

Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS)

The Plain Language Guide for the Mental Health Act 2015
(Australian Capital Territory) , February 2016



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Overview of the Plain Language Guide to the *Mental Health Act 2015 (ACT)*

The Plain Language Guide ('the Guide') is designed to provide the reader with a general understanding of how the Mental Health Act 2015 ('the Act') and associated law affects them. It is particularly aimed at people living with a mental illness or mental disorder, as well as their close family, friends and carers. It can also be used by the various health and other professionals working with them.

The Guide:

- attempts to highlight new additions or changes from the previous *Mental Health (Treatment & Care) Act 1994*;
- seeks to provide information around the general principles for the Act, including the rights of people living with a mental illness or mental disorder regarding their assessment, treatment, care or support;
- sets out to describe the range of people and organisations that are involved with the Act, outlining their specific rights, roles and responsibilities;
- seeks to explain a number of measures that a person with a mental illness or mental disorder can invoke to ensure that their preferences and consent for treatment, care or support are still respected in the event that they lose the capacity to make decisions for themselves;
- sets out a number of the more significant and common processes that may occur under the Act, including those related to Mental Health Orders; and
- attempts to provide the reader with useful information in a more readily-accessible and easily understandable format.

However, this Guide has not been designed, nor should be considered, as an alternative to the Act. The Guide does not provide a complete overview or interpretation of the Act. For the purpose of brevity this Guide mainly focuses on those provisions within the Act that are more 'operational' in nature and have the most significant effects on people. This includes the person with a mental illness or disorder, their families, carers, close friends, as well as the various agencies and services that must also operate in accordance with the Act. The Guide does not seek to address a number of the more 'administrative' elements of the Act; for those areas where it does seek to provide some explanation of these elements, they are covered in less detail.

NOTE: This Guide is not a legally binding document and, as such, the reader should always refer to the Act for the most definitive understanding, interpretation and explanation of the Act itself, particularly when making any decisions in relation to the Act. The ACT Legislative Assembly has provided explanatory statements to guide interpretation of the Act. These are available on the ACT Government Legislation website.

Part 1: The Act and the key principles and stakeholders

1.1 What is the Act?

The Act refers to the law that applies to the assessment, treatment, care or support of people experiencing a mental illness or mental disorder. The Act is designed to maximise the involvement of people who experience a mental illness or mental disorder in their own treatment, care and support. In particular, it seeks to support people to make their own decisions.

The Act comes into effect from 1 March 2016 and replaces the previous *Mental Health (Treatment & Care) Act 1994*.

1.1.1 What is a mental illness and what is a mental disorder?

For the purpose of the Act, a **mental illness** is a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person in one or more areas of their thought, mood, volition, perception, orientation or memory. It has one or more of the following symptoms: delusions, hallucinations, serious disorders of streams of thought, serious disorders of thought form, serious disturbance of mood. The most common mental illnesses dealt with under this law are depression, anxiety (e.g. post-traumatic stress disorder), schizophrenia, and bipolar conditions.

Under the Act, a **mental disorder** is a condition that is not a mental illness, but a disturbance or defect, that substantially disables a person's perceptual interpretation, comprehension, reasoning, learning, judgement, memory, motivation or emotion. This may be caused by conditions including dementia (e.g. Alzheimer's disease), intellectual disability, acquired brain injury, other degenerative neurological conditions (e.g. Huntington's disease), eating disorders (e.g. anorexia nervosa), and personality disorders (e.g. borderline personality disorder).

1.1.2 What is treatment, care or support?

Treatment, care or support for a mental illness or mental disorder refers to those things done (in a professional capacity) to remedy the illness or disorder or lessen its ill effects or the pain or suffering it causes. This could include medication and counselling, training, or therapeutic and rehabilitation programs.

1.2 Who is affected by the Act?

The Act is for all people who experience a mental illness or mental disorder, as well as their family, carers and significant others. It also instructs professionals, such as mental health workers, ambulance and police officers, in terms of their requirements and responsibilities in providing care, treatment and support under the Act. This Act predominantly applies in the Australian Capital Territory (ACT), and the Jervis Bay Territory (JBT). However, some sections of the Act *apply* to people moving between the ACT and other states and territories.

1.3 What does the Act seek to achieve?

What the Act is trying to achieve is set out in the 'Principles' and 'Objects' sections of the Act.

The principles that apply to the Act aim to protect the human rights of people with mental disorder or mental illness. Under these principles a person with mental disorder or mental illness has:

- the same rights and responsibilities as other members of the community and should be supported to exercise those rights and responsibilities without discrimination;
- the right to consent to, refuse or stop treatment, care or support whenever they have the capacity to do so;
- the right to determine their own recovery;
- the right to have their wishes and preferences taken into account in decisions about their treatment, care or support;
- the right to access the best treatment care and support to help their recovery;

- the right to receive services that are sensitive and responsive to their age, gender, culture, language, religion, sexuality, experience of trauma and other life experiences, and which promote their dignity and autonomy;
- the right to receive timely information in a way that they can best understand, that will help them make decisions about their treatment, care or support; and
- the right to communicate in the easiest way possible with others.

Those who are providing services to people with mental illness or disorder should:

- respect the informed consent of the person's decision about the treatment, care or support and support the person in making their own decisions about their recovery;
- assume that a person with a mental illness or disorder has decision-making capacity, unless established otherwise;
- deliver the best possible treatment and care, with a high level of skill, for the benefit of the person;
- recognise the experience and knowledge that family, friends and carers have about the person's mental illness and mental disorder;
- acknowledge the impact of mental illness and mental disorder on close relatives, friends and carers; and
- involve family, friends and carers in treatment, care or support decisions in partnership with the person's treating team.

1.4 What is decision-making capacity?

Under the Act, a person has capacity to make a decision in relation to their treatment, care or support for a mental disorder or mental illness (**decision-making capacity**) if the person can do all of the following (with assistance if needed):

- understand when a decision needs to be made about their treatment, care or support;
- understand the facts of the decision;
- understand the main choices available to the person in relation to the decision;
- weigh up the consequences of the main choices;

- understand how the consequences affect the person;
- make the decision on the basis of the above information; and
- communicate the decision in whatever way they can.

1.4.1 What is supported decision-making?

Supported decision-making means providing a person with the help they need to allow them to make decisions about their treatment, care or support. This may involve providing information about treatment and care in different ways (e.g. the use of an interpreter or translation service) and involving other people that the person trusts (e.g. a family member, carer or close friend) in helping the person understand and make decisions about their treatment and care.

1.4.2 Features of decision-making capacity

The Act provides a set of principles that must be used when assessing the decision-making capacity of people for each decision about their treatment, care, support, detention or movement.

This includes:

- A separate assessment of decision-making capacity needs to be made for each decision.
- For example, a person may be assessed as not having decision-making capacity in terms of the best form of intervention to treat their mental health condition. However, this does not necessarily mean they do not have decision-making capacity regarding where they should live.
- People must be supported to make decisions about their treatment, care or support to the best of their ability.
- A person needs assistance through all available steps to make decisions. If they still do not have capacity, only then may they be treated as not having decision-making capacity.
 - Making an unwise or bad decision does not mean that a person does not have capacity to make that decision.

- Being found to have impaired decision-making capacity under a different law (e.g. Guardianship and Management of Property Act 1991), does not mean that a person should be treated as having impaired decision-making capacity under the Act.
- Accepting treatment, care or support does not mean that a person has decision-making capacity. On the other hand, if a person rejects treatment, care or support, they may still have decision-making capacity.
- People move between having and not having the capacity to make decisions. A person must be given the opportunity to make a decision at a time when they have capacity.

Case study

Mary, a 47 year old lady has a diagnosis of bipolar disorder and has been brought to hospital by her husband for review. Mary has not slept for the past three days, she claims to have special powers and has been sharing these ideas with other people. Mary has also been spending excessive amounts of money and is uninhibited in her behaviour. She ceased her medication two weeks ago. Mary was then offered an alternative medication at the hospital; however she declined as she believes she is not unwell.

To assess Mary's decision-making capacity, staff works with her to help her:

- understand when a decision about treatment, care or support needs to be made;
- understand the treatment choices that are available to her at this time and the facts that relate to her decision;
- weigh up the consequences of those choices;
- consider how the consequences will affect her; and
- communicate her decision.

After this support, Mary still refuses to accept the new medication as she continues to believe that she is not unwell. At this point she is assessed not to have decision-making capacity.

1.4.3 What happens if a person does not have capacity?

Where someone is found not to have decision-making capacity about their mental health treatment, care or support, there are a range of processes to support decision-making in the best interests of the individual. These are explained below.

1.4.4 How are the person's best interests determined?

Deciding what are in the best interests of the person is based on an assessment. This involves weighing up the advantages and disadvantages of making a particular decision for treatment, care or support. These include the person's broader welfare interests, abilities, impacts on their family and likely future outcomes for having (or not having) the treatment, care or support. Best interests are specific to the person for whom the decision is being made.

A decision in the best interests of a person is generally one that a person would make themselves, if they had the capacity to do so at that point in time. It is not necessarily the same decision that another person would make.

