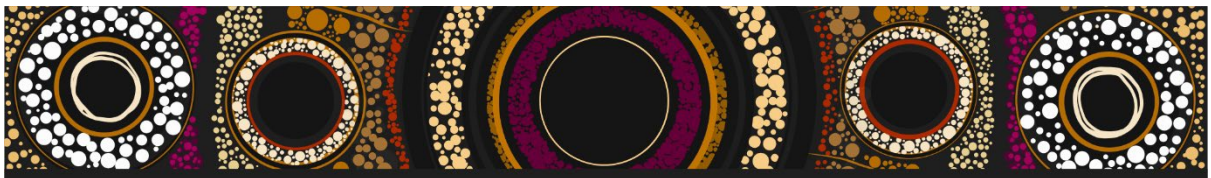
MARCH 2022

Review of the Mental Health (Secure Facilities) Act 2016

ANGELENE TRUE
ON BEHALF OF ACT HEALTH DIRECTORATE



Acknowledgment of Country

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Limitations

This report does not provide legal opinion or advice.

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1. STRUCTURE OF REPORT

1.1 STRUCTURE

This report concludes the review of the operation of the Mental Health (Secure Facilities) Act 2016 (the Act). An executive summary is provided at Part 2 of this report and includes recommendations.

Part 3 summarises the legislative framework for the provision of secure mental health facilities, and the objective, scope, approach, limitations and challenges of the review. In addition, it provides a high-level overview of Dhulwa, the ACTs only designated secure mental health facility.

Parts 4 to 6 of this report consider the operations of the Act, paying particular regard to:

- Whether the rights of the consumer are clear and understood and the Act protects the rights of all people within a closed setting
- Whether the legislative framework has been implemented appropriately and opportunities exist to strengthen provisions to balance the rights of consumers with the need to ensure safe and therapeutic care
- Whether patients and staff would benefit from further protections within the Act.

The Attachment provides observations outside the scope of the review so that matters raised may be considered by government.

During the consultation process, various other matters came to light which, although outside of the scope of the review, are included as an Attachment to ensure the report fairly represents the depth of feedback from stakeholders and that matters pertaining to practice may be appropriately considered by government in the interests of improvement.

1.2 ABBREVIATIONS

The following abbreviations are used throughout the report:

the Act	*Mental Health (Secure Facilities) Act 2016*
ACAT	ACT Civil and Administrative Tribunal
ACTHD	ACT Health Directorate
CEO	Chief Executive Officer, Canberra Health Services
CHS/CHHS	Canberra Health Services/Canberra Hospital and Health Services
Commissioners	Human Rights Commissioners
DG	Director-General, ACTHD
Dhulwa	Dhulwa Mental Health Unit
PTO	Psychiatric Treatment Order
SMHF	Secure Mental Health Facility

2. EXECUTIVE SUMMARY

2.1 BACKGROUND

The Mental Health (Secure Facilities) Act 2016 (the Act) came into effect on 20 June 2016.

Section 79(1) of the Act requires a review of the operation of the Act as soon as practicable after the end of its third year of operation.

This review fulfills that obligation and considers the operations of the Act.

2.2 METHODOLOGY

The review was conducted across the period 9 March to 14 May 2021.

The objective of the review was to determine whether the human rights of consumers are safeguarded by the Act and the facility operates safely for all people.

The review comprised desktop review (related artefacts), stakeholder consultation and engagement, and analysis of data.

The focus of the review was on the operations of the Act distinct from the operations of Dhulwa Mental Health Unit,

2.3 CHALLENGES

Two challenges were presented during the conduct of the review:

- Discerning whether feedback related directly to the Act itself or to primary legislation (i.e., the Mental Health Act 2015)
- Discerning matters relating to the operation of the Act, distinct from matters relating to the implementation of the Act or operations of Dhulwa.

All stakeholders provided feedback on each of the above, alongside feedback on the Act itself.

To ensure the review fairly represents the breadth of feedback from stakeholders, the report:

- Makes recommendations on the operation of the Act and its relationship with the Mental Health Act for consideration by the ACT Legislative Assembly
- Provides additional observations on relationships with intersecting legislation, the implementation of the Act, and/or operations of Dhulwa for consideration by ACT Health Directorate (ACTHD) and/or Canberra Health Services (CHS) as appropriate (see Attachment).

2.4 SUMMARY OF FINDINGS

The report presents the findings of the review and makes recommendations in relation to the objective above.

Opportunity exists to modernise the legislation to better safeguard the rights of consumers and ensure that a designated SMHF is safe for all people within it. In its present form, the Act pays limited regard to vulnerable populations and may be strengthened by further clarifying

rights and provisions for children and young people and the development of specific provisions encompassing the rights of First Nations peoples; people from culturally and linguistically diverse (CALD) communities; people who identify as lesbian, gay, bisexual, transgender, queer or intersex (the LGBTQI community); and people living with cognitive or physical disability.

Discretionary powers to establish statutory instruments contemplated in the Act in a timely manner, together with discretionary provisions for reviewable decisions and the lack of transparency of guidelines on other restrictive practices utilised in the close setting, have the potential to limit the rights of consumers and carers. The lack of guidelines on the implementation of the Act creates information asymmetry and a power imbalance between the service provider and the consumer that has the potential to again limit patient rights.

2.5 SUMMARY OF RECOMMENDATIONS

Recommendations concerning the scope of the review and provisions of the Act include:

Recommendation 1: That consideration be given to the merits of separate secure mental health facility legislation and whether such provisions would best be incorporated into the Mental Health Act (i.e., primary legislation), which pays specific regard to section 40B of the Human Rights Act.

Recommendation 2: That the Act explicitly clarify the cohort of patients a secure mental health facility caters for.

Recommendation 3: That safeguards for the treatment of children and young people in a designated secure mental health facility be strengthened by inclusion of criteria and thresholds for the decision-makers, explicit minimum standards of treatment and care, and oversight by the Public Advocate.

Recommendation 4: That the Act make explicit reference to the rights, culture and protections of First Nations peoples, encompassing culture and cultural safety, and establish explicit standards of care for Aboriginal and Torres Strait Islander peoples while they are receiving treatment in a secure mental health facility.

Recommendation 5: That the Act make explicit provisions for the rights and protections of vulnerable people including people from culturally or linguistically diverse communities, and people who identify as either lesbian, gay, bisexual, transgender, queer and intersex.

Recommendation 6: That safeguards for the treatment and care, and protection of human rights, of people with cognitive and/or physical disability in a designated SMHF be strengthened, minimum standards of treatment and decision-making processes be clarified, and oversight by the Public Advocate be provided.

Recommendation 7: That those directions contemplated by the Act or any other policies, procedures or guidelines that serve to limit the rights of patients be established via statutory instrument to protect the rights of consumers, and enhance transparency, oversight and governance.

Recommendation 8: That the Act and associated policy/procedures specify that any revisions to paper registers must be recorded additionally as a correction, without retroactive change

to the record, and section 27(2) be amended to include a new subsection requiring the grounds for reasonable suspicion be included in the register of searched mail.

Recommendation 9: That the Act confirm that limitations on contact (section 17(1)) be classified as a reviewable decision (Part 5 and Schedule 1) and provisions made for notification and review.

Recommendation 10: That standards of care be positively framed and articulated within the Act.

Recommendation 11: That limitations on contact (Part 3) be established by direction as a disallowable instrument and all limitations on contact be designated a reviewable decision.

Recommendation 12: That, given the current limitations on rights, the Act be amended to clearly define 'prohibited', 'restricted' and 'unapproved restricted items' in relation to distinct patient cohorts, together with the criteria used to determine when the director general believes on reasonable grounds that a declaration is necessary to ensure security or good order of a secure mental health facility.

Recommendation 13: That, in relation to a strip search, Division 4.3 be updated to better reflect the intent of sections 10 and 19 of the Human Rights Act 2005.

Recommendation 14: That section 50(b) of the Act be amended to state that, *'the patient must be present, or if the patient chooses not to be present, a person named by the patient must be present, unless the patient consents to no-one being present*', and that section 57 be amended to ensure that the Public Advocate is directly informed of the seizure of property to ensure patients receive appropriate recourse in the specified timescales.

Recommendation 15: That all instruments that give effect to the operations of the Act with regard to searches, appropriately and consistently reflect requirements and processes for reviewable decisions as set out in Part 5 and Schedule 1 of the Act.

Recommendation 16: That provisions for the use of force, the use of involuntary seclusion and the forcible giving of medication be clarified, and that decision-making criteria and safeguards be established in primary legislation; that a register of all such activity be legislated and provision made to proactively inform the Public Advocate of the use of force.

2.6 SUMMARY OF ADDITIONAL OBSERVATIONS

Much of the feedback provided during stakeholder engagement relates to intersecting legislation and the operations of the Dhulwa secure mental health facility. The following observations are made in the spirit of continuous quality improvement:

Observation 1: That the Chief Psychiatrist ensure that secure mental health facility related guidelines not established via notifiable instrument be accompanied by a statement clarifying how the guideline is consistent with primary legislation and human rights, and that these statements be published alongside guidelines.

Observation 2: That the CHS Secure Mental health Unit Operational Model of Care, 2016 and the consumer information handbook be reviewed and refreshed as appropriate, made available to all patients, carers and representatives, and published on the ACT Health website.

Observation 3: That specific models of care be developed for First Nations peoples; children and young people; people who identify as either lesbian, gay, bisexual, transgender, queer and intersex; people from culturally and linguistically diverse communities; and people with cognitive and/or physical disability.

Observation 4: That a comprehensive set of minimum conditions and standards of care be established to safeguard rights and the provision of optimal care within a SMHF.

Observation 5: That access to rehabilitation services be sustained as a matter of priority to ensure the provision of a therapeutic environment and recovery-focused approach to treatment and care.

Observation 6: That consumers, carers, representatives and advocates be informed of policies and procedures on limitations of contact and the rationale for any exceptional restrictions on contact.

Observation 7: That criteria, standards, processes and provisions for leave be legislated via a direction under the Mental Health Act 2015, where decisions about leave are not specified in the patient's mental health order, and the refusal or withdrawal of leave be considered as reviewable decision and provisions made for external oversight.

Observation 8: That all information on the rights of patients receiving mental health treatment and care be updated and published in accessible formats and that all Dhulwa staff be trained on human rights and be enabled to actively facilitate consumer access to accurate and timely information and community advocacy services and supports.

Observation 9: That consistent terminology and reference to intersecting legislation, policies, procedures or guidelines be used when updating the Act, subordinate legislation and associated operational documents, and that all such documents be made available to consumers, carers, community and civil advocacy services and supports.

Observation 10: That consideration be given to the enhancement of clinical record functionality, to negate the need for paper records and support the creation of electronic registers, encompassing automated notification, as a by-product of the electronic clinical record.

Observation 11: That all SMHF staff receive updated and compulsory training on the:

- Human rights of patients (custodial, forensic and civil)
- Legislative framework within which they operate
- Appropriate and proportionate use of restrictive practices
- Requirement to record and register all restrictive practices
- Associated reviewable decision requirements and administrative processes.

Observation 12: That the Public Advocate be informed of any use of force or strip search and that independent review mechanisms be established to strengthen governance and oversight, and that a learning system approach in support of continuous quality improvement be adopted.

Observation 13: That explicit provisions be made to ensure that both consumers and staff are empowered to voice any issues or concerns within a broader framework of a learning system focused on enhancing safety and the consumer and staff experiences of care.

Observation 14: That a summary of the roles and responsibilities of Canberra Health Services and ACT Health Directorate, including the Chief Psychiatrist and the Office for Mental Health and Wellbeing, with specific regard to secure mental health facility patients, be published to enhance system literacy.

2.7 AGENCY RESPONSE

In accordance with best practice, ACTHD and CHS were provided with a draft report for consideration and comment. All comments were considered and, where appropriate, changes were incorporated into this final report.

3. INTRODUCTION

The following summarises the legislative framework for the provision of a secure mental health facility (SMHF), and the objective, scope, approach, limitations and challenges of the review.

