Mental Health Bill 2014

This Research Brief includes the following sections:

Introduction .......................................................................................................................................................... 1

Background: Victoria’s Reform of the Mental Health Act 1986 ................................................................. 2

Former Labor Government’s Mental Health Act Review .............................................................................. 2
Labor Government’s Response and the Exposure Draft ............................................................................. 13
Stakeholders .................................................................................................................................................. 15

2. Second Reading Speech ......................................................................................................................... 16

3. The Bill ..................................................................................................................................................... 17

Part 1—Preliminary .................................................................................................................................... 17
Part 2—Objectives and Mental Health Principles ..................................................................................... 17
Part 3—Protection of Rights ...................................................................................................................... 18
Part 4—Compulsory Patients ...................................................................................................................... 20
Part 5—Treatment ....................................................................................................................................... 23
Part 6—Restrictive Interventions .................................................................................................................. 26
Part 8—Mental Health Tribunal ................................................................................................................... 27

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For further information on the progress of this Bill please visit the Victorian Legislation and Parliamentary Documents website at http://www.legislation.vic.gov.au.
Part 10—Mental Health Complaints Commissioner ................................................................. 28

4. Other Jurisdictions .............................................................................................................. 30

Tasmania ........................................................................................................................... 30

New South Wales ............................................................................................................... 33

South Australia .................................................................................................................. 35

Queensland ....................................................................................................................... 37

Western Australia .............................................................................................................. 39

References ......................................................................................................................... 41
Introduction

On 18 February 2014, the Minister for Mental Health, the Hon. Mary Wooldridge, introduced the Mental Health Bill 2014 (‘the Bill’). The Bill repeals and replaces Victoria’s Mental Health Act 1986 with a new, updated mental health Act.

Each Australian state and territory has a mental health Act that provides for the compulsory assessment and treatment of people with severe mental illness. Victoria’s current Mental Health Act defines mental illness as a medical condition characterised by a significant disturbance of thought, mood, perception or memory. Some examples of mental illnesses are depression, schizophrenia, schizo-affective disorder and bi-polar disorder.¹

Mental health legislation provides that people with severe mental health problems, who may lack insight into their condition, can be involuntarily treated in hospitals or in the community. In general, although specific criteria may vary, it must be shown that the person needs immediate treatment for their own health and safety or for the protection of others.²

In recent years, there has been a growing movement in Australia and internationally towards a greater protection of the rights of people with mental illness. Australia’s ratification of the United Nations Convention on the Rights of Persons with Disabilities in 2008 (which includes people with mental illness) and the passing of the Victorian Charter of Human Rights and Responsibilities Act 2006, has contributed to the movement in mental health law towards greater emphasis on the rights of involuntary patients.

Against this backdrop, a number of Australian states and territories have established major reviews of their mental health legislation.³ In Victoria, the policy development process that has resulted in this Bill for a new mental health Act has occurred over a number of years.

This Research Brief provides background information on the reform of Victoria’s Mental Health Act 1986. It provides an overview of the former Labor government’s review of the Mental Health Act in 2008; the resulting exposure draft of a proposed Bill for a new Mental Health Act in 2010; and – following the change of government – the further community consultation undertaken by the Coalition Government which lead to the Mental Health Bill 2014.

The Research Brief then provides an overview of the second reading speech for the Bill and a summary of some of the main provisions of the Bill. Notably, it is beyond the scope of the Research Brief to summarise the entire Bill and it excludes provisions relating to security and forensic patients. The Research Brief concludes with an overview of mental health legislation in other Australian states.