Things that are considered in a best interests assessment:

- What the person has said in the past about their decisions on the topic when they did have capacity. For example, what treatment, care or support the person identified previously should be considered.
- Presently expressed views of the person for whom the decision is to be made.
- The nature of the different treatment, care or support that is available. This includes what it involves and its prospects of success.
- The advantages and disadvantages of each available course of action (including not receiving treatment, care or support).
- The likely outcomes (for the person's whole life) of each available course of action (including not receiving treatment, care or support).
- Consultations with the person's close friends, close family and other decision-makers involved in their life (e.g. Attorney, health attorney or guardian).

1.5 Key stakeholders

There are a number of people, agencies and other parties which play an important role in the application of the Act. These include, but are not limited to:

People living with a mental illness or mental disorder

The Act is designed to maximise the involvement of people who experience a mental illness or mental disorder in their own treatment, care, and support. In particular, it seeks to support these people to make their own decisions.

People closely connected with people experiencing mental illness or mental disorder

People who are closely connected with the person experiencing a mental illness or mental disorder include partners, parents (and people with parental responsibility), friends and family members, and carers. The Act seeks to allow them to be better informed about what is happening to their loved ones, and to be involved in decisions that are being made about them.

Carers of people living with a mental illness

A carer (in this Act) provides personal care, support or assistance to a person who has a mental illness or mental disorder. Carers provide important support to people who experience mental illness and mental disorder. People can be carers (in this Act) if they are a partner, parent, child, relative, guardian of the person, or if they live with a person who experiences mental illnesses or disorders. However, they are not automatically deemed a carer simply because they hold such a place/position in a person's life. A person is not a carer for the purposes of the Act if they are employed to provide care, support or assistance or as a volunteer working for an organisation, or as part of a course of education or training.

Parents and other people with parental responsibility

Parents and other people with parental responsibility have certain rights when it comes to people involved with the Act aged under 18 years. These include receiving information and having involvement in decisions that are made about the person.

Nominated persons

Nominated persons help a person with a mental illness or mental disorder by ensuring the person's interests are respected if they require mental health treatment, care or support. Nominated persons also receive information and are involved (consulted) in decisions in relation to the treatment, care or support provided to the person experiencing the mental illness or mental disorder. However, a nominated person does not have the power to make treatment or other decisions on behalf of the person with a mental illness or mental disorder. A nominated person needs to be an adult (18 years or over), able to perform the role (described above), be easily available, and agree to the nomination.

The treating team

For the purpose of this guide and the Act, the treating team refers to the group of people who work together to provide treatment (care or support) to a person living with a mental illness or mental disorder. This includes allied health staff, doctors, nurses, paramedics and professional carers (including staff of community sector agencies) who are employed to work in a person's home or supported accommodation.

The Chief Psychiatrist

The Chief Psychiatrist is employed by ACT Health and has a range of important roles and functions under the Act. This includes responsibility for the treatment, care or support of any person who is subject to a Psychiatric Treatment Order (see relevant section below). The Chief Psychiatrist is able to delegate some functions to Psychiatrists employed by ACT Health.

The Care Coordinator

The Care Coordinator is responsible for coordinating the provision of treatment, care or support for a person living with a mental disorder who is subject to a Community Care Order (see relevant section below). The Care Coordinator is also an employee of ACT Government. The Care Coordinator may delegate many of their functions under this Act to a suitable public servant if the Care Coordinator is satisfied they have the training experience and personal qualities required to exercise the functions.

The ACT Civil and Administrative Tribunal (ACAT)

The ACT Civil and Administrative Tribunal (ACAT) is tasked with making a range of decisions under the Act in regards to a person's mental health treatment, care or support. This includes responsibility for making decisions about whether or not to grant Mental Health Orders, based on their judgement around a submitted application.

The ACT Supreme Court

Regarding mental health, the ACT Supreme Court is tasked with making decisions about matters including consent to electroconvulsive therapy, and consent to psychiatric surgery. The Supreme Court can also hear appeals of decisions made by ACAT. The Supreme Court also refers certain cases to the ACT Civil and Administrative Tribunal for decisions about certain issues. These include decisions about capacity for a person to plead under the *Crimes Act 1900 (ACT)* and the *Children and Young People Act 2008 (ACT)*.

Lawyers

Lawyers are important in the formal processes under the Act. This includes situations where people appear at ACAT hearings. Lawyers can support people to understand the legal implications of applications and orders that are made in these processes. Lawyers can also make formal legal arguments and advocate on behalf of people in these situations. Legal Aid provides legal advice to people in Canberra's mental health facilities, at ACAT, and in their Civic office.

The Public Advocate of the ACT

The role of the Public Advocate of the ACT is to protect and promote the rights and interests of vulnerable people in the ACT. The Act says the Public Advocate of the ACT must receive certain information and be consulted about decisions that are being made on the treatment, care or support of people living with mental illnesses or disorders. This is done for those people who have impaired decision-making capacity and for whom there is no-one else suitable or available to make decisions on their behalf. Public guardians are empowered to make the same decisions as other guardians (see below).

Advocacy

Advocacy services in the ACT provide support to people with disabilities, including mental illness and mental disorders. They can help to ensure that the preferences and views of these people are heard in processes such as assessment orders, Mental Health Orders, decisions for treatment care and support, and review processes. They also provide supported-decision making services. Advocacy services in the ACT include the ACT Disability, Aged and Carer Advocacy Service (ADACAS), and Advocacy for Inclusion.

Guardians

Guardians are people granted the power to make decisions on behalf of those who have lost the capacity to make those decisions for themselves. All guardians, including public guardians, are appointed by ACAT under the *Guardianship and Management of Property Act 1991 (ACT)*. A guardian's decision is not enforceable against the person's disagreement. Guardians are required to be consulted about decisions made by ACAT, the Chief Psychiatrist or the Care Coordinator (or their delegates).

Power of Attorney

People with power of attorney can make a range of decisions for a person who does not have capacity to make those decisions. A person can give someone power of attorney for their affairs while they have the capacity to do so under the *Powers of Attorney Act 2006 (ACT)*. This is done in anticipation that there might be times when they don't have capacity to make those decisions themselves. In relation to mental health treatment, a person with power of attorney may consent for treatment that the person living with mental illness or a mental disorder does not refuse to receive. This does not include psychiatric-surgery or electroconvulsive therapy (ECT).

Health attorney

A health attorney is someone closely connected to a person, who can consent to medical treatment on a person's behalf at the request of a doctor or dentist. This is for immediate or short-term treatment. For consent to treatment for longer-term impairment, an application should be made to appoint a guardian. All of this is done under the *Guardianship and Management of Property Act 1991 (ACT)*.

Under some sections of the Act, health attorneys (like guardians and people with powers of attorney) are able to provide consent and/or are required to be involved in decisions about the assessment, treatment, care or support for people with a mental illness or mental disorder.

Official visitors

Official visitors visit locations where people are being provided treatment, care or support, including mental health facilities. One of their roles is to monitor facilities to ensure that they are operating in accordance with the Act and a person's rights are being upheld. Official visitors are also an avenue for receiving feedback (both positive and negative) from people who are in the care of the ACT Government, including those receiving involuntary treatment or care.

Mental Health Officers

Mental Health Officers are specific nurses or allied health professionals appointed by the Minister for Health (or the Chief Psychiatrist as delegate) to carry out various activities under the Act. In emergency situations they are allowed to take a person who they believe has a mental illness or mental disorder and requires immediate treatment to an approved mental health facility. Mental Health Officers must carry an identification card (which they must show on request).

Ambulance paramedics

Authorised ambulance paramedics can conduct apprehensions under the Act. They are then able to transfer people to mental health facilities for assessment and treatment where they believe that the person has a mental illness or disorder and has attempted (or is likely to) suicide or to inflict *serious* harm to themselves or others. Ambulance officers (who are authorised) have been given these emergency powers to enable people with mental illnesses to be taken to hospital in the same way as people with physical illnesses.

Police officers

Under the Act, police officers can make emergency apprehensions if they believe the person has a mental illness or disorder and has attempted (or is likely to) suicide or cause serious harm to themselves or others. In general, police officers should restrict their role in apprehension and transport to situations where they are providing protection to the community. Health professionals should assist the police to apprehend and transfer wherever possible.

Part 2: Making choices and giving consent to treatment, care or support

There are a number of ways that a person who has decision-making capacity can express their treatment, care or support preferences before possible future temporary or permanent loss of decision-making capacity. These include entering into an Advance Agreement and/or Advance Consent Direction, and/or nominating a nominated person or enduring power of attorney.

2.1 Advance Agreements

An Advance Agreement is a written document stating a person's preferences for future mental health treatment, care or support. It is used when a person's ability to participate in decisions about their treatment and support is significantly impaired.

The Advance Agreement includes:

- the person's expressed preferences for treatment;
- the person's preferences, such as practical arrangements for looking after their property or pets when they are in need of treatment, care or support; and
- contact details about important people such as carers, guardians, legal representatives or a nominated person.

The wishes expressed in a person's Advance Agreement form the basis of the treating team's approach in supporting the person's recovery. They will be taken into account when making decisions about treatment, care or support. The Advance Agreement will be followed provided that the treatment is working and is considered in their best interest at the time.

