Review of the operation of mental health orders under the ACT *Mental Health Act 2015*

Sections 58, 66, 101, 102, 108

ACT Health Directorate

25 October 2019

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Abbreviations

The following abbreviations are used throughout this report.

ACAT	ACT Civil and Administrative Tribunal
The Act	*Mental Health Act 2015* (ACT)
CCO	Community care order
FCCO	Forensic community care order
FMHO	Forensic mental health order
FPTO	Forensic psychiatric treatment order
MHO	Mental health order
PTO	Psychiatric treatment order

Introduction

The *Mental Health Act 2015* (the Act) is the ACT legislation that applies to the assessment, treatment, care and support of people experiencing a mental illness or mental disorder.

The Act came into effect on 1 March 2016.

The ACT Government has conducted two reviews of the Act:

1. A review of the authorised period of emergency detention under the Act, conducted in 2018. A separate report has been prepared on the results of that review.
2. A review of the operation of mental health orders and forensic mental health orders under the Act, including their implementation, conducted in the first half of 2019.

Mental health orders

People with a mental illness or mental disorder who have decision-making capacity can choose if they receive treatment, care or support and the form that this takes.

In instances 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, authorised involuntary measures may be needed to provide the necessary assessment, treatment, care or support for that person.

The ACT Civil and Administrative Tribunal (the ACAT) is responsible for making a range of decisions under the Act about a person's mental health treatment, care and support.

This includes responsibility for granting mental health orders, based on the ACAT's decision. There are different types of mental health orders that the ACAT can make under the Act including:

- Psychiatric treatment orders (PTOs) – for people who have a mental illness;
- Community care orders (CCOs) – for people who have a mental disorder;
- Forensic psychiatric treatment orders (FPTOs) – for people involved with the criminal justice system who have a mental illness; and
- Forensic community care orders (FCCOs) – for people involved with the criminal justice system who have a mental disorder.

Psychiatric treatment orders

The ACAT may make a 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 others, 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.

Community care orders

A 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.

The 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 the 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 PTO 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.

Forensic mental health orders

Forensic mental health orders (FMHOs) are a new feature of the Act. An FMHO may be made by the ACAT where a person with a mental illness or mental disorder is involved with the criminal justice system.

The ACAT may make:

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

FMHOs 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.

Review purpose, scope and approach

Purpose and scope

Under section 271 of the Act, three years after the commencement of the Act, the Minister must review the operation of the following provisions of the Act:

- PTOs under section 58 of the Act;
- CCOs – section 66;
- FPTOs – sections 101 and 102, and
- FCCOs – section 108.

The scope of the review includes:

- the implementation of the Act;
- the impact of the Act on the delivery of mental health services; and
- the impact of the Act on the mental health care experienced by people with mental illness or mental disorder and their carers.

Review Approach

During planning for the review, a multi-stakeholder working group worked with the review team to prepare a program logic model that articulated the relationships between elements of the Act and their intended outcomes. The working group also developed a series of key evaluation questions that apply to the review and which formed the basis of the evaluation framework and plan for the review.

Methods

Data to inform this review was gathered by the following combination of qualitative and quantitative methods:

- a call for public submissions, open from 23 April to 25 June 2019 – six submissions were received in addition to the thirteen received to the earlier review, making a total of nineteen used to inform this review;

- an online public survey, open from 23 April to 25 June 2019 – a total of twenty-six responses were received;
- face to face and telephone surveys conducted in May and June 2019 with a total of 41 people including:
    - people who have received treatment, care or support under the Act;
    - carers and family members of people who have received treatment, care or support under the Act; and
    - health service professionals and members of relevant community advocacy organisations.
- data extracted from the ACT Health Directorate records system, MAJICeR, covering the three-year period prior to commencement and the three-year period after the commencement of the Act; and
- other documentary sources, including the Chief Psychiatrist's Annual Reports and the ACAT's Annual Reviews.

During the public consultation phase of the earlier review of Section 85 (3), respondents to the call for public submissions, survey respondents and interviewees were invited to also provide general feedback on the operation of the Act and how it supports the best treatment, care and support. The feedback received is to be considered in future reports.

Limitations

All evaluations have limitations related to their scope, data collection methods and analysis methods. Findings should be interpreted in the light of those limitations.