**Background: Victoria’s Reform of the Mental Health Act 1986**

**Former Labor Government’s Mental Health Act Review**

Reform of Victoria’s mental health legislation began in 2008, when the former Labor Government announced a review of the existing Act.4 The then Minister for Mental Health, the Hon Lisa Neville, stated that the review would, ‘examine whether [the Act] provides an effective and contemporary legislative framework for the treatment and care of Victorians with a serious mental illness’.5

The consultation paper for the review was released in December, 2008.6 The paper began with a brief history of the current Mental Health Act.7 The Mental Health Act 1986 commenced in 1987 after five years of consultation and policy development. At that time, the Act aimed to define and protect the rights of people with serious mental illness in alignment with international trends. The legislation established criteria for involuntary treatment orders. The Act also established the Mental Health Review Board (the Board), which was formed to provide external reviews of involuntary treatment orders and to hear appeals. In addition, the Act included oversight of particular interventions including electroconvulsive treatment (ECT). The Act also established the role of the Chief Psychiatrist to oversee patients' care.8

In the 1990s, a national approach to mental health commenced in response to deficiencies in the quality of mental health care and policies across Australia. This resulted in the introduction of the National Mental Health Statement of Rights and Responsibilities (1991) and the first National Mental Health Policy and National Mental Health Plan (1992).9 Subsequent plans have since been endorsed by the Commonwealth, State and Territory governments.

In response to changes at the national level, the 1990s also resulted in major reforms to mental health services and policies in Victoria. During this decade, previously stand-alone mental health services were integrated into the general hospital system.

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5 ibid.
6 ibid.
7 ibid., pp. 7-9.
8 ibid., p. 9.
9 ibid., p. 7.
addition, responsibility for the management of mental health services was also transferred from the Department to general hospitals.\textsuperscript{10}

The changes resulted in the highest and most restrictive level of care being offered in acute inpatient beds. Specialised community-based services were also created to improve the management of people with mental illness in the community. These services included psychiatric crisis intervention, continuing care, community residential support services and community bed-based alternatives to hospital admission.\textsuperscript{11}

The consultation paper commented that since the current Mental Health Act was first introduced, there had also been significant developments in the field of international and Australian human rights law. These developments included the introduction of the Victorian Charter of Human Rights and Responsibilities and the United Nations’ Convention on the Rights of Persons with Disabilities.\textsuperscript{12} The review’s terms of reference stated that, ‘The review will aim to ensure that the new Act appropriately protects human rights in light of the Victorian Charter of Human Rights and Responsibilities…’.\textsuperscript{13}

The community consultation phase of the Labor Government’s review was undertaken by a Community Consultation Panel (‘the Panel’), chaired by Mr Julian Gardner.\textsuperscript{14} The Panel released its Community Consultation Report in July 2009.\textsuperscript{15} Some of the key findings of the report are outlined below.

\textbf{Modernising the Law}

In terms of the need for legislation reform, the community consultation report revealed there were several broad areas in which the current Act is significantly outdated.\textsuperscript{16} These included: threshold areas (including the current criteria for a person to be detained involuntarily under the Act); human rights issues; principles of treatment and care and the objects of the law; and codes of practice.

\textbf{Appropriateness of Involuntary Treatment}

The review considered whether or not involuntary treatment for people with mental illness was appropriate. The Panel reported that views on this issue were mixed, however, ‘the majority of submissions identify the need for involuntary treatment, accompanied by robust safeguards to protect human rights’.\textsuperscript{17} On this issue, the Victorian Mental Illness Awareness Council, the peak body for people who have experience with a mental illness or emotional distress, stated in their submission:

\begin{itemize}
  \item \textsuperscript{10} ibid., p. 8.
  \item \textsuperscript{11} ibid., p. 8.
  \item \textsuperscript{12} ibid., p. 10.
  \item \textsuperscript{13} ibid., p. 1.
  \item \textsuperscript{15} ibid.
  \item \textsuperscript{16} ibid., p. 1.
  \item \textsuperscript{17} ibid.
\end{itemize}
Innumerable consumers have stated to the Victorian Mental Illness Awareness Council that if it were not for involuntary detention they would simply not be alive today and on that basis they support the provision in the Act. Others (far less in number) on the other hand believe involuntary detention should not be allowed to occur.\(^\text{18}\)