If a person's wishes cannot be followed at the time (for example, if the preferred person is not available to care for the person's property), they can be amended by a doctor's notation in the person's clinical record.

2.1.1 Making an Advance Agreement

The preferences stated in the Advance Agreement are discussed and agreed between the person and those identified in their support team. These include personal, clinical ('treating team') and other important individuals in the person's life. A close family member, 'nominated person' or significant other may assist the person in developing the Advance Agreement.

The Advance Agreement needs to be written and signed by the person, a representative of their 'treating team', and their nominated person (if they have one). It can also be signed by someone providing practical help to the person.

A copy of an Advanced Agreement must also be given to the nominated person (where one is identified) and any member of the person's treating team who does not have access to the person's clinical record (for example, the person's General Practitioner).

Sharing an Advance Agreement with others is also the person's choice. They are not required to provide it to anyone else if they are not comfortable. A person can also give only the relevant sections of the Advance Agreement to those individuals who might need it. For example, information can be left out about medication choices in the copy provided to the person who cares for their pets while they are in hospital.

A form for making an Advance Agreement is available on request from mental health community-based services and inpatient units.

2.1.2 Limitations on an Advance Agreement

- Health professionals will refer to an Advance Agreement for guidance during a time of mental health crisis such as an admission to hospital. The preferences outlined in the Advance Agreement will be used to guide treatment as long as they are in the person's best interest at the time. If a person wants their preferences, which are written in the Advance Agreement, to be binding, they need to include these in an Advance Consent Direction (see section below).
- Advance Agreements are only valid in the ACT, as they are currently not recognised in other states.
- Advance Agreements can only be taken into account if the information is available when needed. Therefore, it is important that an Advance

Agreement is easily available for the health professionals and support people who are listed on it. A provider of treatment, care or support needs to take reasonable steps to find out if a person has an Advance Agreement. Mental Health Service clinicians will keep a summary of the Advance Agreement on a person's electronic clinical record, which can be accessed when needed.

2.1.3 Ending an Advance Agreement

A person can end an Advance Agreement at any time if they have decision-making capacity. A person can end an Advance Agreement by informing a member of their treating team verbally or in writing (e.g. by letter or email) that they want it to cease. A person can choose to end the Advance Agreement on that day or on a future specified date. Additionally, a person can end an Advance Agreement by entering into a new one. If a person ends their Advance Agreement, this must be entered into their clinical record, and they must be told that it has been entered and be given a copy of the information entered.

2.2 Advance Consent Directions

An Advance Consent Direction contains major decisions about treatment that a person consents to receiving if their mental illness or mental disorder means they don't have decision-making capacity. An Advance Consent Direction sets out information including the:

- treatment, care or support the person is willing to receive;
- medications or procedures the person is willing, and not willing, to receive; and
- people who may, and may not, be given information about the person's treatment, care or support.

A person must consult with their treating team about their treatment, care or support.

An Advance Consent Direction can include consent for Electroconvulsive Therapy (ECT). Refer to the ECT section for details.

2.2.1 Making an Advance Consent Direction

To make an Advance Consent Direction a person must have decision-making capacity and have consulted with their treating team. This involves talking to them about options for treatment, care or support for their mental illness or mental disorder.

A close family member, 'nominated person' or significant other may assist the person in developing the Advance Consent Direction.

The Advance Consent Direction needs to be written down and signed by the person making the direction, a representative of their 'treating team', and a witness to both the person and the treating team representative. The witness must not be someone providing treatment to the person.

An Advance Consent Direction form is available on request from mental health community-based services and inpatient units.

Copies of an Advance Consent Direction must be given to:

- the person making the Advance Consent Direction;
- the nominated person (where one is identified);
- any member of the person's treating team who does not have access to the person's clinical record (for example, the person's General Practitioner)
- the person's guardian and ACAT (if the person has a guardian); and
- The person's attorney if they have a person with power of attorney.

2.2.2 Limitations on Advance Consent Directions

If a person who has an Advance Consent Direction does not have decision-making capacity and resists treatment they have previously given consent to, the treating team can only give the treatment on ACAT's orders.

For example, Graham who has a diagnosis of severe anxiety, has previously developed an Advance Consent Direction with his treating team. As part of his Advance Consent Direction he agreed to take certain medication if his anxiety worsened. His health has now deteriorated and he is refusing to take the medication. The treating team still believe that this medication is the best treatment for Graham. The team cannot give Graham this medication without applying to ACAT. If ACAT orders the medication be given, the team can administer it to Graham.

The treating team may only give different treatment if they believe the treatment, care or support, for which the person has previously given consent, is not safe or appropriate and the:

- person agrees; and
- guardian, attorney, health attorney agree; or
- ACAT orders the treatment, care or support be given.

2.2.3 Ending an Advance Consent Direction

A person can end an Advance Consent Direction at any time if they have decision-making capacity. A person can end an Advance Consent Direction by informing a member of their treating team verbally or in writing (e.g. by letter or email). A person can choose to end the Advance Consent Direction that day or at a future specified date. A person can also end an Advance Consent Direction by entering into a new one. If a person ends their Advance Consent Direction, this must be entered into their clinical record, and they must be told that it has been entered and be given a copy of the information entered.

2.3 The difference between Advance Agreements/Advance Consent Directions and Health Directions

A Health Direction is a written statement advising of the medical treatment a person *does not* consent to being given, or the medical treatment they want withdrawn (generally or specifically) in the event they do not have decision-making capacity. Advance Agreements and Advance Consent Directions are more specifically designed to identify the mental health treatment, care or support that a person does consent to in the event they do not have decision-making capacity.

Health Directions are made under the *Medical Treatment (Health Directions) Act 2006 (ACT)* whereas Advance Agreements/Advance Consent Directions are made under the Act.

If a person makes an Advance Consent Direction and then makes a Health Direction, then the Advanced Consent Direction no longer applies to any area of treatment outlined in the Health Direction.

If a person makes a Health Direction and then a guardian is appointed for that person under the *Guardianship and Management of Property Act 1991* then the guardian must make decisions that are consistent with the Health Direction. Additionally, if a person with a Health Direction has an enduring power of attorney (which deals with health matters), then the Health Direction is revoked.

2.4 A 'nominated person'

As described (in section 1.6 'Key Stakeholders'), the role of a 'nominated person' is to help a person living with a mental illness or mental disorder by making sure their interests are respected if they require treatment, care or support for their condition. The nominated person can receive information, and be involved in (and consulted about) decisions in relation to a person's treatment, care or support. The nominated person must be notified and supplied with information when various things are done under the Act. A nominated person can be a close relative or close friend, a carer, neighbour or any other individual. A person may also nominate another individual as an 'alternate nominated person'.

2.4.1 Protection from liability

A nominated person is not civilly liable for anything that they do (or not do) honestly (and without recklessness) in being a nominated person under the Act. This is designed to assist the nominated person to perform their role effectively and properly.

2.4.2 Nomination criteria

- Only a person who is living with a mental illness or mental disorder can have a nominated person. They need to have the capacity to make that decision.
- The nominated person must be an adult (18 years or over), be able to undertake the functions of the role, be easily available, and agree to the nomination.

2.4.3 Situations in which a nominated person must be consulted

If the person with a mental illness or mental disorder is receiving treatment, care or support at an approved mental health facility or community care facility, the person in charge of the facility is required to 'take all reasonable steps' to:

- ask the person receiving treatment, care or support whether they have a nominated person;
- ensure that details and the written nomination of the nominated person are kept with the person's records;
- ensure that the currency of the nomination and nominated person's details are checked periodically; and
- ensure that ACAT is given the nominated person's name and contact information, if ACAT is involved in decisions about the person.

The person must also be given the opportunity and access to facilities, such as a telephone, to contact their nominated person (along with other people).

There are a range of situations where the nominated person must be consulted by various parties, including:

- ACAT before they make a Mental Health Order.
- The Chief Psychiatrist (or their delegate) before deciding to treat the person with a mental illness or mental disorder under a psychiatric treatment order.
- The Chief Psychiatrist (or their delegate) if they form the belief that the person with a mental illness or mental disorder should no longer be subject to a psychiatric treatment order.
- The Care Coordinator (or their delegate) before making a decision when and where a person is required to attend to receive treatment, care or support under a community care order (or a restriction order).
- The Chief Psychiatrist (or their delegate) must, as soon as possible after authorising the involuntary detention of a person, take all reasonable steps to give required information about the detention to the nominated person.

A nominated person may appear and give evidence at the hearing or a proceeding in ACAT or Supreme Court regarding the person who nominated them.

2.4.4 Ending a nomination

The Nomination can be ended in the following three ways:

- the person who made the nomination has decision-making capacity and tells a member of their treating team, orally or in writing, that they no longer want the nominated person to perform the functions for them;
- the nominated person informs a member of the person's treating team, verbally or in writing, that they are unable to perform the functions of a nominated person; and
- the Chief Psychiatrist decides on reasonable grounds that the nominated person is unable to perform the functions of a nominated person.
 - The member of the person's treating team who is told about a nomination ending is obliged to ensure that:
 - as soon as practicable, information about the end of the nomination is entered in the person's clinical record;
 - the person is told that the information has been entered in their record; and
 - the person is given a copy of the information entered in their record.