3.1 LEGISLATIVE FRAMEWORK

3.1.1 SUMMARY OF LEGISLATION

The *Mental Health (Secure Facilities) Act 2016* (the Act)[1] came into effect on 20 June 2016.

The Act makes provision for '*an approved mental health facility*' (designated under the section 261 of the *Mental Health Act 2015* (Mental Health Act)[2] to be declared *'a secure mental health facility'* (s7(1)), whereby the SMHF is conducted by the Territory and provides for, or will provide for, the involuntary detention and treatment of people, including correctional patients and forensic patients (s7(2)).

This provision provides the opportunity for the Minister to declare any approved mental health facility to be a SMHF should it be considered necessary and meet the test set out in section 7(2).

The Act:

- Governs the operation of a designated SMHF in the ACT
- Establishes a statement of the powers, rights, procedures and obligations of those accessing and working in a SMHF
- Recognises that people residing in a SMHF are deprived of their liberty.

The accompanying Explanatory Statement[3] clarifies the purpose of the Act: *'…The Bill is required to consistently balance two competing demands. One, the need to ensure that secure mental health facilities are safe for all people within them. Two, that any restrictions that are in place are necessary, proportionate and do not unduly restrict the rights of people.'*

The Act was developed to:

- Ensure that those who work or receive care in a secure mental health facility have a clear legislative statement of powers, rights and responsibilities, to best provide a safe therapeutic place that is conducive to a consumer's recovery and safety
- Consistently balance the requirement for safety and security against restrictive practices that are necessary and proportionate, and which may limit the human rights of mental health consumers
- Make provision for adequate checks and balances in the use of restrictive powers.

[1] ACT Government. ACT Mental Health (Secure Facilities) Act 2016. https://www.legislation.act.gov.au/a/2016-31/

[2] ACT Government. Mental Health Act 2015. https://legislation.act.gov.au/a/2015-38/

[3] ACT Government. Mental Health (Secure Facilities) Bill 2016. Revised Explanatory Statement.

3.1.2 DELEGATIONS

The Act refers to the Director-General (DG), ACT Health Directorate (ACTHD) as having specific functions, powers and reporting requirements. In accordance with the Public Sector Management Act 1994, the position of Chief Executive Officer (CEO) of Canberra Health Services (CHS) has the same functions and authority as the DG.

Section 12 of the Act makes provision for the delegation of DG functions under the Act to an authorised health practitioner.

Delegations under the Act are set out in:

- Notifiable Instrument NI2020-472 – Mental Health (Secure Facilities) Delegation 2020 (No. 1), effective 3 April 2020.[4] This revokes Mental Health (Secure Facilities) Delegation 2017 (No. 1) NI2017-606.

3.1.3 PRIMARY LEGISLATION

Primary legislation includes:

- The Mental Health Act, which establishes principles and objects for the provision of 'approved mental health facilities', encompassing designated SMHFs
- The Human Rights Act 2005, which establishes individual rights within the ACT.

However, the ACT Human Rights Commission points out that:

- The absence of an explicit Objects clause in the Act is unique among other Territory laws that regulate closed settings.
- All other Australian human rights jurisdictions govern SMHFs within their primary mental health legislation.
- Staff have public authority obligations under section 40B of the Human Rights Act, to act consistently with human rights and properly consider relevant rights when making a decision.

This view is reflective of feedback from all other stakeholders who, like Commissioners, now query the separation of primary mental health legislation and SMHF legislation.

Recommendation 1: That consideration be given to the merits of separate secure mental health facility legislation and whether such provisions would best be incorporated into the Mental Health Act (i.e., primary legislation), which pays specific regard to section 40B of the Human Rights Act.

3.1.4 SUBORDINATE LEGISLATION

Subordinate legislation made pursuant to section 9 (general power) of the Act include:

Section 10: Prohibited things, and	**Notifiable Instrument NI2021-466** – Mental Health (Secure Facilities) Prohibited and Restricted Items and

[4] ACT Government. Notifiable Instrument NI2020-472 – Mental Health (Secure Facilities) Delegation 2020 (No 1). Effective 3 April 2020. https://www.legislation.act.gov.au/View/ni/2020-472/current/PDF/2020-472.PDF

Section 73 Prohibited things – tradespeople	Items Requiring Approval Secure Mental Health Facility Direction 2021,[5] effective 3 August 2021*
Section 44: Strip searches – when may be conducted	**Notifiable Instrument NI2021-312** – Mental Health (Secure Facilities) Strip Searches Secure Mental Health Facility Direction 2021,[6] effective 28 May 2021* revoking: • **Notifiable Instrument NI2016-624** – Mental Health (Secure Facilities) Strip Searches Secure Mental Health Facility Direction 2016
Section 60: Managing use of force	N**otifiable Instrument NI2021-414** – Mental Health (Secure Facilities) Use of Force Secure Mental Health Facility Direction 2021,[7] effective 9 July 2021* revoking: • **Notifiable Instrument NI2016–623** – Mental Health (Secure Facilities) Use of Force Secure Mental Health Facility Direction 2016
*Subordinate legislation introduced outside of the review period	

No subordinate legislation existed on the definition or restriction of prohibited and restricted items and items requiring approval, prior to or during the review period.

3.1.5 INTERSECTING LEGISLATION

Intersecting legislation is specified throughout the Act including, for example, the ACT Civil and Administrative Tribunal Act 2008[8], the Guardianship and Management of Property Act 1991[9], the Official Visitor Act 2012[10] and the Health Practitioner Regulation National Law (ACT) Act 2010.[11]

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[5] ACT Government. Notifiable Instrument NI2021– Mental Health (Secure Facilities) Prohibited and Restricted Items and Items Requiring Approval Secure Mental Health Facility Direction 2021. Effective 3 August 2021. https://www.legislation.act.gov.au/View/ni/2021-466/current/PDF/2021-466.PDF

[6] ACT Government. Notifiable instrument NI2021-312 - Mental Health (Secure Facilities) Strip Searches Secure Mental Health Facility Direction 2021. Effective 28 May 2021. https://www.legislation.act.gov.au/View/ni/2021-312/current/PDF/2021-312.PDF

[7] ACT Government. Notifiable instrument NI2016–623 - Mental Health (Secure Facilities) Use of Force Secure Mental Health Facility Direction 2021. Effective 28 May 2021. https://www.legislation.act.gov.au/View/ni/2021-414/current/PDF/2021-414.PDF

[8] ACT Government. ACT Civil and Administrative Tribunal Act 2008. https://www.legislation.act.gov.au/a/2008-35/

[9] ACT Government. Guardianship and Management of Property Act 1991. https://www.legislation.act.gov.au/a/1991-62/

[10] ACT Government. Official Visitor Act 2012. https://www.legislation.act.gov.au/a/2012-33/

[11] ACT Government. Health Practitioner Regulation National Law (ACT) Act 2010. https://www.legislation.act.gov.au/a/2010-10/

Offences against the Act are managed under the Criminal Code, chapter 2.[12]

3.2 OBJECTIVE, SCOPE AND APPROACH OF THE REVIEW

3.2.1 OBJECTIVE

The objective of the review was to determine whether the human rights of consumers are safeguarded by the Act and that the legislation ensures a SMHF operates safely.

In doing so, consideration was given to whether:

- The rights of the consumer are clear and understood and consumers are both informed and supported to apply these rights
- The legislative framework has been implemented appropriately and fairly
- There is effective implementation and governance of the requirements of the Act
- There is value in modernising the legislation to better safeguard the rights of consumers or ensure a facility is safe for all people within it.

3.2.2 SCOPE

The focus of the review was the operation of the Act, distinct from the operation of the Mental Health Act 2015, or the operations of Dhulwa, the ACT's only designated SMHF.

3.2.3 APPROACH

The review encompassed:

- Desktop review of artefacts including, for example, the Act and subordinate legislation; records and registers, notices and applications required under the Act (see Appendix A); governance, reporting and oversight artefacts; associated policies, procedures, protocols and guidance; information and supports provided to consumers; and information, education and supports provided to staff
- Analysis of data including, for example, contextual data and service profiles; records and registers required under the Act, and reviewable decision notifications and applications for review required under the Act
- Stakeholder engagement and public consultation[13] encompassing consumers, carers, representatives and advocates; community and community services; executives, clinicians and staff at Dhulwa and CHS mental health services; and ACT Government officials.

Appendix B provides a list of those stakeholders invited to participate in the review.

All stakeholders were encouraged to participate via various means including forums targeted at specific groups, interviews and written submissions.

[12] ACT Government. Criminal Code 2002. Chapter 2. https://www.legislation.act.gov.au/View/a/2002-51/current/PDF/2002-51.PDF

[13] ACT Government. Engaging Canberrans: A Guide to Community Engagement. https://yoursayconversations.act.gov.au/about/community-engagement

The following is a summary of activity:

Engagement and consultation activity					
Forums	One	**Interviews**	Eight	**Written submissions**	Ten

Appendix C clarifies engagement activity, including dates of stakeholder interviews and provides a list of written responses to the public consultation.

Dhulwa patients were given the opportunity to provide direct feedback via interview or in writing. Following several attempts, no patient chose to directly participate in the review. Consumer representatives, carers, consumer advocacy and community organisations that chose to contribute to the review did so via the community and consumer representative forum, interview and/or written responses.

While CHS executives chose not to submit a written response to the consultation and Dhulwa and CHS staff chose not to participate in a forum discussion, several meetings were held with executives, senior officers and clinical directors. In addition, a site visit to both Dhulwa and the Acute Mental Health Unit at Canberra Hospital elicited direct feedback from staff and consumers alike.

3.3 CHALLENGES AND LIMITATIONS

3.3.1 CHALLENGES

Two challenges were presented during the conduct of the review:

- Discerning whether feedback related directly to the Act itself or to primary legislation (i.e., the Mental Health Act)
- Discerning matters relating to the operation of the Act, distinct from matters relating to the implementation of the provisions of the Act and/or operations of Dhulwa.

All stakeholders provided feedback on each of the above, alongside feedback on the Act itself.

To ensure the review fairly represented the breadth of feedback from stakeholders, the report provides observations on the implementation of the Act and/or operations of Dhulwa for consideration by ACTHD and/or CHS as appropriate (see Attachment).

3.3.2 LIMITATIONS

This report does not provide legal opinion or advice.

3.4 SECURE MENTAL HEALTH FACILITIES TO WHICH THE ACT APPLIES

Dhulwa Mental Health Unit (Dhulwa) is the only designated SMHF operating within the ACT.[14] It is currently the only facility to which the Act applies.

Provided by CHS as part of its suite of mental health services, Dhulwa opened on 22 November 2016. This secure mental health unit was managed by the Justice Health Service program comprising:

- Primary health – the provision of health care services at Alexander Maconochie Centre and the Bimberi Youth Justice Centre.
- Forensic mental health – the provision of clinical services including assessment, treatment and management of people with a forensic diagnosis and people with a mental illness who have offended or are at risk of offending.

Since July 2021, Dhulwa has been managed by the Director of Nursing and Clinical Director, Forensic Mental Health Services.

The United Ngunnawal Elders Council gifted the name Dhulwa, which means 'honeysuckle', a plant with healing properties.

Dhulwa is a purpose-built facility and home to some of the most vulnerable people across Canberra and the surrounding region: people with complex mental health needs including those who have been involved in the ACT's criminal justice system and civil patients who cannot be treated in a less restrictive environment. While all consumers are deprived of liberty within the unit, this SMHF is not a corrections facility and does not operate as such.

Dhulwa addresses the need for a secure facility to support those people with serious mental health conditions in need of more complex levels of mental health care. In addition to complex mental health issues, these people likely experience a range of social, economic, physical and health related disadvantages.

The 25-bed unit is a purpose-designed SMHF. Seventeen beds, encompassing both acute and rehabilitation beds, are currently funded by ACTHD within the Lomandra and Cassia wards respectively.