We note that only a very small number of persons with experience of treatment, care and support under the Act responded to the survey, and likewise their carers or family members. It is very difficult to reach this target group through calls for public consultation, especially as people often have short periods of exposure to mental health services and emergency detention is a distressing experience in its own right. It is understandable that the limited scope and reach of this initial review resulted in a greater proportion of responses from mental health services and emergency services personnel.

The small number of survey responses, public submissions and interviews in this review means that no meaningful interpretation of statistical significance is possible from that data. Inferences made from a very small number of qualitative data sources should be drawn cautiously.

Findings

Mental health orders (PTOs and CCOs; sections 58 and 66 of the Act)

Psychiatric Treatment Orders

ACT Health Directorate data on mental health orders show a substantial decrease of 24.5 per cent in the annual number of PTOs in the two years since commencement of the Act compared with the two years prior. This is shown in Table 1, below.

Table 1: Data from MAJICeR – 2-year periods before and after commencement of the Act

Data item	Before commencement of the Act 1/3/2014 – 29/2/2016	After commencement of the Act 1/3/2016 – 28/2/2018	Change
Number of Mental Health Orders	6,494	6,455	– 0.6%
Number of Psychiatric Treatment Orders	2,196	1,659	–24.5%
Number of Community Care Orders	45	26	–42.2%

During this same period, the number of emergency apprehensions has increased by 74 per cent (1,631 cfd. 935) and the number of initial emergency detentions (ED3) has increased by some 40 per cent (1,099 cfd. 796). The number of extended emergency detentions has also increased, by 46 per cent.

Despite this increase in emergency apprehension and detention, qualitative data gained from interviews, written submissions and surveys for the earlier review of Section 85 (3) point to the longer maximum period of further detention in the Act as contributing to a reduced need for PTOs. Interpretation of survey results for the earlier review, though limited by a small number of responses[1]indicate that some members of both health professionals and family and friend respondent groups held positive views about the extension of the maximum further period of detention, noting the importance of the additional time for medication to stabilise the person receiving treatment and care. Other respondents held negative views about the traumatic nature of involuntary detention and emergency detention.

There was general agreement amongst all stakeholders that the extension appears to be supporting good clinical practice by providing more time for comprehensive observations and assessments to be made. There was consensus that the extension is providing time for people to stabilise.

The extension appears to have led to a decrease in the making of PTOs. However, the need for detailed analysis to confirm whether this was the case was emphasised.

Community Care Orders

The number of CCO's is small relative to the number of PTO's. The number of CCOs issued since commencement of the Act remains similar to those in the year immediately preceding: eighteen in 2015-16 and sixteen, fifteen and nineteen in the following three years. It should be noted, however, that an unexplained 50 per cent reduction in the number of CCO's issued was observed in the year prior to commencement of the Act compared with the preceding year.

[1] There were 20 survey responses to this earlier survey involving 1 person with experience of involuntary detention, 7 family or friends of such persons, 5 mental health service workers, three advocacy organisations and four members of the public.