If the Chief Psychiatrist ends the person's nomination they must advise the person who made the nomination, the nominated person and a member of the person's treating team and record their reasons for doing so. They must also advise the person about advocacy services and, if the person has decision-making capacity, ask if there is another person they wish to nominate.

Regardless of who ends the nomination, it ceases effect on the day the verbal or written notice is given, or at a later date if specified in writing.

2.5 Enduring power of attorney

When a person has capacity to do so, they can make an enduring power of attorney.

An appointed attorney can only make decisions about health matters, including mental health matters, while the person does not have the capacity. If a person without decision-making capacity is refusing mental health treatment, care or support, then an application for a Mental Health Order must be made before treatment can be given.

2.5.1 The difference between an enduring power of attorney and a nominated person

A person with enduring power of attorney can make decisions about a wide range of matters, which must be specified in the written document appointing them. This can include decisions about a person's finances and property, as well as their treatment. The enduring power of attorney can make these decisions when the person does not have capacity to do so themselves.

In contrast, a nominated person is more specifically involved in decisions and support for a person. In a general, a nominated person advocates for an individual by taking into account the person's wishes at a particular time, even if it differs to what the person would want when they don't have decision-making capacity.

Part 3: Assessment

Assessments are used to check whether a person has a mental illness or mental disorder and, if so, whether there is any treatment, care or support that might help.

There are two main types of assessment that might take place under the Act:

A psychiatric assessment, which seeks to determine whether a person has a mental illness, and if so, whether it can be diagnosed; or

A psychological assessment, which seeks to determine whether a person has a mental disorder.

Assessments are used if an application is made to ACAT for a Mental Health Order or a Forensic Mental Health Order.

3.1 Application for an assessment order

Anyone, including but not limited to the person themselves, a family member, member of the public or a health professional, can apply to ACAT for an Assessment Order to be made if they believe that the person, because of a mental disorder or mental illness, is:

- unable to make reasonable choices and decisions (judgements) about their own health and safety; or
- unable to do something to look after their own health and safety; or
- likely to do serious harm to themselves or to others.

The Assessment Order application is completed on the form provided by ACAT.

3.2 Granting of an Assessment Order

If ACAT grants an Assessment Order, it provides the legal authority for conducting the assessment. The Assessment Order itself is provided to the person. It must provide information about the type of assessment (e.g. psychiatric or psychological) to be conducted, the name of the health professional who will conduct the assessment (if this is known) and where it will occur.

Most assessments are conducted in community health centres. However, at times, the Assessment Order may request that the person be detained in the mental health facility for the purpose of the assessment. The assessment should be conducted within seven days of the Assessment Order being granted, unless otherwise stated.

3.3 The assessment process

In an assessment, the health professional will observe the person and ask them a range of questions.

They will assess whether or not the person's situation, history, behaviour, thoughts, feelings and experiences suggest the presence of a mental illness or mental disorder.

In order to conduct a thorough assessment, the health professional will discuss a range of matters with the person. This includes, but is not limited to, medical history, childhood and early development, any use of alcohol and/or other drugs, family medical history. A thorough assessment also includes information provided by other people, such as carers, close friends, family members and significant others, where available and appropriate to do so.

If a person is taken into a mental health facility for an assessment they must be allowed to contact (e.g. by phone, text, or email):

- a relative or friend; and
- the public advocate; and
- a lawyer; and

As a general rule, a person should be able to contact all the people that need to know about their situation (e.g. their nominated person).

3.3.1 What happens after the assessment is completed?

After the assessment interview has been completed, the person is free to leave unless they are required to be detained under emergency detention requirements of the Act (see Part 5: 'Emergency apprehension and detention').

The health professional who conducts the assessment must write an assessment report. This report will contain some or all of the following:

- a history of the present situation (illness/disorder);
- results of a mental state examination;
- psychiatric history or past treatments;
- a personal history of the person (including their family, early life, and development);
- medical history;
- current medications;
- drug and alcohol history;
- forensic history (if any);
- risk assessment;
- impression or diagnosis;
- recommendations about whether or not a Mental Health Order is needed; and
- proposed action or management plan for the person.

If a person requires assistance understanding or responding to the assessment they can contact the person who conducted the assessment or other services such as Legal Aid and the ACT Disability, Aged and Carer Advocacy Service (ADACAS).

Following an assessment, a copy of this assessment report must be given to:

- the person assessed;
- ACAT;
- those who have parental responsibility, if the person is a child.

The following people, if they are involved in the person's care, should also be told, in writing about the outcome of the assessment:

- the nominated person;
- the guardian;
- the attorney;
- the health attorney

Depending on the outcome of the assessment:

- The Chief Psychiatrist (or their delegate) may decide to apply to ACAT for a Psychiatric Treatment Order for a person with a mental illness.
- A person who has the qualifications and experience to provide the treatment, care or support required by a person with a mental disorder may apply to ACAT for a Community Care Order.

3.4 Removal Order to conduct assessments

In cases where the person fails to comply with the assessment ordered (e.g. does not attend the assessment interview as scheduled) ACAT may make a Removal Order. For this to occur, ACAT must be satisfied that the person had been made aware of the assessment order and had no reasonable excuse for failing to comply. The Removal Order authorises a police officer, mental health officer, doctor or an authorised ambulance paramedic to take the person to an approved mental health facility for the assessment to be conducted.



Part 4: Mental Health Orders

Fortunately, the majority of people with a mental disorder or mental illness will have decision-making capacity. They are able to choose whether or not they receive treatment, care or support and the form that this takes.

However, at times, where a person does not have decision-making capacity and/or where their mental illness or mental disorder is placing them or the community at significant risk, involuntary measures may be required to provide the necessary assessment, treatment, care or support for that person. The following sections outline the processes involved in assessment, treatment, care or support.

There are a number of Mental Health Orders that ACAT can make under the Act including:

- Psychiatric Treatment Orders (for people who have a mental illness);
- Community Care Orders (for people who have a mental disorder);
- Restriction Orders (for ordering where a person with a mental illness or mental disorder must reside/be detained or not approach particular places or people or do particular activities);
- Forensic Psychiatric Treatment Orders; and
- Forensic Community Care Orders.

Each type of Mental Health Orders are explained below (Forensic Mental Health Orders are explained in Part 6).

4.1 The role of the ACT Civil and Administrative Tribunal (ACAT) in regards to Mental Health Orders

The ACT Civil and Administrative Tribunal (ACAT) is tasked with making a range of decisions under the Act regarding a person's mental health treatment, care or support. This includes responsibility for granting Mental Health Orders, based on their judgement around an application.

4.1.1 Consultations by ACAT

Before ACAT makes a Mental Health Order, it needs to consult with a range of individuals associated with the person who is subject to the order application, including:

- parents or people with parental responsibility (if the person is under 18 years of age);
- the guardian, attorney, nominated person, or a health attorney (if the person has any of these);
- the Chief Psychiatrist (or their delegate) (if they are likely to be responsible for providing treatment to the person);
- the Care Coordinator (or their delegate) (if they are likely to be responsible for coordinating treatment, care or support to the person); and
- the individual who applied for an assessment order (if an assessment order was the process that lead ACAT to consider making a Mental Health Order).

ACAT must also tell the carer(s) (if the person has one):

- in writing about the hearing that will be conducted to consider the Mental Health Order;
- that the carer can make a submission to ACAT about the possible making of a Mental Health Order; and
- that the carer may also contact ACAT and ask to attend the hearing.

Before making an order, ACAT must also:

- ensure that a mental health assessment has been undertaken under a mental health assessment order; or
- receive an application for the particular Mental Health Order(s) being requested; and
- hold a hearing into the matter.

4.1.2 ACAT hearings

As stated above, prior to the actual hearing to consider a Mental Health Order, ACAT will review the assessment report and other relevant clinical information as provided, as well as consult with various involved people.

The hearing is a formal meeting where ACAT members are given further information and arguments can be made both verbally and in written form about whether or not a Mental Health Order should be made for a person experiencing mental illness or disorder. ACAT hearings are private, which means that only a small number of people will be able to attend and know what is being discussed.

These hearings are held in several locations but most are held at ACAT rooms at the Civic Community Health Centre on Level 4, 1 Moore St, Canberra City or the Adult Mental Health Unit at the Canberra Hospital, when a person has been admitted there. However, it is always advised to confirm the location of the hearing with ACAT before attending.

The person who is the subject of the order hearing will be asked to attend the hearing so that they may provide information and express their perspective about the matter. The person may also have a lawyer represent their interests, preferences or perspectives. A lawyer can also be provided through Legal Aid services. The person can also bring a support person with them, but only the person and their legal representative is able to speak (i.e. the support person cannot speak on behalf of the person).

In making a decision about whether or not a Mental Health Order should be made, ACAT will take the following things into consideration:

- the plan for the proposed treatment, care or support;
- the consent to proposed treatment, care or support, whether the person does consent, refuses to consent, and whether they have the decision-making capacity to consent;
- the views and wishes of the person, including those which they may have written in an Advance Agreement or an Advance Consent Direction;
- the views of people who provide the person with day-to-day care;
- the views of people that they consulted (as listed above in section 4.1.1 'Consultations by ACAT').

