas a community order 'allows a person with a mental illness to receive compulsory, community-based treatment for a mental illness'.

25 SACAT, *Mental health*, http://www.sacat.sa.gov.au/types-of-cases/mental-health (accessed 16 January 2016).

extension of a community order (298), issuance of a community order on discharge from hospital (516), and revocation of community order and readmission to hospital (122).[26]

Australian Capital Territory

6.31 In 2014–15, there were 1020 people apprehended by a first responder—police (723) and ambulance (158)—or medical practitioner (139). Of those apprehended, there were 698 detained. Of those detained, 387 were kept for 72 hours or less and 311 had applications lodged for an extension of involuntary detention.

6.32 The Australian Capital Territory (ACT) Chief Psychiatrist is also responsible for the 'treatment and care of a person to whom a psychiatric treatment order (PTO) applies. A PTO can be issued for six months by the ACT Civil and Administration Tribunal (ACAT) whereupon it requires review and re-issue. There were 921 PTOs granted and 156 revoked by ACAT in 2014–15. Although PTOs subject an individual to involuntary treatment, an additional 'restriction order' is required in order for someone to be involuntarily detained or be 'required to reside at a specified place'. There were 14 restriction orders issued by ACAT in 2014–15 and all were in relation to a 'community care order'.[27] It is not clear how many of these are being held as an inpatient in a hospital mental health unit. The ACT currently does not have a secure mental health unit, but is constructing a new low to medium security facility, expected to open in late 2016.[28]

Northern Territory

6.33 There were 235 involuntary detention (inpatient) orders issued in the Northern Territory (NT) in 2012–13. A further 252 community management orders were also issued. These statistics represent a 14 per cent decrease and a 95 per cent increase respectively since 2011. Over 63 per cent of matters scheduled before the NT Mental Health Review Tribunal were with Aboriginal and Torres Strait Islander peoples.[29]

Reviews of involuntary mental health order legislation

6.34 This section will examine and summarise key findings of recent reviews into the administration of involuntary mental health orders, conducted at the national level and for New South Wales, Queensland, South Australia and the Australian Capital Territory.

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26 Western Australia Mental Health Review Board, *Annual Report 2012*, p. 9, http://www.mhrbwa.org.au/publications/pdfs/Annual_Report_2012.pdf (accessed 4 January 2016).

27 ACT Chief Psychiatrist, *Annual Report 2014–15*, http://www.health.act.gov.au/research-publications/reports/annual-reports/2014-2015-annual-report/attachment-1/chief-psychiatrist (accessed 4 January 2016).

28 See: http://www.health.act.gov.au/dhulwa-mental-health-unit (accessed 2 November 2016).

29 Northern Territory Mental Health Review Tribunal, *Annual Report 2012–13*, pp 10–14, http://www.nt.gov.au/justice/general/documents/Annual_report_2012-13/mhrt_and_lpmt/Annual%20Report2012_13.pdf (accessed 4 January 2016).

National —Australian Law Reform Commission

6.35 In 2014, the Australian Law Reform Commission (ALRC) conducted an inquiry into Commonwealth laws and legal frameworks that impact on the recognition of people with disability before the law. As discussed in Chapter 2, the report investigated the system of 'unfit to plead' and forensic mental health orders. Importantly, it also included decisions on medical treatment in the terms of reference.

6.36 In the final report, *Equality, Capacity and Disability in Commonwealth Laws*, the ALRC proposed National Decision Making Principles (NDMP) (and guidelines) that would apply to the provision of disability and health services including mental health services. The NDMP are:

- All adults have an equal right to make decisions that affect their lives and to have those decisions respected.
- Persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.
- The will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives.
- Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.[30]

6.37 The ALRC report recommended state and territory governments review laws and legal frameworks that impact the decision making rights of people with disability and that:

> Any review should include, but not be limited to, laws with respect to guardianship and administration; consent to medical treatment; mental health; and disability services.[31]

6.38 The ALRC report also highlighted new mental health legislation in Tasmania and Victoria which 'has changed the focus of criteria for the involuntary detention and treatment from the risk of harm to a person's capacity to consent to treatment' and 'protects the rights of mental health patients through statements of rights'. These rights include the:

> right to communicate, make advance statements and have a nominated person to support them and help represent their interests. The role of a nominated person is to receive information about the patient; be one of the persons who must be consulted in accordance with the Act about the patient's treatment; and assist the patient to exercise any right under the Act. A person can only nominate another person in

30 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (*Report 124)*, 24 November 2014, p. 63, https://www.alrc.gov.au/sites/default/files/pdfs/publications/alrc_124_whole_pdf_file.pdf (accessed 8 January 2016).