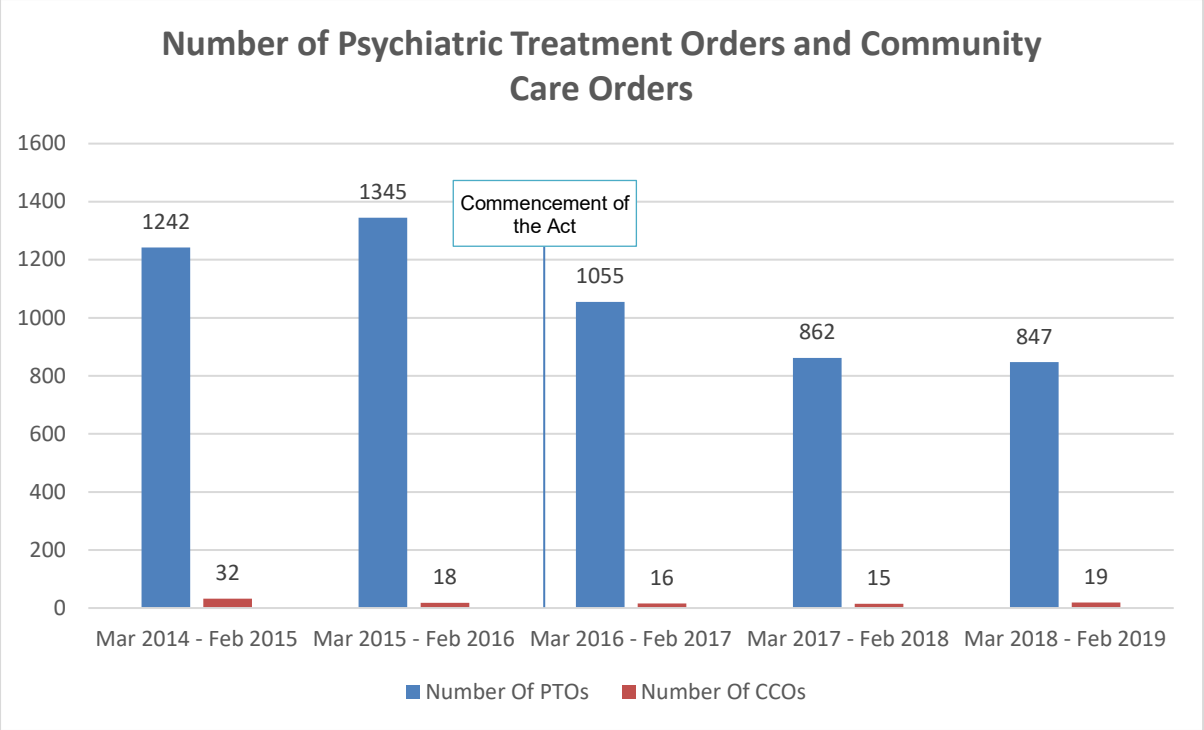

Figure 1: Number of PTOs and CCOs March 2014 – February 2019

Flow on PTOs, CCOs and readmissions

Table 2, below, shows that the number of people subject to emergency detention who were subsequently placed on a PTO or CCO was 1,345 in 2015/16 and 847 in 2018/19. The number of those people readmitted within 28 days was 65 in 2015/16, and 113 in 2018/19.

There are multiple factors that impact on the number of PTOs and CCOs and the number of readmissions including the numbers of people seeking treatment, staffing levels, acuity of presentation from time to time and the availability of beds.

Table 2: Data from MAJICeR – 2 years prior and 3 years post-commencement of the Act

Readmission within 28 days

	Before commencement		**After commencement**		
	Mar 2014-Feb 2015	**Mar 2015-Feb 2016**	**Mar 2016-Feb 2017**	**Mar 2017-Feb 2018**	**Mar 2018-Feb 2019**
Number of psychiatric treatment orders (PTOs)	1,242	1,345	1,055	862	847
Number of community care orders (CCOs)	32	18	16	15	19
Number of people on involuntary detention with subsequent PTO/CCO readmitted within 28 days	49	65	72	92	113
Number of people on involuntary detention with no subsequent	10	17	29	35	50

PTO/CCO readmitted within 28 days					
Re-admission Rate within 28 days for people on a mental health order	3.5%	4.4%	4.9%	6.3%	6.1%
Re-admission Rate within 28 days for people on an involuntary detention with no subsequent mental health order	2.8%	4.7%	7.8%	8.2%	9.7%

Qualitative data elicited from interviews, submissions and surveys provide several possible explanations for this phenomenon. These include matters related to mental health service system capacity and operation, and matters related to the implementation of the legislative provisions under review, outlined below. Despite these operational issues, the provisions within the Act related to PTO's and CCO's were not raised as an issue by interview and survey participants, or in public submissions received.

Concerns related to the implementation of legislative provisions contained in the sections under review were identified by interview participants, stakeholder submission and survey data as:

- the practicability of PTO and CCO application forms;
- the timeliness of information made available to the ACAT;
- the content and granting of orders;
- inconsistency in cancellation of PTOs and CCOs;
- identified practice issues in enacting contravention orders; and
- the consequences of delayed enactment of assessment orders.

Each of these issues is now discussed.

Application Forms

Both stakeholder and mental health service interviewees in general identified that application forms for PTOs and CCOs:

> *"… are very specific in focusing on capacity and on what is happening in the here and now*".

This is consistent with the Act's intent and a positive change from previous practice.

However, concern was raised by mental health service interviewees about elements of:

> "… *duplication and complexity in the forms as well as limitations in the forms' capacity to expand information boxes to take further information*".