On any treatment, care or support that ACAT might write in the order, ACAT needs to take into account:

- the least restrictive means to provide this treatment, care or support and for it to be safe and effective;
- the purpose of the treatment, care or support;
- the benefits that the person is likely to receive from the treatment, care or support;
- the disadvantages of the treatment, care or support (including any distress, discomfort,
- risks, or side-effects); and
- the person's medical history.

4.2 Psychiatric Treatment Order (PTO)

ACAT may make a Psychiatric Treatment Order (PTO) if it finds that:

- the person has a mental illness; and
- the person refuses to receive treatment, care or support where they do not have decision-making capacity or where they do not consent to treatment, care or support and do have decision-making capacity; and
- the person is doing, or is likely to do, serious harm to themselves or someone else, or that they are suffering, or likely to suffer, serious mental or physical deterioration; and
- the harm or deterioration is so serious that it outweighs the person's right not to consent; and
- psychiatric treatment, care or support are likely to reduce the harm or deterioration (or the likelihood of it) or lead to an improvement in the mental illness that the person is experiencing; and
- the treatment care or support cannot be adequately provided to the person in another way which would involve less restriction on their freedom of choice and movement.

4.2.1 What information is included in the PTO?

A PTO includes information about the treatment, including where and when it is to be provided, the type(s) of treatment provided, and who will provide it. A PTO may be made for any period up to six months but must be reviewed before its expiry date or at any time where it is assessed as no longer necessary.

4.2.2 What happens if a PTO is granted?

Once a PTO has been made, the Chief Psychiatrist (or their delegate) is legally responsible for the treatment, care or support provided to the person who is subject to the order.

4.2.3 Decisions about treatment, care or support

The Chief Psychiatrist (or their delegate) needs to make decisions about the form of treatment, care or support, which the person will receive through a PTO and must determine:

- What psychiatric treatment, care or support the person is going to be given and ensure that the nature of the treatment, including any side effects, is explained to the person.
- Whether the person needs to be admitted to an approved mental health facility to receive treatment, care or support. If the person needs to be admitted, the determination must advise if the person can be given leave from that facility. When and where the person will need to attend to receive treatment, care or support, if the person is being treated in the community.

These decisions must be made by the Chief Psychiatrist (or their delegate) within five working days of the PTO being made by ACAT.

4.2.4 Consultation on treatment, care or support

If a psychiatric treatment order has been made for a person, the Chief Psychiatrist (or their delegate) must consult with that person. They must find out about the person's opinions and views around:

- whether or not they should be treated;
- where treatment is to occur;
- whether the person must be admitted for treatment; and
- the type(s) of treatment the person might be given.

There are a range of things that a person might wish to discuss with the Chief Psychiatrist (or their delegate). For example:

- What treatment(s) is being considered and why?
- The treatment, care or support that has worked for person previously. What types of treatment, care or support the person may or may not want and their reasons.

The person's opinions and views must be taken into consideration, but this does not necessarily mean that the treatment, care or support will be provided according to the person's wishes.

In considering the types of treatment, care or support that the person is to receive, the Chief Psychiatrist (or their delegate) should also consult with the following people, if they are involved in the person's care:

- Parent(s) or those who have parental responsibility, if the person is a child;
- the nominated person;
- the guardian;
- the attorney;
- the health attorney;
- the Corrections Director-General, if the person is a detainee, on bail or parole; and
- the Children and Young People's Director-General, if the person is a child who is a detainee or on bail.

The Chief Psychiatrist (or their delegate) must give a copy of their determination to the following people, if they are involved in the person's care:

- the person;
- those who have parental responsibility, if the person is a child;
- ACAT;
- the public advocate;
- the nominated person;
- the guardian;
- the attorney; and
- the health attorney.

4.2.5 Can a PTO be ceased?

If the Chief Psychiatrist (or their delegate) believes that a PTO is no longer required, they must notify ACAT and give notice to those (mentioned in 4.2.4) stating the reasons they believe the PTO is no longer required and seek their input.

Either the carer or nominated person is able to:

- make a submission to ACAT if they believe that the order should not be ceased; and
- apply to ACAT to attend the hearing.

4.3 Community Care Order (CCO)

A Community Care Order (CCO) is a type of Mental Health Order for people who experience a mental disorder. CCOs are applied for by a person with authority to give the treatment, care or support to the person.

ACAT may make a CCO if it finds that:

- the person has a mental *disorder*; and
- the person refuses to receive treatment, care or support and does not have decision-making capacity, or they do not consent to treatment, care or support and do have decision-making capacity; and
- there are reasonable grounds for ACAT to believe that because of the mental disorder, the person is doing, or is likely to do, serious harm to themselves or someone else, or that they are suffering, or likely to suffer, serious mental or physical deterioration; and
- the harm or deterioration is so serious that it outweighs the person's right not to consent; and
- a Psychiatric Treatment Order should not be made instead; and
- the treatment care or support cannot be adequately provided to the person in another way which would involve less restriction on their freedom of choice and movement.

4.3.1 What information is included in the CCO?

A CCO includes information about the treatment, care or support to be provided to the person. This includes where and when it is to be provided, the type(s) of treatment, care or support provided, and who will be involved in providing the treatment. A CCO may be made for a period of up to six months but must be reviewed before its expiry date or at any time where it is assessed as no longer necessary.

4.3.2 What happens if a CCO is granted?

Once a CCO has been made, the Care Coordinator is responsible for coordinating the treatment, care or support of the person who is subject to the order. The Care Coordinator will typically delegate coordination of the treatment, care or support to someone else suitably qualified to perform the role.

4.3.3 Decisions about treatment, care or support

The determination made by the Care Coordinator needs to contain when and where the person needs to go to:

- receive treatment, care or support (under the order); or
- participate in a counselling, training, therapeutic or rehabilitation program;

The Care Coordinator (or their delegate) also needs to ensure that the nature of the treatment, care or support, including any side effects, are explained to the person in a way that they are most likely to understand.

These decisions need to be made by the Care Coordinator (or their delegate) within five working days of the CCO being made by ACAT.

4.3.4 Consultation on treatment, care or support

If a CCO has been made, the Care Coordinator (or their delegate) must consult with the person who is subject to the order. The Care Coordinator (or their delegate) must try to find out the person's views concerning where and when they will be required to go to receive treatment, care or support or to participate in a counselling, training, therapeutic or rehabilitation program.

There are a range of things that a person might wish to discuss with the Care Coordinator (or their delegate). For example:

- What treatment, care or support or counselling, training, therapeutic or rehabilitation program is the Care Coordinator considering and why?
- Where and when the treatment, care or support OR counselling, training, therapeutic or rehabilitation program will take place?
- The treatment, care or support that has worked for the person previously including examples. What types of treatment, care or support the person may or may not want and the reasons for this.

In obtaining the person's opinions and views, this input must be taken into consideration by the Care Coordinator (or their delegate).

The Care Coordinator must not determine the nature of the treatment, care or support the person is to receive. Instead the Care Coordinator will consult other service provider(s) that would be responsible for providing the person with treatment, care or support, such as 'professional carers', and allied health professionals.

In considering the types of treatment, care or support that the person is to receive, the Care Coordinator (or their delegate) should consult with the following people and parties if they are involved in the person's care:

- those who have parental responsibility, if the person is a child;
- the guardian;
- the attorney;
- the carer;
- the nominated person;
- the health attorney;
- the Corrections Director-General, if the person is a detainee, on bail or parole; and
- the Children and Young People's Director-General, if the person is a child who is a detainee or on bail.

The Care Coordinator must give a copy of their determination to the following people, if they are involved in the person's care:

- the person;
- those who have parental responsibility, if the person is a child;
- ACAT;
- the public advocate;
- the guardian;
- the attorney;
- the nominated person; and
- the health attorney.

4.3.5 Can a CCO be ceased?

If the Care Coordinator believes that a CCO is no longer required, they must give notice to ACAT, and those listed in 4.3.4, stating the reasons they believe the CCO is no longer required and seeking input from them.

Either the carer or nominated person is able to:

- make a submission to ACAT if they believe that the order should not be ceased; and
- apply to ACAT to attend the hearing.

4.4 Restriction Orders

A Restriction Order can be made in addition to either a PTO or CCO for a maximum of three months.

In addition to a PTO or a CCO, ACAT may make a Restriction Order on a person if ACAT believes that:

- it is necessary to do so for the person's health and safety or the health and safety of someone else or the public; and
- treatment cannot be adequately provided in a way that involves less restriction of the person's freedom of choice and movement.

The Restriction Order may place restrictions on people or places that the person is allowed to approach, or identify specific activities the person must not undertake. A Restriction Order may also state where the person is to live, or be detained.

4.5 Limits on communication under Mental Health Orders

There are some circumstances in which a person subject to an order may be prevented from talking to, writing to or seeing other people. Examples include risks to the person's reputation or a risk that the person might be exploited.

The person is always allowed to contact and see the public advocate and their lawyer.

These specific limits are imposed by the Chief Psychiatrist (or their delegate) for PTOs or the Care Coordinator (or their delegate) for CCOs.