[14] ACT Government. Notifiable Instrument NI2106-471. Mental Health (Secure Facility) declaration 2016 (1). Effective 30 August 2016. https://www.legislation.act.gov.au/View/ni/2016-471/current/PDF/2016-471.PDF

4. APPLICATION OF THE ACT TO PARTICULAR GROUPS OF PATIENTS

The Explanatory Note specifies that the purpose of the Act is to govern the operations of a designated SMHF, ensuring that it is safe for all people and that any restrictions are necessary, proportionate and do not unduly restrict the rights of people. This section considers rights, limitations and safeguards established in the Act regarding particular groups of patients and opportunities to strengthen these.

4.1 TREATMENT OF CIVIL PATIENTS AND FORENSIC PATIENTS TO BE DIFFERENTIATED

The Act makes provision for the involuntary detention and treatment of people with moderate to severe mental illness in a designated SMHF who are involved or are likely to become involved in the criminal justice system. This includes:

- Correctional patients and forensic patients (s7(2)), who are cared for under:
  - A forensic mental health order (i.e., forensic psychiatric treatment order[15]); or
  - A psychiatric treatment order (PTO) [16] where application is made for a forensic mental health order and the ACT Civil and Administrative Tribunal (ACAT) is satisfied that a PTO should be made instead
- Civil patients who are cared for under a psychiatric treatment order and are unable to be safely or adequately treated in a less restrictive setting.

Both the Act and supporting CHS Secure Mental Health Unit Operational Model of Care, 2016 (unpublished) recognise that as well as secure mental health care for correctional and forensic patients, there is also a need to provide longer term acute and rehabilitation inpatient care for civil patients with severe and unremitting mental illness or disorder and behavioural disturbance, who are unable to be safely and adequately treated in a less restrictive setting.

While the Explanatory Note makes provision for patient cohorts, no provisions are made in the Act for the cohort of patients it caters for, nor the distinction of rights between correctional, forensic or civil patients while receiving treatment and care within a SMHF.

All stakeholders express significant concern about the imbalance within the Act, which is considered more aligned with correctional legislation, primarily focusing on the security of a SMHF and limitations of rights, with limited regard for the rights of consumers.

Recommendation 2: That the Act explicitly clarify the cohort of patients a secure mental health facility caters for.

4.2 CHILDREN AND YOUNG PEOPLE AND SECURE MENTAL HEALTH FACILITIES

The Act makes provision for a children or youth approved mental health facility to be designated a SMHF (s7), noting that no declaration has been made in this regard and no such facility presently exists in the ACT.

[15] ACT Government. Mental Health Act 2015. Division 7.1.4, Forensic psychiatric treatment order. https://legislation.act.gov.au/a/2015-38/

[16] ACT Government. Mental Health Act 2015. Section 58 (2) (f). https://legislation.act.gov.au/a/2015-38/

Section 13 of the Act makes provision for the treatment of children and young people and sets out the responsibility of a decision-maker in relation to the patient when residing in a SMHF.

The rationale for and circumstances in which section 13 of the Act would apply are unclear to key stakeholders. Feedback from consumers, carers, representatives and advocates asserts that an adult SMHF is not an appropriate environment for the provision of care to vulnerable children or young people.

Section 13 of the Act offers limited protections to children and young people who are treated at a SMHF, should:

a) the Minister designate an approved children or youth mental health facility to be a SMHF or on an exceptional basis,
b) a child or young person be admitted to an adult SMHF.

Commissioners point out that:

- The placement of a child or young person in a SMHF should be considered only as a last resort and not where other alternative settings are available (e.g., Adolescent Mental Health Unit or bespoke arrangements).
- 'The best interest' of the child (s 13(2)) is not, in this context, accompanied by legislative criteria that would consistently guide a decision-maker's understanding of how this concept would be interpreted and applied in the context of a SMHF (e.g., akin to but not modelled on section 349 of the Children and Young Persons Act 2008).

Essential safeguards missing from the Act include:

- Clear process, binding thresholds and criteria for a decision-maker when directing a child or young person be placed in a SMHF for treatment and care
- Oversight of process by the Public Advocate
- Specific minimum standards of treatment and care of children and young people (recognising that on an exceptional basis they may be the only child or young person in the SMHF); for example, access to additional family supports.

Recommendation 3: That safeguards for the treatment of children and young people in a designated secure mental health facility be strengthened by inclusion of criteria and thresholds for the decision-makers, explicit minimum standards of treatment and care, and oversight by the Public Advocate.

4.3 TREATMENT OF FIRST NATIONS PEOPLES

The Act makes limited provision for the safe and protective care of First Nations peoples in a culturally appropriate and therapeutic facility and environment.

The only reference to Aboriginal and Torres Strait Islander peoples is contained in section 13 of the Act, where a decision-maker must take into account matters mentioned in section 10 of the Children and Young Persons Act (Aboriginal and Torres Strait Islander children and young people).

The CHHS Operational Model of Care, Secure Mental Health Unit, 2014 (published yet obsolete)[17] does, however, address the cultural sensitivities of Aboriginal and Torres Strait Islander peoples and people from CALD communities, making provisions for the cultural, gender and spiritual needs of patients.

In recognising the elevated incarceration rates and prevalence of mental illness among Aboriginal and Torres Strait Islander peoples, specific regard should be paid to the explicit rights, culture and cultural safety, and standards of care for Aboriginal and Torres Strait Islander peoples while in a closed setting. Feedback from stakeholders advocates that the development of these should be premised on inclusive engagement with the ACT's Aboriginal and Torres Strait Islander communities.

Recommendation 4: That the Act make explicit reference to the rights, culture and protections of First Nations peoples, encompassing culture and cultural safety, and establish explicit standards of care for Aboriginal and Torres Strait Islander peoples while they are receiving treatment and care in a secure mental health facility.

4.4 TREATMENT OF VULNERABLE PEOPLE

Similarly, the Act makes no explicit provision for the safe and protective care of other vulnerable people while in a closed setting, including, for example, people from CALD communities, and people from the LGBTQI communities.

The CHS Secure Mental Health Unit Operational Model of Care 2016 (unpublished yet operationalised) does, however, include sections on maintaining culturally sensitive practice for CALD communities and people from the LGBTQI communities.

Recommendation 5: That the Act make explicit provisions for the rights and protections of vulnerable people including people from culturally and linguistically diverse communities, and people who identify as either lesbian, gay, bisexual, transgender, queer and intersex.

4.5 TREATMENT OF PEOPLE WITH COGNITIVE OR PHYSICAL DISABILITY

The ACT Mental Health Consumer Network and patient representatives, carers, and Advocacy for Inclusion (incorporating People with Disabilities ACT) point out that the Act makes no explicit provision for the care of patients with cognitive or physical disability in a designated

[17] Mental health, Justice Health and Alcohol & Drug Service. Secure Mental Health Unit Model of Care. May 2014. https://health.act.gov.au/services-and-programs/mental-health/models-care

SMHF, nor references the protections of people with cognitive and physical disability established in international conventions,[18, 19] or Australian or jurisdictional legislation.[20, 21, 22, 23]

In the absence of alternative, less restrictive services or community support, clear processes, criteria and thresholds for decision-makers, and oversight and review mechanisms for the length of detention, carers, representatives and advocates raise concerns about the *'process through which consumers are brought to [a SMHF] Dhulwa, and the detention of people on the basis of disability'*.[24] They point to recommendations made to the Senate Community Affairs Reference Committee 2016 review of *'Indefinite detention of people with cognitive and psychiatric impairment in Australia'*.[22] And in the absence of an appropriate step out/down facility, carers state that the ACAT has no alternative but to continue to detain these patients in the SMHF. As such, the level of restrictions continuing to be placed on people with cognitive and physical disability and their length of stay may be considered unwarranted.

In addition, carers, representatives and advocates point out that people with cognitive and physical disability have limited access to the National Disability Insurance Scheme,[25] and have not been afforded the opportunity to engage with the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.[26]

Advocacy for Inclusion (incorporating People with Disabilities ACT) and Commissioners assert that essential safeguards missing from the Act include:

- Clear process, binding thresholds and criteria for a decision-maker when directing a person with cognitive or physical disability be detained in a SMHF
- Notifications, review of goals of care and length of stay, and oversight of process by the Public Advocate.

Recommendation 6: That safeguards for the treatment and care, and protection of human rights, of people with cognitive and/or physical disability in a designated SMHF be strengthened, minimum standards of treatment and decision-making processes be clarified, and oversight by the Public Advocate be provided.

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[18] International Covenant on Civil and Political Rights. Art 9.
[19] Convention on the Rights of People with Disabilities
[20] Australian Government. Disability Discrimination Act 1992. See https://www.legislation.gov.au/details/c2013c00022
[21] Australian Government. Department of Social Services. National Standards for Disability Services 2013. See https://www.dss.gov.au/sites/default/files/documents/05_2021/nsdsfullversion-may-2021.pdf
[22] ACT Government. Disability Discrimination Act 1991. See https://www.legislation.act.gov.au/a/1991-81/
[23] ACT Government. Disability Services Act 1991. See https://www.legislation.act.gov.au/a/1991-98/
[24] Mr Povey, Victoria Legal Aid. Recorded in the Senate Community Affairs References Committee *'Indefinite detention of people with cognitive and psychiatric impairment in Australia'*. Commonwealth of Australia. Nov 2016, p 147.
[25] ACT Government. Disability and Community Services Commissioner. See https://hrc.act.gov.au/disability/
[26] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. ACT https://disability.royalcommission.gov.au/

5. LEGISLATIVE INSTRUMENTS AND REVIEWABLE DECISIONS

This section considers the power of the DG to make directions and the recording and reporting of notifiable decisions. It makes recommendations for improvement to balance the rights of consumers with the limitations of rights established in the Act and strengthen transparency, oversight and governance.

5.1 DIRECTIONS

Section 9 of the Act empowers the DG '*to make directions in relation to a secure mental health facility (a SMHF direction) to facilitate the effective and efficient management of the facility*' (s9(1)).

Under NI2020-472, this authority is delegated to the following positions:

- Clinical Director, Forensic Mental Health Service
- Operational Director, Justice Health Services
- Director of Nursing, Mental Health, Justice Health and Alcohol and Drug Services.

Section 9 specifies that a SMHF direction must be consistent with the Act, the Mental Health Act and applicable health practitioner registration standards (s9(2)); workers must comply with a SMHF direction (s9(3)); and a SMHF direction is a notifiable instrument (s9(4)).

5.2 DIRECTIONS IN FORCE

Directions required under the Act (i.e., whereby *'the director-general **must** make a direction …'*) and subordinate legislation in force include:

Direction	Subordinate legislation
Section 44: Strip searches – when may be conducted	**Notifiable Instrument NI2021-312** – Mental Health (Secure Facilities) Strip Searches Secure Mental Health Facility Direction 2021,[27] effective 28 May 2021* revoking: • **Notifiable Instrument NI2016-624** – Mental Health (Secure Facilities) Strip Searches Secure Mental Health Facility Direction 2016
Section 60: Managing use of force	**Notifiable Instrument NI2021-414** – Mental Health (Secure Facilities) Use of Force Secure Mental Health Facility Direction 2021,[28] effective 9 July 2021* revoking:

[27] ACT Government. Notifiable instrument NI2021-312 - Mental Health (Secure Facilities) Strip Searches Secure Mental Health Facility Direction 2021. Effective 28 May 2021. https://www.legislation.act.gov.au/View/ni/2021-312/current/PDF/2021-312.PDF

[28] ACT Government. Notifiable instrument NI2016–623 - Mental Health (Secure Facilities) Use of Force Secure Mental Health Facility Direction 2021. Effective 28 May 2021. https://www.legislation.act.gov.au/View/ni/2021-414/current/PDF/2021-414.PDF

	• **Notifiable Instrument NI2016–623** – Mental Health (Secure Facilities) Use of Force Secure Mental Health Facility Direction 2016
*This legislation was introduced outside the review period.	

In this report, Part 6.4 (Searches and seizure of property) and Part 6.5 (Use of force) provide feedback on these directions and opportunities for improvement to subordinate legislation and how it is followed.