**Consistency of Involuntary Treatment with the Charter**

The community consultation also considered whether involuntary treatment is consistent with the Victorian Charter of Human Rights and Responsibilities ("the Charter"). On this issue, the report referenced a judgement by the Honourable Justice Bell, then President of the Victorian Civil and Administrative Tribunal, who delivered the first judicial decision relating to the Charter and the review of involuntary orders. The judgement (in the matter of *Kracke v Mental Health Review Board & Ors*) stated:

> The purposes of the Mental Health Act are to ensure mentally ill people who cannot or do not consent get medically necessary care, treatment and protection. Since the treatment will be involuntary, achieving that purpose will seriously interfere with the human rights of patients. Consistently with its purposes, the legislation attempts to protect those rights as far as possible. The purposes of the legislation are therefore to ensure such treatment is given only, first, when medically necessary according to definite criteria and, second, subject to strict safeguards that protect the human rights of patients as far as possible.\(^\text{19}\)

The Panel stated that, given recent developments in human rights and mental health legislation both in Australia and overseas, there was an 'overwhelming community view' that rights protections in the current Act were not sufficient.\(^\text{20}\) Further to this, the Panel stated, 'The Victorian Equal Opportunity & Human Rights Commission notes a failure to ensure that proper safeguards are put in place when a person receives involuntary treatment for mental illness engages rights under the Charter and under the Disabilities Convention.'\(^\text{21}\)

On this issue, the Panel concluded that limitations on human rights 'should be proportionate and include effective safeguards.'\(^\text{22}\) The Panel stated that the Charter and the Disabilities Convention provided 'a clear impetus and framework to improve the rights safeguards in the new Act.'\(^\text{23}\)

**Supporting Patient Participation and Carer Involvement**

**Capacity and Informed Consent**

The Panel’s report stated that the current Act is ‘largely based on a substitute decision-making model where psychiatrists make treatment decisions for people subject to [involuntary] orders’\(^\text{24}\). The Panel indicated there was support for the new

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\(^\text{18}\) ibid.

\(^\text{19}\) ibid., p. 1.

\(^\text{20}\) ibid.

\(^\text{21}\) ibid., p. 7.

\(^\text{22}\) ibid.

\(^\text{23}\) ibid., p. 8.

\(^\text{24}\) ibid., p. 39
legislation to provide for people to make their own decisions and to exercise their autonomy as much as possible.\textsuperscript{25}

The Panel suggested that the new Act could promote patient autonomy by including a presumption that all people with a mental illness have the capacity to make decisions, including people subject to involuntary orders.\textsuperscript{26} In their submission to the review, the Human Rights Law Resource Centre stated, ‘…there should be a presumption of capacity, until it is established, by taking all practicable steps to assist that person to make the decision, that he or she cannot [consent]…’ \textsuperscript{27}

The Panel indicated that capacity is a decision-specific concept and that it would be reasonable for the new Act to require health care practitioners to seek informed consent to treatment decisions. The Panel noted, however, that where a patient was unable to make an informed decision, substitute consent would still apply.\textsuperscript{28}

**Advance Statements**

With regard to the inclusion of advance statements in the new Act, there was prevailing support from stakeholders.

The Mental Health Legal Centre noted that the argument for the inclusion of advance directives (their preferred terminology) was powerful, because the episodic nature of mental illness meant that there would be periods of impaired capacity to make decisions: ‘This is precisely where the use of advance directives is so compelling – an advance directive is drafted primarily by reference to the fact that the person has in the past experienced becoming unwell and has reflected on the experience, their treatment and how they felt at the time’.\textsuperscript{29}

The Victorian Mental Health Carer’s Network supported advance statements as an avenue that had the potential to circumvent some of the complex problems around autonomy and consent.\textsuperscript{30}

Stakeholders such as the Victorian Equal Opportunity & Human Rights Commission supported the inclusion of advance statements as recognition of human rights, stating that it was ‘timely’ and ‘appropriate’.\textsuperscript{31}

Other stakeholders (the Inner South Community Health Service and the Mental Health Legal Centre) submitted that advance statements facilitated the involvement of carers and family members.\textsuperscript{32}

Stakeholders differed in their views about the appropriateness of overriding a person’s wishes in an advance statement.