31 *Equality, Capacity and Disability in Commonwealth Laws* (*Report 124)*, p. 21.

writing and the nomination must be witnessed. A nomination can be revoked in the same manner by the person who made the nomination or if a nominated person declines to act in the role.[32]

Outcomes

6.39 As outlined in Chapter 2, in 2015, with the agreement of all Australian Governments, the National Mental Health Commission (NHMC) commenced 'a project to look at best practice in reducing and eliminating the seclusion and restraint of people with mental health issues and to help identify good practice approaches'. The outcomes of that project are discussed in greater detail in a section on 'restrictive practice' in Chapter 9.

New South Wales

6.40 In May 2013, the NSW Ministry of Health concluded a review into the *Mental Health Act 2007* which assessed current legislation and practice to improve mental health services.

Outcomes

6.41 The *Mental Health Amendment Act (Statutory Review) Act 2014* was passed in late 2014. The amendments sought to align the NSW approach to 'national and international trends towards a consumer-led approach to treatment.' The key changes were:

- requirements that clinicians make every effort to take into account the consumers' views and wishes about their treatment to ensure the principles of recovery are supported;
- increased safeguards that protect the rights of people with mental illness such as enhanced rights of young people undergoing treatment;
- strengthened emergency mental health care by empowering more clinicians to undertake assessments – a measure which will save mental health consumers in country areas from arduous travel in seeking assessment of their mental health condition and treatment; and
- recognising the need for a consumer's primary care provider to receive certain information.[33]

32 *Equality, Capacity and Disability in Commonwealth Laws* (*Report 124)*, pp 286–288. Western Australian legislation also provides for a 'nominated person', someone chosen by the person with mental illness to assist them in ensuring their rights under the Act are observed and their interests and wishes are taken into account by medical practitioners and mental health workers. A nominated person is entitled to 'uncensored' communication with the person with mental illness, and to receive information related to that person's treatment and care.

6.42 A subtle amendment to the objects and principles of the Act saw the replacement of 'control' with 'to promote the recovery of', with the effect being that the first object of the Act now reads:

> (a) to provide for the care and treatment of, and **to promote the recovery of**, persons who are mentally ill or mentally disordered…[34]

Queensland

6.43 The review of the Queensland *Mental Health Act 2000* commenced in July 2013 with a discussion paper released in May 2014.[35] This paper made a number of recommendations with regard to involuntary detention and treatment of people with mental illness. Key recommendations were:

- An authorised doctor may not make both a recommendation for assessment and an involuntary treatment order for the same person in the same examination and assessment process, unless the doctor is located in a regional, rural or remote area designated by the Director of Mental Health.
- Simplification of documentation leading up to and including detention.
- Timely transfer of acutely unwell prisoners from prison to an authorised mental health service.
- Clarification of treatment plans, and that statutory requirements for treatment and care of involuntary patients should be aligned with 'good clinical practice'. Improved recognition of and consultation by medical professionals with the involuntary patient's family and carers.
- Increased clarity on the role and powers of the Mental Health Tribunal.
- Improved provisions that provide 'consistency, clarity and effectiveness of restraint and seclusion'. These improved provisions should lead to a reduction in the use of restrictive practices and improve safeguards when they are used.[36]

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33 The Hon Jai Rowell MP, Minister for Mental Health & Assistant Minister for Health, 'NSW Government delivers key improvements to mental health care', Media Release, 19 November 2014, http://www.health.nsw.gov.au/news/Documents/20141119_00.pdf (accessed 11 January 2016). See also: NSW Ministry of Health, *Review of the NSW Mental Health Act 2007—Report for NSW Parliament*, May 2013, pp i–iv, http://www.health.nsw.gov.au/mhdao/Documents/Review-of-the-Mental-Health-Act-2007.pdf (accessed 11 January 2016).

34 *Mental Health Act 2007* (NSW), s. 3(a).

35 The Mental Health Bill 2015, a product of the review, is still being considered by the Queensland parliament.

36 Queensland Health, 'Review of the *Mental Health Act* 2000: Discussion Paper, May 2014, pp 10, 11, 23, 28 & 34, http://www.qmhc.qld.gov.au/wp-content/uploads/2014/02/Mental-Heath-Act-Discussion-Paper.pdf (accessed 15 January 2016).