5.3 ADDITIONAL DIRECTIONS TO BE MADE

Directions contemplated by the Act (i.e., whereby '*the director-general **may** make a SMHF direction …*') and required to ensure transparency in respect of various restrictions on rights and any subordinate legislation in relation to a SMHF include:

Direction	Anticipated subordinate legislation
Section 10: Prohibited things, and Section 73 Prohibited things – tradespeople	**Notifiable Instrument NI2021-466** – Mental Health (Secure Facilities) Prohibited and Restricted Items and Items Requiring Approval Secure Mental Health Facility Direction 2021,[29] effective 3 August 2021*
Section 16: Contact with family and others – general	**No direction has been made**
Section 19: Patient may request no contact with stated person	**No direction has been made**
Section 24: Electronic communications – directions	Encompassed in **Notifiable Instrument NI2021-466** – Mental Health (Secure Facilities) Prohibited and Restricted Items and Items Requiring Approval Secure Mental Health Facility Direction 2021,[30] effective 3 August 2021*
Section 28 Visiting conditions – direction – general	**No direction has been made**

[29] ACT Government. Notifiable Instrument NI2021 – Mental Health (Secure Facilities) Prohibited and Restricted Items and Items Requiring Approval Secure Mental Health Facility Direction 2021. Effective 3 August 2021. https://www.legislation.act.gov.au/View/ni/2021-466/current/PDF/2021-466.PDF

[30] ACT Government. Notifiable Instrument NI2021 – Mental Health (Secure Facilities) Prohibited and Restricted Items and Items Requiring Approval Secure Mental Health Facility Direction 2021. Effective 3 August 2021. https://www.legislation.act.gov.au/View/ni/2021-466/current/PDF/2021-466.PDF

	Noting:* *Dictionary – visiting conditions*, at a secure mental health facility, means conditions included in a SMHF direction made under section 28 in relation to the facility*

***** This subordinate legislation was introduced outside the review period.

Note:

- *A SMHF direction is a notifiable instrument (see s 9(4)).*
- *Prohibited things (ss 10 and 73) are discussed in this report in Part 6.4 (Searches and seizure of property)*
- *Limitations on contact (ss 16, 19 and 28) are discussed in the Attachment to this report under Part 6* (*Undue limitations on contact).*
- *Electronic communications (s 24) are discussed in this report under Part 6.2* (*Undue limitations on contact) and Part 6.4* (*Searches and seizure of property)*

The Human Rights Commission asserts that reasonable limits on rights must be established in law. However, *'due to their status as notifiable instruments, the rationale and proportionality of select provisions made by direction can be difficult to ascertain.'*

If the purpose of the Act is to govern the operation of a designated SMHF (i.e., ensuring that it is safe for all people and that any restrictions are necessary, proportionate and do not unduly restrict the rights of people) it is unclear why the discretionary power of the DG to establish directions has partially been applied.

Where a discretionary power is provided to restrict rights, it would seem preferable, especially within a human rights jurisdiction, to have clear objects legislated via notifiable instrument.

Unanimous feedback from stakeholders asserts that the lack of transparency of policy in relation to directions contemplated by the Act has the potential to restrict the human rights of patients. Further, Commissioners point out that, *'reasonable limits on rights under the Human Rights Act 2004 must be set by laws (see HR Act, s28)'* and that a *'reliance on unnotified policy and procedures impedes transparency and oversight and may be found to unreasonably interfere with individuals' rights.'*

Recommendation 7: That those directions contemplated by the Act or any other policies, procedures or guidelines that serve to limit the rights of patients be established via statutory instrument to protect the rights of consumers, and enhance transparency, oversight and governance.

5.4 RECORDS AND REGISTERS

The Act makes provisions for the recording and registering of acts that restrict human rights (see Appendix A).

Access to patient records to validate the recording of such activity was not pursued given patient confidentiality. Redacted registers for both Lomandra and Cassia wards were however provided to ACTHD, covering the period 22 November 2016 to 30 December 2020.

Sections of the Act relating to the registers (i.e., sections 18, 27, 42, 59, 54) state that Commissioners are allowed to access registers on request. To strengthen oversight and patient rights, it is suggested that this be amended to also encompass official visitors.

To ensure compliance with the Act, CHS has determined that the register is a compilation of all registered items, which is maintained in paper format on each of the two wards.

A review of the registers provided confirms that, information on restrictive practice appears to be documented in line with the requirements of the Act. While an assurance was provided that all restrictive practice is recorded in the registers, it was noted on the site visit that an operational staff member was unaware of the obligation to record and register restrictive practices and did not know where the registers were located on either ward.

All provisions relating to the use of registers specify, *'The director-general may correct a mistake, error or omission in the register.'* While there appears to be no evidence of changes made to a paper record within either register, Advocacy for Inclusion (incorporating People with Disabilities ACT) points out that if paper registers are to be maintained, the Act should qualify that any revisions must be recorded additionally as a correction, without retroactive change to the record and/or register so as not to impact on transparency and accountability.

With specific regard to provisions for the searching of mail, Commissioners point out that the DG must record in the patient's health record the details of the search including reasons for the search (s25(5)) and keep a register of mail searched (s25 – Monitoring mail) noting that compulsory details do not include the reason for search (i.e., grounds for reasonable suspicion) (s27(2)). This situation thereby impedes effective and proactive oversight of searches.

Recommendation 8: That the Act and associated policy/procedures specify that any revisions to paper registers must be recorded additionally as a correction, without retroactive change to the record, and section 27(2) be amended to include a new subsection requiring the grounds for reasonable suspicion be included in the register of searched mail.

5.5 REVIEWABLE DECISIONS

The Act makes provision for the notification and review of reviewable decisions summarised in Appendix D, whereby an application to the ACAT for review of a decision can be made subject to a notification being made.

This does not preclude the consumer, their representative or a Commissioner from making an application to the ACAT in relation to broader rights established in the Mental Health Act or the Human Rights Act and actions taken in relation to the operations of the Act.

CHS executives, senior officers and clinical directors reported that across the period 22 November 2016 to 31 December 2020, no notification of a reviewable decision was made by Dhulwa staff.

This is corroborated by:

- The Human Rights Commission, which advised that no notifications of reviewable decisions were received across the review period
- A review of the two redacted registers, which suggests no notification was warranted.

In the absence of evidence, it is difficult to substantiate whether this is due to best practice mental health care or a lack of understanding among staff of the rights of consumers, the provisions of the Act, and their obligation to record and notify reviewable decisions.

It is unclear whether a decision under section 17(1) – *Limits of contact with others* as referenced in section 18(1) – *Limits of contact with others – register* is a reviewable decision, given Schedule 1 – *Reviewable decisions* references section 17(2) and not 17(1) as likely intended.

Recommendation 9: That the Act confirm that limitations on contact (section 17(1)) be classified as a reviewable decision (Part 5 and Schedule 1) and provisions made for notification and review.

6. HUMAN RIGHTS ISSUES THAT WARRANT FURTHER PROTECTION IN THE ACT

This section considers the need for additional protections of human rights within a SMHF and makes recommendations to strengthen the rights of vulnerable consumers in a closed setting.

6.1 STANDARDS OF CARE

Advocacy for Inclusion (incorporating People with Disability ACT) points out that, The Act *'does not provide a clear [and comprehensive] statement for the rights, powers and responsibilities for consumers.'* Commissioners, supported by all stakeholders, report that, *'In its present form the Act fails to accord proportionate weight to ensuring a therapeutic environment that supports consumers' recovery and is overly deferential to security concerns.'*

Stakeholders consider the Act does not balance the rights of consumers with safety considerations and makes limited provision for standards of care for those people within a SMHF. Where these are included, they are often written in terms of restrictions rather than rights (including, for example, contact with family, and others (including accredited people) (s16); contact via electronic communications (s 23); contact via mail (s25); contact via visits (s28; and access to health care (s74)).

Feedback from consumer representatives and carers asserts that the absence of positively framed standards of care leaves patients susceptible to coercive behaviour (intentional or not) within the closed setting. Commissioners point out it is ethically, clinically and legally necessary to address the risk of coercion and make mental health care more consensual.[31]

Recommendation 10: That standards of care be positively framed and articulated within the Act.

6.2 UNDUE LIMITATIONS ON CONTACT

Part 3 of the Act makes provision for contact encompassing general contact (Div 3.1) and visitors (Div 3.4), and the monitoring of electronic communications (Div 3.2) and mail (Div 3.3).

Although contemplated by the Act, no explicit SMHF directions have been made by the DG in relation to the following limitation of rights:

- *Section 16 – Contact with family and others – general* – The Human Rights Commission clarifies that while the DG may, in consultation with the Chief Psychiatrist, limit a patient's contact with others (s 17) there is no guidance regarding the criteria or thresholds a decision-maker should have regard to when deciding when to limit contact with others; for example, clarifying in what way contact may '*prejudice the effectiveness of the patient's treatment care or support'.* Further, that while such as decision may be subject to review by the ACAT (s68), '*the Commission and interested people will have limited practical ability to challenge improper decisions to limit a patient's contact in the absence of a more transparent framework'.* Advocacy for Inclusion (incorporating People with Disabilities ACT) points out that in the absence of clear oversight and review processes such limitations may be imposed via reaffirmed limits without end.

[31] Sashidharan S, Mezzina R, Pura D. Reducing coercion in mental healthcare. Epidemiology and Psychiatric Sciences. 2019; Vol 28(6); 605-612. Cambridge University Press.

- In addition, suggested amendments to the Act include section 16(2) to read: '*In particular, the director-general must ensure that adequate facilities are available to contact an accredited person or nominated family member/carer (if nominated person not identified)'*; and sections 17(3) and 17(5) be amended to include: '*advice to nominated person phone nominated family member/carer'.*
- *Section 19 – Patient may request no contact with stated person* and *section 20 – Request by others for no contact with patient* – these sections make provision for contact with a person be prevented. Commissioners point out that the criminal justice system has measures in place to prevent contact between offenders and victims of crime to ensure the safety and wellbeing of community members.[32] These mechanisms provide a way to automatically prevent patients from contacting victims or a person on the Affected Persons Register.
- *Section 24 – Limitations on contact via electronic communications* – No explicit direction is made, nor rationale presented for the limitation of contacts via electronic communications within the Act, although noting that Notifiable Instrument NI2021-466 restricts access to telecommunications devices. Commissioners, consumers, carers, representatives and advocates voice considerable concern over this provision given unreasonable limits on rights, including the freedom of expression. For example, the Consumer Mental Health Forum asserts that detainees at the Alexander Maconochie Centre appear to have greater access to telecommunications such as email or video calls.
- *Section 28 – Visiting conditions – direction – general* – Criteria and thresholds for decision-making regarding limitations on visits are not included in the Act, providing unduly broad discretion to decision-makers. The absence of a SMHF direction in respect of visiting conditions may therefore unreasonably limit rights to family, children, fair hearing, etc. In addition, application and powers in sections 29 and 30 (i.e., to give notice of visiting conditions to visitors; to direct a visitor to leave for non-compliance) appear to rely on visiting conditions having been declared under a SMHF direction made under section 28 of the Act. In this regard, the Human Rights Commission suggests that visiting conditions be established as a disallowable instrument (given their impact on the rights of patients and families). This would enable scrutiny by the Justice and Community Safety Committee of the ACT Legislative Assembly. In addition, that the threshold in section 28 (2)(j) be qualified to read: *'anything else the director-general considers on reasonable grounds to be necessary to protect …'*

In addition:

- Consumer Mental Health Forum, together with Advocacy for Inclusion (incorporating People with Disabilities ACT), note that section 25(3) makes no provision for the reading of mail, yet section 26(3) makes provisions for actions having read mail.
- The Human Rights Commission notes that while a register of searched mail should be maintained (s 27) the grounds for reasonable suspicion precipitating the search of a patient's mail is not required to be included in the register. By contrast, section 25(5) specifies those details to be recorded in patient records, including the *'reasons for the search'*. Access to such information by Commissioners would thereby require patient consent. Omission of the reason for search of mail from the register therefore limits oversight of such activity.