As part of a Mental Health Order made by ACAT, limits can be imposed on the person's communication with other people. The limitation must be necessary and reasonable and must not reduce the effectiveness of the person's treatment, care or support on their mental illness or mental disorder. If a limit is imposed on a person's communication, the person must be informed of those limits, the period of time (a maximum of seven days at a time) and the reasons for imposing the limit.

4.6 Review of orders

All Mental Health Orders can be reviewed. This includes psychiatric treatment orders, community care orders, and restriction orders.

4.6.1 What starts the review process?

- ACAT decides to initiate a review itself;
- a person who has had an order made about them applies for a review;
- a representative of a person who has had an order made about them applies for a review. Possible representatives are a guardian, an attorney, a nominated person, a close relative, a close friend, or a legal representative (lawyer);
- a Mental Health Order is in place, and the Chief Psychiatrist or the Care Coordinator (or their delegates) decide that the person's order is no longer required, they must inform ACAT who then need to review it;

- a person contravenes a restriction order under a Mental Health Order; or
- a person absconds from an approved mental health facility or Community Care Facility.

A hearing needs to be held by ACAT if the person, their representative or ACAT initiated the review of the Mental Health Orders. In reviewing an application, ACAT must decide whether the person (the order(s) are about) is someone they could make a PTO or a CCO.

If they are not, then ACAT must remove the order. If they are, then ACAT is allowed to do any or all of the following:

- amend or revoke particular parts of the Mental Health Orders;
- add additional parts to the Mental Health Orders; and
- make an Assessment Order for the person to be assessed.

4.7 Contravention of Mental Health Orders (*breach under the Mental Health (Treatment and Care) Act 1994*)

4.7.1 What happens if a person refuses to comply with a Mental Health Order?

If a person refuses to comply with a Mental Health Order made by ACAT, they will be told by staff involved in their care that if they continue to refuse to comply with the order they will be taken to an approved mental health facility or an approved community care facility for treatment, care or support. If they continue to refuse to comply with the order they will be informed in writing that they will be taken to an approved mental health facility or an approved community care facility for treatment, care or support.

If a person continues to refuse to comply with the order they can be taken by the police, an authorised ambulance officer, a doctor, or mental health officer to an approved mental health facility or an approved community care facility for treatment, care or support.

Note that if someone has left a mental health facility without permission they can be returned to the facility by authorised personnel.

4.7.2 Powers in relation to contravention of a Community Care Order

If a Community Care Order has been made about a person; AND

- a restriction order has been made about the person; OR
- the Care Coordinator (or their delegate) has required the person to be detained because they have contravened an order and been properly warned on several occasions of the consequences of doing so.

THEN the Care Coordinator is allowed, but not required, to:

- detain the person at a facility (in the custody that the Care Coordinator considers appropriate); and
- confine or restrain the person in the least restrictive necessary and reasonable to prevent the person from causing themselves harm, OR to ensure that they stay in the facility for the treatment, care or support under the order; and
- seclude the person if that is the only way to prevent them from doing harm to themselves or someone else.

Each of these actions and decisions above must be done in a way that is consistent with principles of the Act (as outlined in section 1.3 'What does the Act seek to achieve?') and it must be the case that:

- the requirement is needed to adequately provide the person with treatment, care or support; and
- that treatment, care or support cannot be provided in any other way that would be less restrictive of the person's freedom of choice and movement.

Part 5: Emergency detention

There are situations where a person may be detained without the full mental health assessment and order process being undertaken. This is called emergency detention in the Act, and includes apprehension, assessment and treatment.

5.1 Emergency apprehension

A police officer or authorised ambulance paramedic may apprehend a person and take them to a mental health facility if they believe that they have a mental disorder or mental illness and are likely to attempt suicide, or to seriously harm themselves or another person.

A doctor or mental health officer may apprehend a person and take them to an approved mental health facility if:

- the person has a mental disorder or mental illness; and
- the person requires immediate treatment, care or support; or
- the person's condition will deteriorate within three days to the extent that they would need immediate treatment, care or support; and
- the person has refused treatment, care or support;
- detention is necessary for the person's well-being or for the protection of someone else or the public; and
- adequate treatment, care or support cannot be provided in a way that involves less restriction of the person's freedom of choice and movement.

5.1.1 Transfer to the mental health facility

If it is not possible to persuade the person to go to the facility, only the police are empowered to physically make the person go. After the person is taken to the facility, the doctor, mental health officer, police officer or ambulance paramedic (i.e. whoever took the person to the facility) must write a detailed statement. This must include the person's name and address, the process they used to take person to the facility, and anything that happened to the person during the process that might have affected their physical or mental health.

A doctor or mental health officer is also able to detain a person who has attended a mental health facility voluntarily, provided the person meets the criteria for apprehension (as described above).

5.1.2 What will happen at the facility?

When a person is taken to an approved mental health facility under emergency detention, they should be assessed by a doctor within four hours. If the assessment has not occurred within four hours, the person may be detained for a further two hours. This can occur if the person in charge of the facility believes that the person's health or safety would be at risk, or the person is likely to do significant harm to another person or to public safety if released.

If the person continues to be detained, the Chief Psychiatrist (or their delegate) must assess the person as soon as possible, and within a further two hours.

If the person is not assessed within a total time period of six hours, they must be released. Exceptions to this include:

- if the person has been detained under the Crimes Act (section 309), they must be released into the custody of the police; and
- if a court order states that a person is to be detained at a correctional centre, the person must be released into the custody of the Corrections Director-General.

The public advocate must be advised if the person is not assessed within six hours.

5.2 Authorisation of involuntary detention

A doctor may authorise involuntary detention at a mental health facility for a period of no more than three days if, after conducting an initial examination, the doctor believes that:

- the person requires immediate treatment, care or support; and
- the person has refused treatment, care or support; and
- detention is necessary for the person's well-being or for the protection of someone else or the public; and
- adequate treatment, care or support cannot be provided in a less restrictive environment.

In addition, another doctor should also examine the person and agree with the above points.

During the three-day period of detention, the Chief Psychiatrist (or their delegate) may apply to ACAT for an extension of the period of detention for a maximum of a further 11 days, if the person continues to meet the criteria for having a mental disorder or mental illness.

A person can apply to ACAT for a review of involuntary detention, in which case ACAT must conduct a review within two working days. A hearing does not have to be conducted for ACAT to make a decision.

5.2.1 What happens during detention?

If a person is involuntarily detained, they must receive a thorough physical examination by a doctor and a thorough psychiatric examination by a psychiatrist or registrar within 24 hours of being detained (this must be done by a different doctor to the one who conducted the first examination). There will also be an assessment (as covered in Section 3.3). The person will also be provided with treatment, care or support necessary to treat their condition.

During a person's detention in the mental health facility, they may be given treatment, care or support, and in very rare circumstances, a person may be 'secluded or even 'restrained' (see glossary for definitions of seclusion and restraint). However, any of these interventions must occur only when necessary and must be done in the least restrictive way necessary. They must also be done in way that prevents the person from causing harm to themselves or someone else.

For other more substantial treatment (beyond what is the minimum necessary), a Psychiatric Treatment Order or a Community Care Order is required (as described in 'Part 4: Mental Health Orders').

There are strict requirements around the use of both seclusion and restraint to both minimise their use and also ensure, if used, it is done appropriately.

5.2.2 Who will be notified of the detention?

- ACAT;
- those who have parental responsibility, if the person is a child;
- the guardian;
- the attorney;
- the nominated person; and
- the health attorney.

5.2.3 Review of emergency (involuntary) detention

A person can make an application to ACAT to review their detention which may or may not involve a hearing. If ACAT overturns the decision, they will order the person to be released from the facility.

5.2.4 Release from detention

A doctor, the Chief Psychiatrist (or their delegate) or ACAT must order that a person be released from where they are being detained if the justification for being detained no longer exists. A person must be released if an order is made to do so, or once the period of time for their detention has ended.

5.3 Information that must be provided to a person at a mental health or community care facility

If there has been a decision to provide a person treatment, care or support at a mental health or community care facility then the person must be told of their rights under the Act.

The person must be given information in writing telling them that they:

- can get another opinion from a health professional about the proposed treatment; and
- have the right to obtain legal advice (assistance from a lawyer).

The person also needs to be given written information about the role of a 'nominated person' and that they can nominate someone to do so if they have 'decision-making capacity'. As mentioned previously, a person must be asked whether they have a nominated person. If the person has one, then the person in charge of the facility must obtain:

- the contact details of the nominated person (and periodically ensure those contact details are correct); and
- a copy of the written nomination (the form on which the person wrote down the details of their nominated person).

Further, if a person has decision-making capacity, they must be told that they can create an Advance Agreement or Advance Consent Direction, which sets out their preferences and consent in relation to treatment should the person lose capacity (these documents are described in more detail in Part 2).

The following must be available and accessible for the person:

- the Act;
- the *Guardianship and Management of Property Act 1991* [and other relevant legislation];
- documents explaining the legislation (such as this Plain Language Guide and associated fact sheets and brochures);
- information statements in languages other than English; and
- a list of the names, addresses, telephone numbers and relevant functions of people and organisations that they should be able to contact.

5.4 Ongoing involuntary treatment

If the treating team believes that treatment is required beyond the 14-day period of involuntary detention, an application for a PTO must be made to ACAT (See Section 4.2).