Outcomes

6.44 The Queensland parliament has recently passed the *Mental Health Act 2016*. The main objects of the Bill are:

> • to improve and maintain the health and wellbeing of persons with a mental illness who do not have the capacity to consent to treatment
>
> • to enable persons to be diverted from the criminal justice system if found to have been of unsound mind at the time of an alleged offence or to be unfit for trial, and
>
> • to protect the community if persons diverted from the criminal justice system may be at risk of harming others.[37]

Victoria

6.45 The Victorian Government recently passed the *Medical Treatment Planning and Decisions Bill 2016* (Bill), which provides for the Victorian Civil and Administrative Tribunal to make an order in relation to the decision making capacity of a person in relation to medical decisions, and establishes who can be appointed as a medical decision maker of behalf of a person deemed not to have such capacity. The Bill also contains provisions around advanced care planning.[38]

6.46 The Victorian Government stated the reasons for the change was to give statutory recognition to advance care directives, and to 'simplify Victoria's medical treatment laws to clarify people's rights and obligations by removing the current array of relevant laws to create a single framework for medical treatment decision making for people without capacity.' The changes include separating medical decisions from other powers of attorney to ensure such decisions are considered separately from issues such as financial decisions.[39]

South Australia

6.47 The South Australian *Mental Health Act 2009* was reviewed by the Office of the Chief Psychiatrist with a report issued in May 2014. It should be noted that SA is the only jurisdiction that has three levels of inpatient and community treatment orders that reflect the differing durations of illnesses and treatment (i.e. short, medium and long).

6.48 This review found that

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37 Explanatory Note (EN), *Queensland Mental Health Bill 2015*, p. 1, http://www.legislation.qld.gov.au/Bills/55PDF/2015/MentalHealthB15E.pdf (accessed 7 March 2016).

38 Explanatory Memorandum, *Medical Treatment Planning and Decisions Bill 2016* (Bill), pp. 1–3.

39 Department of Health and Human Services (Victoria), *Medical Treatment Planning and Decisions Bill 2016 - frequently asked questions*, https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/medical-treatment-planning-and-decisions-bill/frequently-asked-questions (accessed 3 November 2016).

- Level 1 community orders were underutilised and recommended that these types of involuntary orders be made more accessible by removing the requirement for these to be reviewed by the Guardianship Board.[40] Broader use of and easier access to Level 1 community orders may lead to a reduction in Level 1 inpatient treatment orders (inpatient orders).
- There is a need for early revocation of level 3 orders if a psychiatrist deems that a patient has sufficiently recovered to continue their treatment in the community without a review tribunal hearing.
- Simplification of the administrative requirements for psychiatrists.
- A 'threshold criteria for involuntary treatment should include a capacity criterion' as is the case in NT, Queensland, Tasmania and WA'.[41]

6.49 The impact of the review recommendation on practise in South Australia is not known to the committee.

Australian Capital Territory

6.50 A review of the *Mental Health (Treatment and Care) Act 1994* commenced in 2006.

Outcomes

6.51 The *Mental Health Act 2015* was passed in late 2015. This new Act incorporates some of the suggested changes made during the review of the former Act including:

- A focus on recovery.
- Availability and access to early preventative treatment for people with mental illness.
- Extension of permissible period for involuntary detention from 10 up to 14 days.[42]
- That the ACT Civil and Administrative Tribunal must take into account the following when making a forensic mental health order:
    - whether the person consents, refuses to consent or has the decision-making capacity to consent, to the proposed treatment, care or support.

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40 A Level 1 community order requires an individual to receive involuntary treatment for a mental health issue whilst living in the community. It has effect for 28 days.

41 South Australian Health, Office of the Chief Psychiatrist, 'The Review of the *Mental Health Act 2009*', May 2014, pp 44–46, 48–51, http://www.sahealth.sa.gov.au/wps/wcm/connect/f2df5880450e379a8164d1005ba75f87/Mental+Health+Act+Review+Report+MHSA+20140805.pdf?MOD=AJPERES&CACHEID=f2df5880450e379a8164d1005ba75f87 (accessed 15 January 2016).

42 This can result in a longer initial involuntary holding but mitigates the risk of the 'ACAT having to make a longer term order than it might have, had the treating team had more time in which to observe the person's responses to treatment and had the person had more time in which to recover'.

- whether there are reasonable grounds that the person has seriously endangered or is likely to seriously endanger public safety.

- A new scheme for the transfer of prisoners with a mental illness from a correctional facility to an approved mental health facility.[43]

Committee view

6.52 The committee notes work undertaken at a Commonwealth level to provide advice to states and territories on ways to make mental health laws more consistent across the jurisdictions, particularly with a view to sharing best practice initiatives:

- Australian Law Reform Commission's *Equality, Capacity and Disability in Commonwealth Laws* report, and

- Council of Australian Governments *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*.

6.53 However, the implementation of best practice initiatives across Australia has been left to states and territories to address individually and remains patchy at best. It is clear that a significant task remains for some states and territories to bring mental health acts into line with nationally accepted standards.

43 Revised Explanatory Statement, Mental Health (Treatment and Care) Amendment Bill 2014 (ACT), pp 5–33, http://www.legislation.act.gov.au/es/db_49560/20141030-59397/pdf/db_49560.pdf (accessed 15 January 2016).