[32] ACT Government. Corrections Management (No-Contact List) Policy 2019.

- Official visitors raise concerns around the transparency for exclusion of accredited people (s 31). In this regard, they suggest that where accredited people are asked to leave [or alternatively restricted access to the SMHF] clear reasons for decision-making should be given to the accredited person as soon as practicable, as per Part 2 of the Act.

All other stakeholders consider provisions for the limitation on contact concerning, especially with regard to those consumers on civil orders. Consumers, carers, representatives and advocates point out that significant restriction of contact has the potential to intensify isolation and loneliness, distress and institutionalisation and further reduce connection with community – all counter to a recovery focus and determinants of poor health outcomes. Further, they point out that a measurable standard of contact should be provided within legislation to allow for sufficient contact and to balance the limitations established within the Act.

Recommendation 11: That limitations on contact (Part 3) be established by direction as a disallowable instrument and all limitations on contact be designated a reviewable decision.

6.3 PROHIBITED THINGS

NI2021-466 – Mental Health (Secure Facilities) Prohibited and Restricted Items and Items Requiring Approval Secure Mental Health Facility Direction 2021 qualifies *'prohibited things'* in accordance with the directions envisaged by the Act (s 10). However, both NI2021-466 and NI2021-312 – Mental Health (Secure Facilities) Strip Searches Secure Mental Health Facility Direction 2021 extend this provision and introduce the terms *'restricted items'* and *'unapproved restricted items'.* These terms are not qualified in the Act and provisions are not made for the restriction of access to items over and above those anticipated as a *'prohibited thing'*.

Consumers, carers, representatives and advocates point out that the Act and subordinate legislation curtail patient rights, especially those of civil patients.

The Act also specifies that seizure of property is a notifiable decision (Part 5 and Schedule 1 of the Act). This is reflected in NI2021-466 which specifies that a notifiable decision notice should be made if prohibited or unapproved restricted items be seized following a search.

CHS reports that no notifiable decisions were made across the period 22 November 2016 to 30 December 2020. However, carers reported that property had been seized yet subsequently returned during the review period (see Part 6.4 below also).

Recommendation 12: That, given the current limitations on rights, the Act be amended to clearly define *'prohibited', 'restricted' and 'unapproved restricted items'* in relation to distinct patient cohorts, together with the criteria used to determine when the director general believes on reasonable grounds that a declaration is necessary to ensure security or good order of a secure mental health facility.

6.4 SEARCHES AND SEIZURE OF PROPERTY

Searches are conducted under the provisions of the Act to find prohibited things and seizable items. Under NI2021-466 and NI2021-312 this provision has been extended to include 'restricted items' and 'unapproved restricted items', damaged property and any item which

may compromise the security of Dhulwa. The use of force (see Part 6.5 of this report) is allowable when conducting searches, a per section 52 of the Act.

A review of both registers provided, covering the period 22 November 2016 to 30 December 2021, evidence that searches appear to be recorded as per section 59(2) and indicate that there were no occasions whereby any items were seized. Yet, as mentioned above, carers reported that property had been seized during a search and did not appear to have been returned in its original state.

Strip searches – Division 4.3 of the Act makes provision for the use of strip search in exceptional circumstances, noting that health practitioners do not have an implied consent to conduct a strip search. A direction must be given by the DG (or delegate) to an authorised health practitioner to conduct a strip search (s 44(2)). This is reflected in NI2021-312, referred to as a 'personal search'.

The Human Rights Commission and Advocacy for Inclusion (incorporating People with Disabilities ACT) assert that Division 4.3 – Strip searches pays limited regard to the provisions of the Human Rights Act, (s10 and s19): *'Protection from torture and cruel, inhumane or degrading treatment'* and *'Anyone deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person'.* This view is shared by consumers and carers, representatives and advocates and qualified in feedback provided by the Australian Nursing and Midwifery Federation.

The use of strip search is not considered to be appropriately balanced with the rights of the consumer. The Act does not adequately reflect that:

- This judgement is made on an assessment of risk.
- The patient has the right to be informed that a strip search may be conducted, regardless of the level of risk.
- If the patient is not deemed high risk at the time, verbal consent should be requested.

Recommendation 13: That, in relation to a strip search, Division 4.3 be updated to better reflect the intent of sections 10 and 19 of the *Human Rights Act 2005*.

Premises – Section 50(b) allows for the patient, or a person named by the patient to be present during a search of premises. NI2021-312 states that, '*The consumer <u>may</u> be offered the opportunity to be present …'.* Given patients may not be offered, informed or supported to make such a request, section 50(b) is not considered proactive protection of rights.

Seizure of property – Section 57 makes provision for a consumer to apply to the Magistrates Court for an order to disallow the seizure of prohibited items, including personal property. A time limit of 10 days for application is established, noting that the DG must be served a copy of the application.

There is no provision for the proactive and timely notification of the Public Advocate nor the pathway to advocacy services to ensure patients understand or are proactively supported to uphold their legal rights in the timescale provided.

Carers reported that they were aware of property being seized during a search during the review period, yet no evidence of this being recorded in registers or notified as required was provided during the review period.

Consumers, carers, representatives and advocates highlight that:

- The logging of seized property in a search register (Div 4.7) and availability of the register on request by a Commissioner does not provide sufficient and timeous oversight or trigger proactive advocacy or support in these circumstances.
- Limitations on access to telecommunications (NI2021-466) exacerbates the tension between intent of the Act and the practical application of the provisions of the Act. Any delay or lack of support which results in the timeframe being missed is considered a significant restriction of rights.

Further, consumers, carers, representatives and advocates highlight that the DG has a duty of care for seized property:

- This relates to taking care and accepting accountability for property in the state it was found, or alternatively replacing property disturbed or damaged in the search.
- A patient should not need to resort to a claim for compensation from the Territory (s 71(3)) for loss or damage caused.

Recommendation 14: That section 50(b) of the Act be amended to state that, *'the patient must be present, or if the patient chooses not to be present, a person named by the patient must be present, unless the patient consents to no-one being present*', and that section 57 be amended to ensure that the Public Advocate is directly informed of the seizure of property to ensure patients receive appropriate recourse in the specified timescales.

Register – Division 4.7 confirms a register of searches must be maintained (s 59(1)), the details and outcome of and any seizure of property must be recorded (s59(2)), and the register must be available for inspection on request by a Commissioner (s59(5)).

The Office for Mental Health and Wellbeing maintains that the mere availability of a register does not ensure that good practice is occurring and that there is a need to do more than make a register available. Further, it maintains that while there are provisions for reviewable decisions, this process is not easily accessible for patients, their guardians or nominated persons.

Both the Office for Mental Health and Wellbeing and Commissioners suggest that a learning system approach be adopted, and processes established in legislation whereby:

- All events relating to an individual should be reviewed in case planning with a view to reducing the use of searches through other strategies and approaches over time.
- The rationale, level, approach to and outcomes of searches should be reviewed by an expert panel to address best practice approaches, human rights consideration and continuous improvement.

Recommendation 15: That all instruments that give effect to the operations of the Act with regard to searches, appropriately and consistently reflect requirements and processes for reviewable decisions as set out in Part 5 and Schedule 1 of the Act.

6.5 USE OF FORCE

The Act specifies that the use of force should be used as a last resort, whereby the authorised health practitioner believes on reasonable grounds that the purpose for the act of force cannot be achieved in any other way (s 61). However, all stakeholders voiced concern over provisions for the use of force.

The use of force is governed by Division 4.8 of the Act, which governs the use of force in relation to searches conducted under section 52 (Searches – use of force), in relation to Division 4.5 (Searches of premises and personal property only). A direction for the use of force can only be given pursuant to section 11, where that is also consistent with sections 60 and 61, and subject to the conditions set out in section 62 of the Act.

The Australian Salaried Medical Officers' Federation highlights a discrepancy between the Explanatory Note and the Act, whereby the Explanatory Note extends to use of force under the Act to the Mental Health Act, which makes provision for the use of restraint and seclusion and the forcible giving of medication (s65) (Powers in relation to psychiatric treatment orders).

The Explanatory Note to the Act states, *'This section engages the right to freedom for forced medical treatment in section 10 (2)(b) of the Human Rights Act 2004'*. The rationale for this being *'to ensure a parity of access to medical services for those in a SMHF that would be enjoyed by the general population'.*

This incongruity appears to leave both patients and medical staff vulnerable. Feedback from clinicians asserts that provisions and intersection with the Mental Health Act are unclear and staff are uncertain of their rights or obligations under the Act.

Subordinate legislation related to the use of force includes:

- Notifiable Instrument NI2021-414 – Mental Health (Secure Facilities) Use of Force Secure Mental Health Facility Direction 2021[33] establishes the CHS clinical procedure for the use of force at Dhulwa by authorised health practitioners, security officers, court security officer and escort officers. This operational procedure makes reference to an unnotified Use of Force Policy. It specifies that, *'Use of force may only be used on a consumer of Dhulwa in conjunction with a search.'* No reference is made to limitations of use in relation to advance agreements or advance consent agreements.
- Notifiable instrument NI2021-312 – Mental Health (Secure Facilities) Strip Searches Secure Mental Health Facility Direction 2021[34] authorises the use of force in accordance with Division 4.8 of the Act only.
- Notifiable Instrument NI2021-466 – Mental Health (Secure Facilities) Prohibited and Restricted Items and Items Requiring Approval Secure Mental Health Facility Direction 2021[35] specifies that all searches must be conducted in line with the Dhulwa Searching Policy (i.e., NI2021-312 above) and in accord with the Dhulwa Use of Force Policy (i.e., NI2021-414).

[33] ACT Government. Notifiable instrument NI2016–623 - Mental Health (Secure Facilities) Use of Force Secure Mental Health Facility Direction 2021. Effective 28 May 2021. https://www.legislation.act.gov.au/View/ni/2021-414/current/PDF/2021-414.PDF

[34] ACT Government. Notifiable instrument NI2021-312 - Mental Health (Secure Facilities) Strip Searches Secure Mental Health Facility Direction 2021. Effective 28 May 2021. https://www.legislation.act.gov.au/View/ni/2021-312/current/PDF/2021-312.PDF

[35] ACT Government. Notifiable Instrument NI2021- Mental Health (Secure Facilities) Prohibited and Restricted Items and Items Requiring Approval Secure Mental Health Facility Direction 2021. Effective 3 August 2021. https://www.legislation.act.gov.au/View/ni/2021-466/current/PDF/2021-466.PDF

NI2016-623 (revoked) combined both the provision of the Act (i.e., searches of premises and personal property) and provisions set out in the Mental Health Act pertaining to the use of force encompassing involuntary seclusion and the forcible giving of medication (s 65). It also specified that the use of force should not be used to give effect to an advance agreement (s 28(2)) or advance consent agreement (s28(3) of the Mental Health Act).

There now appears to be no notifiable instrument (nor visible policy or procedure) encompassing risk assessment, de-escalation and application of force as previously encompassed in section 2 of NI2016-623 (revoked).

Consumers, carers, advocates and representatives, including Commissioners, are concerned that Division 4.8 and subordinate legislation align more closely to corrections management legislation and not a recovery-focused model of mental health care premised on a therapeutic environment and least restrictive practice.

Patient advocates consider the sanctioning of the use of force is extreme (i.e., *'as far as practicable, in a way that reduces the risk of causing death or grievous bodily harm'* (s62(d) - a sentinel event), and that the Act should emphasise that the use of force should always be exercised subject to the terms of human rights legislation and the principles of *'least restriction'* and the minimisation of potential harm (i.e., physical and psychological).

The Human Rights Commission asserts that human rights in a SMHF require more exacting and transparent standards of care given the additional vulnerability of patients in a closed setting. Further, it asserts that the circumstances, kinds and use of force must not be relegated to a notifiable instrument but specified in primary legislation within a human rights jurisdiction.