In particular, it was stated that:

> *"… there is no room to highlight a person's strengths and what is working from a strengths-based perspective*."

Thus, the forms do not enable or encourage a strengths-based view of practice.

Timeliness of information made available to the ACAT

Stakeholders expressed concern about the untimely provision of reports for ACAT consideration. It was stated, and confirmed by the ACAT, that reports prepared for the Tribunal by treating doctors might only emerge in the course of the ACAT hearings. A view was expressed in a submission that this is a serious systemic failing, leaving not only the ACAT disconcerted, but also the parties unprepared and legal representation unable to take adequate instruction.

> *Information is not prepared in a timely manner ...there is too much pressure on psychiatrists to be able to do this…. often the report reaches the tribunal but not the patient … we have to get on with it.* (interview participant with ACAT experience).

> *The consumer has the right to see those reports. If we are not getting them, neither are the consumers, nor is there time to prepare.* (Public Advocate interview)

> *In two hearings last week we (Legal Aid) received additional information from the treatment team ten minutes before. We can't get instructions and represent properly. Sometimes new documents are put forward in the hearing. Consumers need more time to read and digest. It is very distressing for them*. (Legal Aid Commission interview*).*

Reasons for this acknowledged delay in the provision of information to the tribunal were identified by some mental health service staff and stakeholders as including factors such as the number of reports required on any particular day and staff capacity to liaise with all stakeholders involved (including carers). It is of note that a feature of the system is that if symptoms change or new matters arise before the ACAT hearing, new reports must be prepared to reflect the most correct and up to date circumstances.

Another concern expressed by stakeholders and people with experience of treatment, care and support under the Act, was that notice of hearings often comes with as little as 24 hours-notice, particularly for people in community settings.

> *I couldn't go to a tribunal hearing. I got 12 hours' notice of a changed venue and time*. (Person with experience of mental health treatment and care).

In consequence:

- It was attested that legal counsel and other advocates were hampered by an inadequate and often absent approach to supported decision-making prior to and during to hearings. Legal counsel must be guided and instructed entirely by the person before them. The person may not have or may not be able to communicate full knowledge or advice. (Legal Aid Commission interview)
- Legal counsel does not have access to the ACAT notes and prior history which may then be used by the ACAT to inform their decision-making. The ACAT acknowledged this use in instances where they are weighing ongoing risk of harm. Additionally, effective legal and other advocacy, including the ability of the person to effectively state their own case, was said to be routinely stymied by the untimely and late submission of reports. (Legal Aid Commission interview)

There was a view in some submissions by people with experience of treatment and care under the Act (and their advocates) that people were not given adequate time to prepare for a hearing and reports are given in the absence of a comprehensive contemporary assessment.

> *They do not let me know when the tribunal is or give me really short notice and the I have to prove myself. I am not tested about my abilities or ability to give consent*. (Person with experience of mental health treatment and care).
>
> *Consumers assume a 'fait acompli' and don't even turn up.* (Public Advocate interview).

The content of and granting of orders

Both PTOs and CCOs allow for orders to be made regarding the provision of treatment, including the administration of medication, and the provision of other care and support including counselling, training, therapeutic or rehabilitation programs. These orders also allow for restrictions on communication and place of residence.

Interviewees in general identified a concern with a perceived inconsistency with the ACAT decision-making. This was explained by an interview participant with ACAT experience as resulting from the ACAT panels being reliant upon subjective and qualitative analysis and interpretation, including medical opinions submitted. It was also suggested that

> *"… having different people on panels will inevitably give rise to different understandings and judgement'.*

The ACAT website gives some information which provides a reference point to prior decisions. No suggestions were made by participants in the review about how a greater level of consistency in the ACAT decision-making could be achieved or demonstrated.

Interview participants reported an observation that the ACAT is currently issuing shorter (three month) orders more routinely than previously. This was seen and identified by the ACAT as a response aimed at acknowledging the human rights intent inherent within the Act. The ACAT also noted, however, that this practice places greater administrative strain on a system of care which is already stretched by administrative and other issues. Interviewees, in particular, advocates and mental health interviewees observing this practice suggested that the outcome may be seen in a greater frequency of orders affecting the same person, causing greater stress and uncertainty.