Part 6: Forensic Mental Health Orders (FMHOs)

Forensic Mental Health Orders are a new feature in the Act. A Forensic Mental Health Order may be made by ACAT where a person with a mental illness or mental disorder is involved with the criminal justice system.

ACAT may make:

- a FPTO for a person with a mental illness; or
- a FCCO for a person with a mental disorder.

6.1 What is the purpose of FMHOs?

FPTOs may be used to:

- identify and provide for the care, treatment and support of people subject to criminal proceedings who are living with a mental illness or mental disorder;
- promote the least intrusive treatment and care of those people;
- ensure the safety of members of the community from the risk of serious harm; and
- provide a process to allow important information about the person to be shared under appropriate controls with people who have been harmed by the person's conduct.

6.2 Under what circumstances will FMHOs be made?

ACAT may make a FMHO where the person with a mental illness or mental disorder is:

- detained in a correctional centre or place of detention; or
- serving a community-based sentence; or
- referred to ACAT by a court where the person has been deemed as 'unfit to plead' or 'mentally impaired' (see glossary for definitions of these terms) under the *Crimes Act 1900 (ACT)* or the *Crimes Act 1914 (Cwlth)*.

Before ACAT makes a FMHO, ACAT must be satisfied that the person not only has a mental illness or mental disorder, but must also believe on reasonable grounds that the person:

- is doing or is likely to do serious harm to themselves or someone else; or
- is suffering or is likely to suffer serious mental or physical deterioration; and
- has seriously endangered, or is likely to seriously endanger, public safety.

ACAT must also be satisfied that the treatment, care or support is likely to improve the person's condition and reduce the risk to the person, another person or to public safety. ACAT must also be satisfied that treatment cannot be provided in a way that is less restrictive to the person's freedom of choice and movement. It is not required to consider decision-making capacity in making a Forensic Mental Health Order.

Finally, ACAT must be satisfied that, in the circumstances, a MHO should not be made.

6.3 How long can a FMHO last?

ACAT may make an order for three months. If a person has been subjected continuously to orders for 12 months or more (i.e. 4 x three month orders or more consecutively), ACAT may make an order for up to 12 months.

6.4 What are the main differences between a MHO and a FMHO?

The key differences between a **Mental Health Order** and a **Forensic Mental Health Order** are that:

- a person's decision making capacity is not a criterion for making a Forensic Mental Health Order; and
- ACAT must be satisfied that the person presents a risk of serious endangerment to the community to be placed on a Forensic Mental Health Order; and

- ACAT has an additional important and active role in decisions about the person's care and support arrangements under a Forensic Mental Health Order. This includes decisions about whether a person will be detained or released from a mental health facility. It also includes whether a person will be given leave from a mental health facility; and
- a person who was harmed by the person on a Forensic Mental Health Order is entitled to certain information about the order. The person receiving the information is known as the 'affected person'.

6.5 Forensic Psychiatric Treatment Order (FPTO)

6.5.1 What information is included in the FPTO?

A FPTO may set out the facility that the person is to be admitted to, the types of treatment, care or support (other than ECT or psychiatric surgery) the person is to receive, any restrictions on people the person can communicate with, where the person must live (if not detained in a facility), any people or places that the person must not approach or any activities that the person must not undertake.

6.5.2 What happens if a FPTO is granted?

If a FPTO is granted, the Chief Psychiatrist (or their delegate) must determine:

- whether a person needs to be treated in a mental health facility;
- if the person is being treated in the community, when and where they need to attend to receive treatment, care or support;
- the nature of the treatment the person is to receive, including any medication to be given; and
- where the person may be directed to live, if the FPTO does not state place of residence.

In considering the types of treatment, care or support that the person is to receive, the Chief Psychiatrist (or their delegate) should consult with:

- the person;
- those who have parental responsibility, if the person is a child;

- the guardian;
- the attorney;
- the nominated person;
- the Corrections Director-General, if the person is a detainee, on bail or parole; and
- the Children and Young People's Director-General, if the person is a child who is a detainee, on bail or a community-based sentence.

The Chief Psychiatrist must give a copy of their determination to the following people:

- the person;
- those who have parental responsibility, if the person is a child;
- ACAT;
- the public advocate;
- the guardian;
- the nominated person; and
- the health attorney.

6.5.3 Can a FPTO be ceased?

If the Chief Psychiatrist (or their delegate) believes that a FPTO is no longer required, they must notify ACAT and give notice to those above (in 6.5.2) stating the reasons they believe the FPTO is no longer required and seek their input.

Either the carer or nominated person is able to:

- make a submission to ACAT if they believe that the order should not cease; and
- apply to ACAT to attend the hearing.

6.6 Forensic Community Care Order (FCCO)

6.6.1 What information is included in the FCCO?

A FCCO may set out the types of treatment, care or support a person is to receive, where the person is to live or be detained and any restrictions on communications and people or places the person cannot approach.

6.6.2 What happens if a FCCO is granted?

If a FCCO is granted, the Care Coordinator (or their delegate) must determine:

- when and where the person needs to attend to receive treatment, care or support; and
- ensure that the nature of the treatment, care or support, including any side effects, are explained to the person.

In considering the types of treatment, care or support that the person is to receive, the Care Coordinator (or their delegate) should consult with the following people, if they are involved in the person's care:

- the person;
- those who have parental responsibility, if the person is a child;
- the guardian;
- the attorney;
- the nominated person;
- the health attorney;
- the Corrections Director-General, if the person is a detainee, on bail or parole; and
- the Children and Young People's Director-General, if the person is a child who is a detainee or on bail.

The Care Coordinator (or their delegate) must give a copy of their determination to the following people, if they are involved in the person's care:

- the person;
- those who have parental responsibility, if the person is a child;
- ACAT;
- the public advocate;
- the guardian;
- the attorney;
- the nominated person; and
- the health attorney.

6.6.3 Can a FCCO be ceased?

If the Care Coordinator (or their delegate) believes that a FCCO is no longer required, they must notify ACAT and give notice to those (mentioned in 6.6.2) stating the reasons they believe the FCCO is no longer required and seek their input.

Either the carer or nominated person is able to:

- make a submission to ACAT if they believe that the order should not be ceased; and
- apply to ACAT to attend the hearing.

6.7 Leave on a FMHO

If ACAT has ordered the detention of a person at an approved mental health or approved community care facility under a FPTO or FCCO, ACAT may grant or cancel leave on application or on its own review. The Chief Psychiatrist and the Care Coordinator may grant leave in special circumstances and where the safety of the person, other people or the public will not be seriously endangered.

If leave is cancelled, a police officer, authorised ambulance paramedic, doctor or mental health officer may apprehend the person and take them to a relevant facility. If a person is detained, the person in charge of the approved mental health facility must advise ACAT and the public advocate within 12 hours.

6.8 An affected person

An affected person is someone who has suffered harm because of an offence committed, or alleged to have been committed, by a forensic patient.

The Director-General responsible for ACAT must notify affected people of their rights and responsibilities as an affected person and maintain the Affected Person's Register.

6.8.1 What are the responsibilities of an affected person?

An affected person who wishes to receive information about an issue they have been affected by must sign an undertaking not to publish the information that they receive. Failure to abide by this undertaking may result in the person's details being removed from the Affected Person's Register.

6.8.2 What information can an affected person obtain?

Information that may be disclosed to an affected person is information necessary for the registered affected person's safety and well-being. If a Forensic Mental Health Order is made in relation to a forensic patient, the Director-General of ACAT must disclose information about any of the following events to the affected person(s):

- when an application for a Forensic Mental Health Order has been made;
- when a Forensic Mental Health Order is in force;
- if the person absconds, or fails to return from leave, from a facility;
- if the person is transferred to another jurisdiction;
- when the person is released from a facility; and
- any other information the Director-General considers necessary for the affected person's safety and well-being.

Part 7: Providing care for correctional patients

A correctional patient refers to a detainee at a correctional centre who requires transfer from a correctional centre to an approved mental health facility. They must have a mental illness and require inpatient mental health treatment and consent to such treatment.

7.1 Transfer of correctional patients

If the Chief Psychiatrist is satisfied a detainee has a mental illness that requires treatment, care or support in an approved mental health facility, and a Mental Health Order or a Forensic Mental Health Order cannot be made in relation to the person, the Chief Psychiatrist can ask the Corrections Director-General to transfer the detainee from a correction centre to an approved mental health facility.

7.2 Review of correctional patients

If a correctional patient under a transfer direction has not been transferred to an approved mental health facility, ACAT must review the direction at the end of one month from when the direction was made and every month after that until the transfer is made or the order revoked.

For correctional patients who have been transferred to an approved mental health facility, ACAT must review the transfer direction as soon as possible after the transfer.

If a person is detained, the person in charge of the approved mental health facility must advise ACAT and the public advocate within 12 hours.

Part 8: Electro convulsive therapy (ECT)

Electroconvulsive therapy (ECT) is a psychiatric treatment in which small electric currents are passed through the brain to intentionally triggering a brief seizure. On rare occasions, ECT is used as an emergency measure. There are strict criteria for this (defined below).