Commissioners point out that provisions made in sections 138–139 of the Corrections Management Act 2007 and sections 224–225 of the Children and Young People Act 2008 offer minimum safeguards based on international and domestic case law. These may include, but are not limited to:

- Thresholds for the use of force (e.g., that the health practitioner believes on reasonable grounds that the purpose for using force cannot be achieved in any other way)
- Setting out the purpose for which force will be used (i.e., which may be further qualified by subordinate legislation)
- Requirements that the health practitioner be trained and skilled in de-escalation strategies and non-coercive practices
- Requirements that the health practitioner give a clear warning of their intention to use force (except in urgent circumstances)
- The use of force is considered the last resort and proportional to the desired outcomes (i.e., be no more than what is considered necessary and reasonable in the circumstances)
- Medical examination to be provided to a person as soon as practicable and within a maximum period (e.g., 2 hours after the incident) recognising that officers may not be in a position to ascertain whether a patient has been harmed or impacted, physically or psychologically, by the use of force
- Recording, registering, reporting and review requirements clearly established.

While those Acts make provision for the medical review of patients following the use of force where the patient has been injured, consumers, carers, advocates and representatives and the Human Rights Commission suggest that all patients should be medically reviewed within a

defined time period (e.g., no more than 2 hours), in recognition that staff may not be aware that a patient has been injured.

The Act requires that a register must be kept of any incident involving use of force (s 65). The use of force is not however considered a reviewable decision because the clinical decision-making process cannot be overturned since the action has occurred. This is not to say that the consumer doesn't have rights of recourse or that keeping a register negates the need to adopt a learning system approach to inform future best practice.

While the register must be available for inspection at the request of a Commissioner (should the Commissioner be made aware of the occurrence), there is no provision in the Act to proactively inform the Public Advocate of such an occurrence in a timely manner.

Recommendation 16: That provisions for the use of force, the use of involuntary seclusion and the forcible giving of medication be clarified, and that decision-making criteria and safeguards be established in primary legislation; that a register of all such activity be legislated and provision made to proactively inform the Public Advocate of the use of force.

ATTACHMENT: OBSERVATIONS OUTSIDE OF THE OPERATION OF THE ACT

During the consultation process various other matters came to light which, although outside of the scope of this review, are included here to ensure the report fairly represents the depth of feedback from consumers and other key stakeholders and that matters pertaining to practice may be appropriately considered by government in pursuit of clinical excellence and continuous quality improvement.

Additional observations relate to intersecting legislation and/or the operations of Dhulwa and include:

1. STATEMENT OF CONSISTENCY WITH MENTAL HEALTH ACT AND HUMAN RIGHTS ACT

'Section 198A of the MHA [Mental Health Act] provides for the Chief Psychiatrist to make guidelines for a mental health facility in relation to any matter under this Act. [Where not made by notifiable instrument] *Such guidelines must be accompanied by a statement about how the guideline is consistent with the MHA's objects and principles and human rights.'*

Consideration of human rights in the development of all guidelines pertaining to the Act is required under section 40B of the Human Rights Act. While SMHF directions made via notifiable instrument need not be accompanied by a statement on their impact on human rights, it may be beneficial for all other guidelines to be accompanied by such a statement.

Observation 1: That the Chief Psychiatrist ensure that secure mental health facility related guidelines not established via notifiable instrument be accompanied by a statement clarifying how the guideline is consistent with primary legislation and human rights, and that these statements be published alongside guidelines.

2. MODEL OF CARE

A model of care[36] for a secure mental health unit was developed and published in May 2014. This document appears to present a business case for the development of a secure mental health facility while providing a framework to inform the design and operations of the unit and documentation for community engagement. This published document predates the development of the Act, associated notifiable instruments, the opening of Dhulwa and introduction of Dhulwa policies and procedures. It also predates the Mental Health Act 2015.

The Human Rights Commission advised that it provided a submission on the published Dhulwa model of care on 4 March 2015[37] in response to the introduction of the Mental Health Act and concerns over misalignment and the need to safeguard the rights of consumers in a SMHF setting. The need for a review of the model of care was again raised by the Human Rights Commission during the redevelopment of the Extended Care Unit, Brian Hennessey Rehabilitation Centre. The Human Rights Commission reports that issues raised remain unaddressed.

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[36] Mental health, Justice Health and Alcohol & Drug Service. Secure Mental Health Unit Model of Care. May 2014. https://health.act.gov.au/services-and-programs/mental-health/models-care

[37] ACT Human Rights Commission. Submission. Secure Mental Health Unit Model of Care. 4 March 2015. https://hrc.act.gov.au/resources/submissions/secure-mental-health-unit-model-care/

The Mental Health, Justice Health and Alcohol and Drugs Services, CHHS established an Operational Model of Care – Secure Mental Health Unit in August 2016.[38] It seems that this unpublished document was developed in response to consultation on the consultative document, May 2014 published version.

The revised yet unpublished but operationalised model of care, 2016 now sits alongside the Forensic Mental Health Services model of care document[39] released (i.e., published) in November 2019, highlighting a discrepancy of approach.

The CHS Operational Model of Care – Secure Mental Health Unit, 2016 (unpublished yet operationalised) is not accessible to consumers, carers, representatives and advocates or any other key stakeholder.

The CHS Operational Model of Care – Secure Mental Health Unit, 2016 (unpublished yet operationalised) is supported by a consumer information booklet.[40] This aims to provide an overview of the operations of Dhulwa and information relevant to consumers, including legislative provisions, rights and limitations on liberty. Again, this document is unpublished. No carer or patient representative/advocate reported having received a copy of this booklet and advised that they weren't aware of patients having received or having access to a copy either.

Patient representatives and carers recognise that these two publications (i.e. the unpublished CHS Operational Model of Care – Secure Mental Health Unit, 2016 and the consumer information booklet) operationalise the provisions of the Act.

The lack of visibility of these documents creates information asymmetry and a power imbalance for patients and external stakeholders including carers, consumer advocates and representatives.

Feedback highlights that the lack of access to such documents often leads to a mismatch of expectations, frustration and sense of helplessness as consumers, carers, advocates and representatives try to determine how to interact with service providers and navigate care processes and, most importantly, how consumer rights are upheld within the SMHF closed setting.

This situation appears to be incongruous with the Human Rights Act, the ACT's standing as a human rights jurisdiction, the intent of the Act, the objects of the Mental Health Act, and the ACT Charter of Rights for People Who Experience Mental Health Issues.[41]

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[38] Canberra Hospital and Health Services. Operational Model of Care. Secure Mental Health Unit. Mental Health, Justice Health and Alcohol & Drugs Service. August 2016.
[39] Canberra Health Services. Forensic Mental Health Services. Model of Care. November 2019. https://health.act.gov.au/services-and-programs/mental-health/models-care
[40] Canberra Hospital and Health Services. Welcome to Dhulwa Mental Health unit. Consumer Information Booklet. Secure Mental Health Unit. Mental Health, Justice Health and Alcohol & Drugs Service.
[41] ACT Health. The ACT Charter of Rights for people who experience Mental Health Issues. https://health.act.gov.au/sites/default/files/2018-09/ACT%20Charter%20of%20Rights%20for%20people%20who%20experience%20mental%20health%20issues.pdf

Observation 2: That the CHS Secure Mental health Unit Operational Model of Care, 2016 (unpublished) and the consumer information handbook be reviewed and refreshed as appropriate, made available to all patients, carers and representatives, and published on the ACT Health website.

3. TREATMENT OF VULNERABLE PEOPLE

The unpublished CHS Secure Mental Health Unit Operational Model of Care, 2016 is a generic document, aiming to address the needs of all patients while receiving treatment and care within a SMHF. The document translates the operation of the Act into implementation and service delivery.

However, the needs of consumers are not homogenous. To ensure the service explicitly addresses the needs of specific cohorts of patients, stakeholders suggest that explicit models of care be developed to better address the needs of, and in doing so protect the rights of, First Nations peoples; children and young people; people from the LGBTQI communities; people from culturally and linguistically diverse communities; and people with cognitive or physical disability.

Observation 3: That specific models of care be developed for First Nations peoples; children and young people; people who identify as either lesbian, gay, bisexual, transgender, queer and intersex; people from culturally and linguistically diverse communities; and people with cognitive and/or physical disability.

4. MINIMUM CONDITIONS AND STANDARDS OF CARE

In line with the ACT Government's standing as a human rights jurisdiction, the Human Rights Commission points out that section 19 of the Human Rights Act mandates government to ensure the humane treatment and dignity of detained people, including those residing in a closed setting, informed by international law.

Further, that *'these people should not be subjected to hardship or constraint beyond that resulting from their deprivation of liberty'* and that the ACT Government is obligated to establish minimum standards for conditions and treatment of involuntary detention, recognising that some patients may be detained in a SMHF for a lengthy period of time.

Although noting that the following legislation encompass places of residence and not places of treatment, examples of minimum conditions and standards of care while in a closed setting are established by the ACT Government in:

- Section 141 – Detention places – minimum living conditions, and Part 6.5 – Living conditions at detention places of the Children and Young People Act[42]
- Chapter 6 – Living conditions at correctional centres of the Corrections Management Act.[43]

[42] ACT Government. The Children and Young People Act 2008, s 141, Detention places – minimum living conditions and Part 6.5, Living conditions at detention places https://www.legislation.act.gov.au/View/a/2008-19/current/PDF/2008-19.PDF

[43] ACT Government. The Corrections Management Act 2007, Chapter 6, Living conditions at correctional centres. https://www.legislation.act.gov.au/View/a/2007-15/current/PDF/2007-15.PDF

These specify the minimum conditions of care and support a recovery focused approach in a closed setting.

A compilation of feedback from all stakeholders suggests minimum conditions and standards of care should be framed positively and articulated within the Act and include (but are not limited to):

- The right and ability to participate in elections and vote
- Provision for religious, spiritual and cultural needs
- access to fresh air and exercise, nutritional food, meaningful activities and programs, publications, news and current affairs
- Access to education (including higher education) and training, associated tools and resources including (e.g., laptops and online learning platforms) and educational supports where appropriate
- The ability to express one's personal identify through choice of clothing
- Personal hygiene and sleeping conditions
- Cultural safety and mental health safety
- Access to high quality prevention, primary, secondary and tertiary health care
- A recovery-based care plan and interventions focused on transition to less restrictive practice and environments
- The right of review of outcomes and evaluation of effectiveness of and time limits on detention
- Transitional support, case management and care coordination to support step out and step down provisions that sustain person-centred care and the recovery journey
- The right to a second opinion or change in health practitioner to strengthen relational safety, person-centred and trust-based care
- Access to advocacy and supported decision-making services – as per the principles of decision-making capacity set out in the Mental Health Act (s 8(1)) and the Australian Law Reform Commission which states that legislation and legal frameworks must contain appropriate and effective safeguards and provisions for those people who may require decision-making support, including to prevent abuse and undue influence[44]
- Services and supports that address health determinants and social inequality including, for example, access to finance including benefits (as appropriate), the National Disability Insurance Scheme and My Aged Care where eligible, and access to housing, transitional care and step down services post discharge etc.
- Opportunities to provide feedback on the experience of care and raise concerns/complaints without fear of reprisal and the administrative burden of ACAT proceedings.

Further, feedback suggests that these provisions should provide for the differential treatment of custodial, forensic and civil patients.

[44] The Australian Law Reform Commission. Equity Capacity and Disability in Commonwealth Laws Final Report ALRC Report 124, Aug 2014, pg. 64. https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/

Commissioners assert that minimum conditions and standards of care are considered a right rather than a privilege and that lack of clarity within a closed setting unduly limits the rights of the individual.

Feedback from consumer representatives and carers assert that the absence of these rights mean patients may be susceptible to coercive behaviour (intentional or not) within a SMHF. Commissioners point out it is ethically, clinically and legally necessary to address the risk of coercion and make mental health care more consensual.[45] Further, they point out that a decision to restrict access to these minimum living conditions should never be used in a coercive or punitive manner.

Observation 4: That a comprehensive set of minimum conditions and standards of care be established to safeguard rights and the provision of optimal care within a SMHF.