Confusion regarding the application of CCO's

Mental health service practitioners and other interviewees also highlighted a need to develop mental health workforce expertise and service system capacity for providing best practice approaches to mental disorder.

Specifically, mental health practitioners claimed that:

> *'… it will always be more difficult to define and understand the nature of mental disorder.'*

This was reported as a challenge when considering the way in which CCOs fit in to a productive response. They claimed a need for improved practice guidelines, as well as service system developments directed towards:

- a complex trauma approach to borderline personality and other complex trauma related disorders;
- a more effective interface between mental health responses and alcohol and drug use, particularly where use of substances is linked to the purpose of self-harm;
- a more effective interface between mental health responses and cognitive and intellectual impairment; and
- a focused service response to eating disorders.

The Public Advocate has observed confusion among clinicians about the use and applications of CCOs, including powers in relation to CCOs and how restriction orders interact with CCOs. This may reflect issues regarding the associated with the implementation of the Act. The Public Advocate recommends further training and education on the use of CCOs, including on the definition of mental disorder.

Inconsistency in Cancellation of PTOs and CCOs

The Chief Psychiatrist is required to cancel mental health orders when they are no longer required. This is done by advising the ACAT of this fact and why it is so. The order is then subject to review by the ACAT within 72 hours.

Some interview participants made an observation that this practice was inconsistent and depended on the awareness and willingness of individual medical practitioners to advise the Chief Psychiatrist accordingly. There is no evidence available of this occurring however the observations of the interviewees is noted.

Practice issues in enacting a contravention notice

Community mental health practitioners identified a dilemma which arises when they are deciding to issue a contravention notice. This is often a consequence of a person refusing treatment as required under the order, but then claiming a willingness to co-operate when the process of giving effect to a contravention notice is underway. In general, they feel that they must follow through on the contravention process, regardless of the late consent to treatment which has been given. A corollary issue arises when the treatment plan contained in a PTO or CCO does not specifically authorise apprehension and admission.

Community mental health service interviewees indicated their understanding that this then requires that the process of emergency admission takes place, creating stress both for the person and the system.

However, these concerns appear to be contingent upon practitioner understanding of operational requirements rather than provisions within the Act. Section77(2)(c) of the Act provides that:

> *The relevant official for the order may …. if the noncompliance continues after the taking of action under paragraph (b)—require the person to be taken to an approved mental health facility or approved community care facility to ensure compliance with the order.*

Additionally, the Chief Psychiatrist may make a determination requiring a person to be taken to a place for treatment, care or support under section 62 (Role of Chief Psychiatrist—psychiatric treatment order).

The legislation does not provide a clear answer on what happens in the circumstances that a contravention notice is in force but the patient consents to the treatment. This is an area for potential improvement in the legislation to enable treatment to be provided in a

community setting when a contravention notice has been issued but the patient consents to the treatment.

Consequences of delayed enactment of assessment orders

Assessment orders were identified as a valuable tool in preventing deterioration and consequent emergency action and the later need for mental health orders, where the potential for acute deterioration is foreseen. However, there is in practice, a noted lag between application for an assessment order and the date it is issued when granted. This was identified as resulting from a requirement in the Act for assessment to occur within seven days of issuing the order – extendable to fourteen days – and the reality that appointments for assessment involved a waiting period of several weeks.

> *If I make an order it has to be done within seven days. But they (Mental Health Services) don't really have the capacity to do this.* (interview participant with ACAT experience)

To cater for this anomaly in service capacity, the ACAT routinely delays the issuing of assessment orders until seven days before a pre-arranged appointment.

> *We line up an appointment within about six weeks but do not make an order until seven days prior.* (interview participant with ACAT experience)

A new model of care has come into operation since the review commenced and it is recommended that this data be reviewed after a period of operation.

Forensic mental health orders (FPTOs and FCCOs; sections 101, 102 and 108 of the Act)

There have been no Forensic Mental Health Orders (FPTOs and FCCOs) taken out since the commencement of the Act. In the same period, there have been 53 people on non-forensic mental health orders who have been treated and cared for in the mental health services with forensic capacity listed in Table 2 below.