8.1 Adults and ECT

8.1.1 Adults with decision-making capacity

ECT can be administered to an adult with decision-making capacity if the person:

- has given consent to the administration of ECT;
- has not withdrawn their consent, either verbally or in writing;
- ECT has not been administered more than nine times since the consent was given. If the consent was to the administration of ECT for a specific number of times (less than nine), then it must be administered according to that specified number; and
- the person's consent for further ECT can be reviewed and renewed.

8.1.2 Adults without decision-making capacity

ECT can be administered if:

- the person has an Advance Care Direction consenting to the administration of ECT; and
 - ECT is administered in accordance with the Advance Consent Direction; and
 - the person does not refuse or resist.
- In accordance with an emergency ECT order that is in force in relation to the person; and
- the person does not refuse or resist ECT; or
- a PTO or FTPO is in force in relation to the person.

8.2 Young people with decision-making capacity

This section applies to children at least 12 years old and less than 18 years old who have decision-making capacity to consent to ECT.

ECT can be administered to a person aged:

- between 12 and 15 years if an ECT order is in force in relation to the person; or
- between 16 and 17 years if an ECT order or an emergency ECT order is in force in relation to the person; and
- either:
 - the person does not refuse or resist; or
 - a PTO or FTPO is in force in relation to the person.

A person commits an offence if they are not a doctor and they administer ECT to a person.

A doctor commits an offence if they administer ECT to a person without meeting the above requirements.

8.3 ECT Orders

The Chief Psychiatrist or a doctor can apply to ACAT for an ECT Order if the person is under 18 years old (with decision-making capacity to consent) and the application is supported by another doctor. At least one of the doctors must be a child and adolescent psychiatrist.

8.3.1 Who must ACAT consult with about ECT Orders?

Before making an ECT order ACAT must, where practical, consult with the following people if they are involved in the person's care:

- those who have parental responsibility, if the person is a child;
- the guardian;
- the attorney;
- the nominated person; and
- the health attorney.

ACAT must hold a hearing before making an ECT Order in relation to a person.

8.3.2 What must ACAT take into account in making an ECT Order?

In making an ECT order, ACAT must take the following into account:

- whether the person consents, refuses to consent or has the decision-making capacity to consent to ECT;
- the person's views as set out in an Advance Agreement or Advance Consent Direction;

- the views of the person responsible for the person's day-to-day care;
- the views of people appearing at proceedings;
- the views of people listed above (under 'who must ACAT consult');
- any alternate treatment, care or support available; including:
 - the purpose of the treatment, care or support;
 - the benefits likely to be received by the person by the treatment, care or support; and
 - the distress, discomfort, risk, side-effects or other disadvantages associated with the treatment, care or support; and
- any relevant medical history of the person.

8.3.3 Making an ECT Order

ACAT may make an ECT Order in relation to a person (if the person is at least 12 years old) if they are satisfied that the person has a mental illness and:

- the person does not have decision-making capacity to consent to the administration of ECT; and
- the person does not have an Advance Consent Direction refusing consent to ECT;
- the administration of ECT is likely to result in substantial benefit to the person; and
- either:
 - all other reasonable forms of treatment available have been tried but have been unsuccessful; or
 - the treatment is the most appropriate treatment available.

ACAT may make an ECT Order in relation to a person (if the person is at least 12 years old but under 18 years of age) if they are satisfied that the person has a mental illness and:

- the person has decision-making capacity to consent to the administration of ECT; and
- the person consents to the administration of ECT; and
- the administration of ECT is likely to result in substantial benefit to the person.

As soon as possible after making an ECT Order under this section, ACAT must give a copy of the Order to:

- the person in relation to who the order is made;
- the person who applied for the order;
- the people consulted about the order.

8.3.4 What will the ECT Order include?

The ECT Order must state:

The matters that ACAT is satisfied of (i.e. that):

- the person has a mental illness;
- the person has decision-making capacity to consent to the administration of ECT;
- the person consents to the administration of ECT;
- the administration of ECT is likely to result in substantial benefit to the person; and
- the maximum number of times ECT may be administered.

The person in charge of the facility where ECT is to be administered must ensure that the person receiving ECT is told about it and how it is administered.

8.4 Emergency ECT Orders

ACAT may make an Emergency ECT Order if an application is made by the Chief Psychiatrist and another doctor. The emergency ECT order must be accompanied by an application for an ECT order.

8.4.1 What must ACAT take into account in making an Emergency ECT Order?

In making an Emergency ECT Order, ACAT must take the following into account:

- whether the person consents, refuses to consent or has the decision-making capacity to consent to ECT;
- the person's views as set out in an Advance Agreement or Advance Consent Direction;
- the views of people appearing at proceedings;
- the views of the person responsible for the person's day-to-day care;
- if the person is under 18 years of age, the views of each person with parental responsibility;
- the guardian;
- the attorney; and
- the health attorney.

8.4.2 Making an Emergency ECT Order

ACAT may make an Emergency ECT Order in relation to a person (of at least 16 years old) if they are satisfied that the person has a mental illness and:

- the person does not have decision-making capacity to consent to the administration of ECT; and
- the person does not have an Advance Consent Direction refusing consent to ECT;
- the administration of ECT is necessary to:
 - save the person's life; or
 - prevent the likely onset of a risk to the person's life within three days.
- either:
 - all other reasonable forms of treatment available have been tried but have not been successful; or
 - the treatment is the most appropriate treatment reasonably available.

ACAT may make an Emergency ECT Order in relation to a person (if the person is at least 16 years old) if they are satisfied that the person has a mental illness and:

- the person has decision-making capacity to consent to the administration of ECT and consents to the administration of the administration of ECT is necessary to:
 - save the person's life; or
 - prevent the likely onset of a risk to the person's life within three days.
- either:
 - all other reasonable forms of treatment available have been tried but have not been successful; or
 - the treatment is the most appropriate treatment reasonably available.

8.4.3 What will the Emergency ECT Order include?

The Emergency ECT Order must state that:

- ECT may be administered to the person a stated number of times (not more than three); and
- the order expires in a stated number of days (no more than seven).

8.5 Records of ECT

A doctor administering ECT must record the administration, including whether administration:

- was in accordance with an ACAT order;
- was with the person's consent.

The doctor must give the record to the person in charge of the facility.

Records of ECT must be kept for five years.

Part 9: Other provisions within the Act

9.1 Psychiatric surgery

Psychiatric surgery is an extremely rare procedure in current mental health treatment. For information on how this is managed under the Act, please refer to the Office of the Chief Psychiatrist.

9.2 Interstate application of mental health legislation

The Act can also be applied to a number of situations including:

- the apprehension of people who are subject to certain interstate warrants or orders, or may otherwise be apprehended, under mental health legislation; and
- the interstate transfer of people under mental health legislation; and
- the treatment, care or support in the ACT of people subject to Mental Health Orders or similar orders made in other states; and
- the interstate operation of certain Mental Health Orders.

The Minister for Health in the ACT may enter into an agreement with a Health Minister of another state about any matter relating to the operation of this law, and vice-versa.

For information on how this is managed under the Act, please refer to the Act and the Office of the Chief Psychiatrist.

Part 10: Glossary

Affected person	<p>An affected person may be the person who the offence was committed against, a person who witnessed the offence, a family member of the person affected by the offence, a person who is dependent on the person primarily affected by the offence or if the person affected by the offence is a child or legally incompetent person, a guardian of the child or legally incompetent person</p>
Electroconvulsive therapy	<p>Electroconvulsive therapy means a procedure for the induction of an epileptiform convulsion in a person.</p> <p>An electroconvulsive therapy order means an order under section 157 for the administration of electroconvulsive therapy to a person.</p> <p>An emergency electroconvulsive therapy order means an order under section 162 for the emergency administration of electroconvulsive therapy to a person.</p>
Facilities	<p>A Community care facility is a place for the treatment, care or support, protection, rehabilitation or accommodation of people with a mental disorder or a prescribed psychiatric facility. A community care facility does not include a correctional centre or detention place.</p> <p>A Mental health facility is a place for the treatment, care or support, rehabilitation or accommodation of people with a mental illness; and includes a psychiatric facility.</p>
Leave	<p>Leave is a period of time out of a facility agreed between the person receiving treatment and care and their treating team. The period of leave is designed to enhance recovery and help the person return to their usual life in the community.</p>
Mental impairment and unfitness to plead	<p>A mental impairment is a defence for a criminal charge. This defence will be used where the person committed the physical act of the crime where they have a mental illness or other mental disorder and as such they:</p> <ul style="list-style-type: none">• did not understand the nature of their actions;• did not know that their conduct was wrong; or• could not control their conduct. <p>Where a court finds a person mentally impaired in relation to a criminal charge the person will not be held criminally responsible for that conduct.</p> <p>A person who is charged with a criminal offence is deemed unfit to plead if their mental process is disordered or impaired affecting their ability to understand important court processes.</p>
Restraint and seclusion	<p>Restraint refers to restriction of the movements of a person (who is being provided with treatment, care or support at the facility). Physically restraining a person involves applying bodily force to a person's body to restrict the person's movement.</p> <p>Seclusion refers to confining a person (who is being provided with treatment, care or support at the facility) by leaving them alone in a room where they cannot physically leave for some period of time.</p>

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