5. ACCESS TO REHABILITATION SERVICES AND FACILITIES

The Act specifies that the DG must ensure that patients have access to timely preventative and health care services and, as far as practicable, specialist health care and rehabilitation programs. The model of care documentation qualifies that a range of therapeutic interventions will be provided based on a recovery-orientated treatment and rehabilitation program. The ACT Charter of Rights for people who experience Mental Health Issues[46] states that, 'people (regardless of setting) have the right to care that promotes independence and recovery.'

During the site visit there was no evidence of rehabilitation services in progress. Patients and staff (and subsequently, carers) reported that rehabilitation and recreational activities were limited by the availability of appropriately trained staff and the curtailment of activities due to COVID-19 restrictions implemented by CHS.

It was, however, encouraging to hear that a new Director of Allied Health had commenced and was developing a new therapeutic program for patients to address their goals of care and increase activity.

Observation 5: That access to rehabilitation services be sustained as a matter of priority to ensure the provision of a therapeutic environment and recovery-focused approach to treatment and care.

6. LIMITATIONS ON CONTACT AND THE COVID-19 RESPONSE

Feedback from consumers, carers, representatives and advocates suggests that the rights of the consumer are curtailed in practice beyond the limitations of the Act, citing, for example:

[45] Sashidharan S, Mezzina R, Pura D. Reducing coercion in mental healthcare. Epidemiology and Psychiatric Sciences. 2019; Vol 28(6); 605-612. Cambridge University Press.
[46] ACT Health. The ACT Charter of Rights for people who experience Mental Health Issues. https://health.act.gov.au/sites/default/files/2018-09/ACT%20Charter%20of%20Rights%20for%20people%20who%20experience%20mental%20health%20issues.pdf

- Limits on the number of family and friend phone contacts a patient may have (i.e., limited to 3 approved people)
- Limits on the number of visits and the amount of time a visitor may spend with a patient (e.g., extended visits), and the timing of the visits (e.g., outside of business hours)
- Limits on the number of letters Dhulwa will post on behalf of consumers
- Limits on staff availability and scheduling
- A lack of person-centredness and the accommodation of personal communication preferences (e.g., a patient may prefer written rather than verbal communication methods or vice versa).

In addition, these stakeholders point out the lack of clarity on a pathway to raise concerns and fair processes to remedy these concerns should a consumer, carer, friend, or visitor believe their rights have been curtailed.

Further, restrictions on contact appear to have been intensified during bushfires and the COVID-19 pandemic whereby procedures implemented by CHS are reported to have unduly restricted visitors, while no compensation has been made to strengthen alternative methods of communication or contact (e.g., FaceTime video calls versus a face-to-face visit). For example, carers reported that:

- During summer 2019–20, on days of extreme fire danger, no visits we permitted to Dhulwa thereby curtailing a crucial link to family or friends – an important component of the recovery process during periods of anxiety and stress. In addition, all activities were curtailed, including access to the grounds and exercise facilities.
- Restrictions on visiting rights during Sydney COVID-19 lockdowns as a result of two cases of community acquired transmission in May 2020 were considered overly prescriptive. While the ACT Government ruling stipulated that anyone who had visited specific locations at specific times should self-isolate, CHS rulings were more restrictive, disallowing anyone who had visited the Greater Sydney region from visiting a health facility.
- At one point, CHS restricted visits to one visitor at a time (but allowed different visitors on the same day). Dhulwa typically allows limited visits per week, and no two visits in one day.

Observation 6: That consumers, carers, representatives and advocates be informed of policies and procedures on limitations of contact and the rationale for any exceptional restrictions on contact.

7. LEAVE ARRANGEMENTS

Provisions for leave are made under the Mental Health Act. These may be specified in a mental health order established under Division 7.1.8 of the Mental Health Act, although noting that such an order may not contemplate leave arrangements.

The Human Rights Commission asserts that in the interest of transparency and oversight it is critically important that patients, their carers, and advocates are informed of and understand patient rights to leave and those legislative provisions and processes that serve to protect or limit those rights while a custodial, forensic or civil patient in a closed setting. Further, *'the default approach has been that leave will be granted or refused at the discretion of authorised health practitioners and/or the SMHF.'*

This view is upheld by consumers, carers, representative and advocates who report there is a lack of:

- Transparency of patient rights to leave and the decision-making processes for the granting, refusal and/or withdrawal of leave
- Understanding of the types of leave and specifically the criteria for the granting of what is described as *'internal leave'* (i.e., the ability to use the gym, visit the sport court or the walking track and gardens). (Note: Internal leave is defined as *'ground leave'* in the draft CHS operational procedure for leave management provided to ACT Health).

While conducting a site visit, Dhulwa patients reported frustrations regarding their limited ability to access recreational facilities to aid recovery and fulfil a *'productive day'*, pointing out the health benefits of doing so. Concerns included, for example, only being allowed to access the gym if they had approved leave, for a specified number of times per week, only when a staff member was free to supervise, and at times convenient to staff rosters. As a result of these stipulations, access to the gym could be restricted at any point.

It is noted that the CHS draft operational policy on leave management provided to ACT Health (and subsequently endorsed as CHS21/170 - CHS Operational Procedure – Leave Management for People Admitted to Dhulwa Mental Health Unit and Gawanggal Mental Health Unit, February 2021):

- Adopts a two-stage process for non-urgent medical leave requiring multidisciplinary team approval for the patient to apply for clinical leave followed by leave panel consideration of the request for leave
- Curtails access to escorted leave (including ground leave) for up to two hours per time, three times per week, following approval by the leave panel.

Carers believe unnecessary restrictions are placed on patients and use both the terms 'rights' and 'privileges' when discussing leave.

To ensure patients' rights to leave are upheld appropriately and fairly, the Human Rights Commission asserts that decisions about leave must be based on clear and notified criteria (including patient status and involvement). Further, they and the Consumer Mental Health Forum assert that decisions to refuse or withdraw leave should be considered a reviewable decision for the purpose of Part 5 of the Act and independent review mechanisms established. Again, the Corrections Management Act and the Children and Young Peoples Act provide a useful framework for the management of leave in a closed setting, although noting that these relate purely to the forensic custodial environment.

Observation 7: That criteria, standards, processes and provisions for leave be legislated via a direction under the *Mental Health Act 2015*, where decisions about leave are not specified in the patient's mental health order, and the refusal or withdrawal of leave be considered as reviewable decision and provisions made for external oversight.

8. INFORMATION ON PATIENT RIGHTS

Consumers, carers, representatives and advocates report that in light of the complexities of the mental health system and associated legislation, the lack of transparency of notifiable instruments anticipated by the Act and the fact that ACT Health published information on

patient rights under the Mental Health Act and intersecting legislation is out of date,[47] it is difficult to understand the rights of consumers within the ACT. For example:

- In the absence of clear objects, the purpose of this distinct legislation and its relationship to the Mental Health Act and the Human Rights Act is often misunderstood.
- The ACT Charter of Rights factsheet, including links to legislation, charters, standards and conventions,[48] is not comprehensive and is outdated (e.g., it makes no reference to the Act and references the revoked *Mental Health (Treatment and Care) Act 1994*).

The Mental Health Consumer Network points out that there is no reference in any published SMHF documentation or on the ACT Health website to the My Rights, My Decisions program[49] funded by the ACTHD and provided by them. This service helps consumers establish their nominated person, advance agreement and advance consent direction regardless of setting.

Similarly, there is no reference to the joint ACT Health/Health Care Consumers' Association of the ACT health literacy initiative which promotes mental health literacy.[50]

Consumers, carers, representatives and advocates, and community organisations point out that limited regard is paid to the important role of community and civil advocacy services and the rights of consumers to access these services while in a closed setting. One carer reported that consumers and carers often choose not to seek advocacy support or use their rights, for fear of reprisals in a closed setting.

Further, there is insufficient information in a format that patients, carers and nominated persons (i.e., laypersons) are more likely to understand.

This situation again creates information asymmetry and a power imbalance, limiting consumer access to timely and relevant information in an accessible format and access to advocacy services and supports.

Observation 8: That all information on the rights of patients receiving mental health treatment and care be updated and published in accessible formats and that all Dhulwa staff be trained on human rights and be enabled to actively facilitate consumer access to accurate and timely information and community advocacy services and supports.

9. DHULWA POLICIES AND PROCEDURES

Dhulwa-related policies and procedures provided by CHS during the review are summarised in Appendix E.

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[47] ACT Health. Charter of Rights. https://www.health.act.gov.au/services-and-programs/mental-health/charter-rights

[48] ACT Health. Charter of Rights. Factsheet- Legislation, Charters and Rights based documents that align with Charter of Rights for people who experience mental health issues. https://www.health.act.gov.au/sites/default/files/2018-09/Related%20Legislation%2CCharters%2CStandards%20and%20Rights%20Based%20documents.pdf

[49] *My Rights, My Decisions* program. Mental Health Consumer Network. https://www.actmhcn.org.au/mrmd/

[50] Canberra Health Literacy. Mental Health Literacy. https://cbrhl.org.au/what-is-health-literacy/mental-health-literacy/

A review of those policies and procedures provided determines that, on the whole, they remain consistent with the provisions of the Act (recognising the limitations of the Act as it currently stands).

However:

- Consistent use of terminology used within the Act is not always upheld, often making it difficult to draw a direct relationship between the Act and the operational or clinical policy, procedure or guideline. For example, the term 'strip search' used in the Act is referred to as a 'personal search' in the search policy.
- References to intersecting legislation is not always consistent. For example:
    - CHHS 17/214 CHHS Clinical Procedure – Transfer for Emergency Physical Care: Alexander Maconochie Centre (AMC) and Dhulwa Mental Health Unit (DMHU) makes no reference to the Act or the Mental Health Act 2015.
    - There is inconsistency between the policy (NI2021/312) and procedure (unnotified) on the use of force.

Consumer representatives, carers and advocates again point out that lack of transparency of Dhulwa policies, procedures and guidelines creates information asymmetry, and a mismatch of expectations that has the potential to undermine patient rights.

Observation 9: That consistent terminology and reference to intersecting legislation, policies, procedures or guidelines be used when updating the Act, subordinate legislation and associated operational documents, and that all such documents be made available to consumers, carers, community and civil advocacy services and supports.

10. ADVANCES IN CLINICAL RECORDS MANAGEMENT SYSTEMS, REGISTERS AND REPORTING

Registers are currently maintained in paper format on each of the two wards of Dhulwa.

Given advances in clinical record management systems, it is unclear why, in the digital era, paper registers are still maintained. A comprehensive electronic health record would allow for:

- A clear audit trail, date and time stamping of revisions, and capture of the reason for changes, and entry officer and authorising officer details
- Reduction of duplication via the recording of restrictive practices and their outcomes in the patient record alone
- The flagging and automation of a reviewable decision notice
- Automated generation of registers to be oversighted and scrutinised to support governance arrangements and inform learning and continuous quality improvement.

Observation 10: That consideration be given to the enhancement of clinical record functionality, to negate the need for paper records and support the creation of electronic registers, encompassing automated notification, as a by-product of the electronic clinical record.

11. EXPLICIT STAFF GUIDANCE AND TRAINING ON REVIEWABLE DECISIONS

Although it is noted that all staff receive training on the Mental Health Act and the Act, a review of the CHHS Operational Model of Care, Secure Mental Health Unit 2014 (published yet

obsolete) and the CHS Secure Mental Health Unit Operational Model of Care, 2016 (unpublished yet operationalised) establishes that no reference is made to reviewable decisions or to requirements to notify Commissioners and each entity mentioned in section 67 and column 4 of Schedule 1 of the Act.

The Human Rights Commission reports that *'… many of the most significant challenges the Commission experiences in respect of oversight of practices … relate to consistent patterns of non-compliance with the Act.'*

A review of Dhulwa-related policies and procedures identifies that while some discrepancies may have existed in relation to requirements for and the making of reviewable decisions notices, these appear to have now been resolved in policies and procedures established outside the review period.

Observation 11: That all SMHF staff receive updated and compulsory training on the:

- Human rights of patients (custodial, forensic and civil)
- Legislative framework within which they operate
- Appropriate and proportionate use of restrictive practices
- Requirement to record and register all restrictive practices
- Associated reviewable decision requirements and administrative processes.