Table 3: PTOs in mental health services with forensic capacity since Commencement of the Act

Service	Number of PTOs since 1 March 2016
Forensic Mental Health Community Outreach Team	39
Dhulwa Mental Health Unit	27

Interviewees across the board reported no known application of forensic orders during the period of operation of the new Act. Several views were expressed about why this is so, and whether or not forensic orders have a beneficial purpose.

It was argued by mental health service interview participants that forensic orders were unnecessary because, in all cases, other mental health orders – PTOs and CCOs – provided a least restrictive alternative.

> *A forensic order is never the least restrictive option*. (Forensic Mental Health Practitioner)

From one practitioner's viewpoint, forensic orders allow for additional restrictions on the person, with no additional benefit.

Forensic orders are extremely restrictive with no additional benefits at all. (Forensic Mental Health Practitioner)

From the viewpoint of an interview participant with ACAT experience, it was noted that prior to issuing a forensic order – FPTO or FCCO – the ACAT:

> "… *must be satisfied that a normal PTO or CCO should not be made in the circumstances*".

It was claimed that:

> "… *this requirement has never been satisfied"*

It was confirmed that only one application for a Forensic Order has been submitted to date but this was withdrawn before hearing.

However, the Public Advocate argued that the understandings outlined above do not take into account the restrictions which apply when the person subject to a PTO or CCO is also affected by the provisions of a Conditional Release Order.

> *A Conditional Release Order is prescriptive and micro-managing. A person would be better off in terms of balancing their rights and against community protections by using a forensic order*. (Public Advocate)

A Conditional Release Order involves conditions which might not be applied within the context of a forensic order issued under the *Mental Health Act*. These provisions were seen by the Public Advocate and the Human Rights Commission to be over-prescriptive, weighting correctional perspectives on community safety concerns more heavily than the rights of the person as referenced within the *Mental Health Act*. Additionally, it was noted by these review participants that a forensic order requires that consultation with Victims of Crime must occur as part of the deliberations. This provision is for the protection of those victims but is absent from processes involved with the setting of conditional release orders.

Only a few submissions commented on FMHOs, possibly because none have been raised since the commencement of the Act.

The ACT Human Rights Commission (HRC) expressed concern at the lack of use of forensic mental health orders:

> *'We recognise that the MH Act seeks to strike a balance between the legitimate needs of affected people, and the interests of those subject to a forensic mental health order. We are therefore concerned that, as far as we are aware, no FPTO or FCCO has been made by the ACAT. Instead, PTOs and CCOs are being used, or at times, conditional release orders under section 180 in isolation, with no corresponding forensic order. This would seem to frustrate the intent of the new orders, and the specific safeguards that would put in place for such orders, including the legislative test and register of affected persons. Absent any such forensic order, the victim has no right to information or to participate in the ACAT proceedings.'*

The HRC is concerned that FMHOs will continue to not be used in future because ordinary MHOs suffice to provide treatment, care and support to the mentally impaired person. They identified two cases where FMHOs might have been made but were not, and victims of crime were not adequately informed as a consequence. The HRC recommends that the definition of 'forensic patient' in section 127 of the Act be changed to also include a person who is subject to a conditional release order (CRO). This would extend the Director-General's right to share information with persons entered on the Affected Persons Register.

The HRC also recommended that there be an ability for a victim of crime to request an explanation from the ACAT as to how the victim's views have been taken into account, if they have participated in the ACAT's proceedings.

Conclusions and recommendations

The conclusions and recommendations outlined below are restricted to matters requiring a legislative response.

Conclusions

This review has focussed on the operations of the following provisions of the Act:

- Psychiatric treatment orders (PTOs) section 58;
- Community care orders (CCOs) – section 66;
- Forensic psychiatric treatment orders (FPTOs) – sections 101 and 102; and
- Forensic community care orders (FCCOs) – section 108.

The sections of the legislation about PTO's and CCO's are operating as intended, with some issues arising from implementation.

However, forensic orders are clearly not operating as intended. No forensic orders have been made since the commencement of the Act. Possible explanations are that the specific intent "… *has been lost*…" or the implementation of these provisions is perceived as impractical.

Recommendations

1. Review of the purpose and intent of forensic mental health orders within the context of least restrictive care.
2. Review the legislation to provide clarity in the circumstances that a contravention notice is in force but the patient consents to the treatment; and
3. A new model of care has come into operation since the review commenced. It is recommended that the data be reviewed again after a period of operation of the new model of care.