12. LEARNING SYSTEM APPROACH

All stakeholders consider the use of force and the use of strip search as being the most inhumane and intrusive restrictions of rights within the Act. Neither are considered reviewable decisions since the clinical decision to use force or conduct a strip search triggers an immediate action that cannot subsequently be overturned.

While the Act makes provision for the recording and registering of the use of force (s 64 and s 65) and the recording of the use of strip search (s 47 and Div 4.7, as reflected in NI2021-312), there is no provision to proactively notify the Public Advocate of such actions to support the consumer after the event.

While internal clinical governance arrangements are in place at Dhulwa, it appears that a formalised process is not established for independent oversight and review of the use of force and/or strip search when it occurs (unless it results in a critical incident or sentinel event). Stakeholders advocate that this be addressed to strengthen oversight and accountability. This would align with the Office for Mental Health and Wellbeing's suggestion that a learning system approach be adopted.

Observation 12: That the Public Advocate be informed of any use of force or strip search and that independent review mechanisms be established to strengthen governance and oversight, and that a learning system approach in support of continuous quality improvement be adopted.

13. COMMENTS, CONCERNS OR COMPLAINTS

Consumers and carers, representatives and advocates raise concerns over the ability of consumers to voice comments or raise concerns or complaints regarding their rights, treatment and experience of care for fear of being seen as resistant or non-compliant.

Further, they suggest that there is no fair process for the consideration of feedback prior to taking an issue to the ACAT.

It is reported that in the current service there is fear that any assertiveness will be interpreted negatively rather than be considered an indication of increasing confidence, capability and independence. Further, it is reported that self-expression may work to the determinant of individual consumers (e.g., it may impact on leave requests/approvals).

The onus is on the patient to voice their concerns; yet the physical environment and vulnerabilities of patients and the above concerns restrict their ability to advocate on their own behalf.

In the absence of provisions on the right of access to community advocacy services, there appears to be an imbalance of power that has the potential to limit consumer rights, restricts transparency and prevents accountability.

In addition, the Act makes no provision for staff or officials to raise concerns regarding actions undertaken that have contravened or risked contravention of the provisions of the Act and human rights.

Observation 13: That explicit provisions be made to ensure that both consumers and staff are empowered to voice any issues or concerns within a broader framework of a learning system focused on enhancing safety and the consumer and staff experiences of care.

14. ROLES, RESPONSIBILITIES AND RELATIONSHIPS

Finally, feedback from all stakeholders suggests there is a lack of understanding of the role, responsibilities and relationships between ACTHD and CHS, the Chief Psychiatrist and the Office for Mental Health and Wellbeing in relation to the operation of the Act and Dhulwa services. This challenges the ability to understand or navigate the mental health system and understand rights and responsibilities.

Observation 14: That a summary of the roles and responsibilities of Canberra Health Services and ACT Health Directorate, including the Chief Psychiatrist and the Office for Mental Health and Wellbeing, with specific regard to secure mental health facility patients, be published to enhance system literacy.

APPENDICES

APPENDIX A: RECORDING AND REGISTERING REQUIREMENTS

The Act makes provisions for the recording and registering of acts that restrict human rights including:

Records, Registers, Notices and Applications

Name of register/record	Pages
Section 18 – Limits on contact with others – register	Pages 10, 11
Section 22 – Patient contact with others – record	Page 14
Section 27 – Searched mail – register	Pages 17, 18
Section 30 – Visitors conditions – record	Page 20
Section 34 – Direction to visitors – record	Page 23
Section 42 – Scanning, frisking and ordinary searches – record	Page 30
Section 47 – Strip search – record	Page 33
Section 51 – Personal property search – record	Page 36
Section 59 – Searched premises and personal property – register	Pages 41, 42, 43
Section 65 – Use of force – register	Pages 45, 46
Section 67 – Reviewable decision notices	Page 47
Section 68 – Applications for review	Page 48

APPENDIX B: STAKEHOLDERS

Stakeholders invited to participate in the review included:

Consumers and community

ACT Health Directorate

Chief Psychiatrist

Chief Medical Officer

The Office for Mental Health and Wellbeing – Co-ordinator General

Canberra Health Services – Mental Health, Justice Health and Alcohol and Drug Services

Executive Director

Operational Director Justice Health Services – Community and Corrections

Director of Clinical Services

Clinical Director, Adult Acute Mental Health

Operational Director, Adult Acute Mental Health

Clinical Director, Dhulwa

Operational Director Justice Health Services – Secure Inpatient

ACT Government

ACT Policing – Mental Health Community Policing Initiative

ACT Corrective Services – Executive Director

Public Trustee and Guardian

Justice and Community Safety Directorate – Legislation Policy and Programs

ACT Human Rights Commission

ACT Human Rights Commissioner

ACT Health Services and Discrimination Commissioner

Victims of Crime Commissioner

Public Advocate and Children and Young People Commissioner

Official visitors

Mental Health Official Visitors

Other (e.g., peak, health, elected body)

Legal Aid Commission

ACT Administrative Appeals Tribunal (*ACAT)*

Mental Health Community Coalition of the ACT

ACT Mental Health Consumer Network

Carers ACT

Capital Health Network

Mental Health Forum (U3A)

Winnunga Nimmityjah Aboriginal Health and Community Services

Aboriginal and Torres Strait Islander Elected Body

ACT Disability, Aged and Carer Advocacy Service

Women's Centre for Health Matters

ACT Disability, Aged and Carer Advocacy Service

Women's Centre for Health Matters

Alcohol, Tobacco and Other Drug Association ACT (ATODA)

Unions

Australian Medical Association (ACT)

The Royal Australian and New Zealand College of Psychiatrists, NSW and ACT

Australian College of Nursing

Australian Salaried Medical Officers' Federation

Health Services Union

ACT Government, Community and Public Sector Union (CPSU)

Australian Nursing and Midwifery Federation

APPENDIX C: ENGAGEMENT ACTIVITY

The following outlines stakeholder engagement activity conducted across the duration of the review.

Interviews

Organisation	Representatives	Date
ACT Human Rights Commission	Health Commissioner	8 April 2021
Legal Aid ACT	Director	8 April 2021
Canberra Health Services – Mental Health, Justice Health and Alcohol and Drug Services	Clinical Director, Dhulwa Operational Director, Dhulwa	8 April 2021
Mental Health Consumer Network – Forum for consumers	Various members	6 May 2021
Carers ACT	Chief Executive Officer	11 May 2021
ACT Human Rights Commission	Public Advocate Deputy Public Advocate	11 May 2021
Public Trustee and Guardian	Deputy Public Trustee	11 May 2021
Mental Health Official Visitors	Official Visitors	11 May 2021
Mental Health Community Coalition	Chief Executive Officer	11 May 2021
Canberra Health Services – Mental Health, Justice Health and Alcohol and Drug Services	Executive Director	14 May 2021
ACT Health Directorate	Chief Psychiatrist	

Written submissions

Responses	
• ACT Human Rights Commission • ACT Mental Health Consumer Network • Advocacy for Inclusion incorporating People with Disabilities ACT • Australian College of Nursing • Australian Nursing and Midwifery Federation	• Canberra Mental Health Forum • Individual carer submission • ACT Mental Health Consumer Network • Mental Health Official Visitors • The Office for Mental Health and Wellbeing

APPENDIX D: REVIEWABLE DECISIONS

As per Schedule 1 of the Act, the following are considered reviewable decisions:

column 1 item	column 2 section	column 3 decision	column 4 entity
1	10 *	declare something to be a prohibited thing	patient
2	17 (2)	restrict a patient's contact with others	patient patient's guardian patient's nominated person
3	20 (2)	prevent a patient's contact with a complainant	patient patient's guardian patient's nominated person
4	24	direction about access to and supervision of electronic communication facilities at secure mental health facility	patient patient's guardian patient's nominated person
5	25 (3)	search a patient's mail	patient patient's guardian patient's nominated person
6	28 (1)	direction about visiting conditions for a secure mental health facility	patient patient's guardian patient's nominated person
7	30 (2)	direction to leave secure mental health facility after failing to comply with visiting condition	visitor directed to leave facility
8	33 (3)	refuse to allow intending visitor to visit patient in secure mental health facility	intending visitor
9	34 (2) (a)	direction to not enter secure mental health facility	visitor directed to not enter facility
10	34 (2) (b)	direction to leave secure mental health facility after failing to comply	visitor directed to leave facility
11	36 (5) (a)	refuse to allow visitor to enter secure mental health facility after refusing to allow authorised person to search personal property	visitor refused entry to facility

12	36 (5) (b)	direction to leave secure mental health facility after refusing to allow authorised person to search personal property	visitor directed to leave facility
13	53 (1)	seizing property	patient patient's guardian patient's nominated person
Key: *Those reviewable decision whereby a related notifiable instrument exists			

APPENDIX E: DHULWA POLICIES AND PROCEDURES

The following provides an overview of related policies and procures provided within the review period:

Document reference	Policy/procedure	Issue date	Review date	Reissued*
CHHS16/198	CHHS Operational Policy: DMHU – Searching	25/10/2016	01/10/2021	CHS21/234 19/04/21 **(NI2021-312)***
CHHS16/208	CHHS Operational Procedure: DMHU – Search Procedure	07/11/2016	01/10/2021	
CHHS16/199	CHHS Operational Policy: DMHU – Use of Force by Authorised Health Practitioners, Security Officer, Court Security Officers and Escort Officers	25/10/2016	01/09/2021	
CHHS16/200	CHHS Operational Procedure: DMHU – Use of Force by Authorised Health Practitioners, Security Officer, Court Security Officers and Escort Officers	25/10/2016	01/09/2021	CHS21/333 **(NI2021-414)***
CHHS16/222	CHHS Operational Procedure: DMHU – Prohibited and Restricted Items	22/11/2016	01/11/2017	CHS21/373 **(NI2021-466)***
CHHS16/224	CHHS Operational Clinical Procedure: DMHU – Valuables, Property and Access to Mail	22/11/2016	01/11/2021	
CHHS16/225	CHHS Operational Clinical Procedure: DMHU – Visitors to Consumers	22/11/2016	01/11/2021	CHS21/375
CHHS17/006	CHHS Clinical Guideline: DMHU – Practice Sensitive to Gender Identity and Sexual Orientation	08/09/2017	01/09/2021	

CHHS17/214	CHHS clinical Procedure – Transfer for Emergency Physical Care: Alexander Maconochie Centre (AMC) and Dhulwa Mental health Unit (DMHU)	05/09/2017	01/09/2021	
CHHS18/147	CHHS Operational Clinical Procedure: DMHU – Provision of Physical Health Care Procedure	25/05/2018	01/03/2021	CHS21/169

* *Reissued versions were noted/provided outside of the review period.*

The following provides an overview of related draft policies and procures provided outside the review period and subsequently recorded on CHS policy and procedures register:

Document reference	**Policy/procedure**	**Issue date**	**Review date**	**Previous version***
CHS21/170	CHS Operational Procedure – Leave Management for People Admitted to Dhulwa Mental Health Unit and Gawanggal Mental Health Unit	17/02/2021	01/03/2024	CHHS16/216*
CHS21/143	CHS Operational Procedure: DMHU – Transfer of Custody	27/01/2021	01/02/2024	
CHS21/192	CHS Procedure: DMHU – Referral, Admission and Transfer of Care	30/03/2021	01/02/2024	CHHS16/179*
CHS21/333	CHS Operational Procedure: DMHU – Escort – Role of Security	03/06/2021	01/07/2024	
CHS21/333	CHS Policy: DMHU – Perimeter Security	03/06/2021	01/07/2024	
CHS21/333	CHS Operational Procedure: DMHU – Perimeter Security	03/06/2021	01/07/2024	
CHS21/333	CHS Operational Procedure: DMHU – Escape or Abscond	03/06/2021	01/07/2024	

***** *Previous versions were not provided to the reviewer during the review period*

Review of the Mental Health (Secure Facilities) Act 2016

MARCH 2022