\textsuperscript{25} ibid.
\textsuperscript{26} ibid., p. 42.
\textsuperscript{27} ibid., p. 41.
\textsuperscript{28} ibid., p. 42.
\textsuperscript{29} ibid., p. 43.
\textsuperscript{30} ibid.
\textsuperscript{31} ibid.
\textsuperscript{32} ibid.
The Health and Community Services Union submitted that it would be appropriate to override a person’s advance statement where ‘the person’s circumstances have clearly changed or where the person’s capacity to make a statement is unclear, or where there is a serious and imminent risk to the person or others’.  

The Mental Health Legal Centre did not support the overriding of a person’s advance directive which prohibited ECT. They also submitted that a person should be informed of the reasons why their advance directive is overridden and should have the right to appeal the decision to an independent body.

The Panel reported there was widespread community support for the new Act to recognise advance statements, particularly as a way of reinforcing the presumption of a patient’s competence as well as recognising and maximising their autonomy.

**Information Sharing with a Nominated Person**

There was broad stakeholder support for the required disclosure of information to a nominated person.

The view of the Victorian Equal Opportunity & Human Rights Commission was that notwithstanding an underpinning of the new Act by principles of autonomy, it should ‘permit a person who is receiving involuntary treatment to stipulate a nominated person who can access information relevant to treatment and care and who can be notified at all stages of the treatment process’.

The Eating Disorders Foundation of Victoria submitted that people should be allowed to decide who their nominated person is and the Australian Nursing Federation supported the respecting of such a nomination unless ‘there are grounds for believing this person’s involvement may be harmful to the patient and/or others’.

There were diverse views on whether disclosure of information to a nominated person should take place without patient consent. The AMA Victoria recommended that without patient consent the Act should not mandate the disclosure of information to families, carers, guardians, and nominated persons under any circumstances, ‘unless there is an overwhelming risk of harm to the patient or others by failing to do so’.

Victoria Legal Aid highlighted the integral nature of trust to the patient/doctor relationship and submitted therefore, that disclosure of information to families and carers without a person’s consent should only occur in limited circumstances, such as to avoid significant risk.

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33 ibid., p. 44.
34 ibid.
35 ibid., p. 44.
36 ibid., p. 54.
37 ibid.
38 ibid., p. 55.
39 ibid.
The Panel found that many other jurisdictions require mental health service providers to give information about key events to a nominated person. It indicated that there is ‘broad support among the community for a similar scheme in Victoria’. The Panel commented that, in circumstances where a person has the capacity to consent to the release of information, the information should be disclosed in accordance with the person’s wishes (e.g. they could specify a nominated person). In circumstances where the person does not have capacity to consent to the release of information, the Panel reported that the new legislation should require (rather than allow) that information be disclosed as follows: to a person who has previously been nominated; to the nominated person specified in the person’s advance statement (where such a statement has been made); to a recognised carer who needs the information in order to perform their caring role.

**Minimising Use of Orders**

The Panel reported that the current Act has some safeguards designed to limit the use of orders. Two of these safeguards include criteria for placing a person on an involuntary order and the requirement for an external review of an involuntary order within 8 weeks and annually thereafter. However, the Panel stated that community consultations suggested these safeguards were not sufficient.

**Criteria for Involuntary Treatment**

Under section 8(1) of the 1986 Act, the current criteria for involuntary treatment are:

a) the person appears to be mentally ill; and
b) the person’s mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and
c) because of the person’s mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person’s physical or mental condition or otherwise) or for the protection of members of the public; and
d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

Community opinions revealed concerns about some of the current criteria. For example, the Victorian Mental Illness Awareness Council noted that it supported involuntary detention for those consumers that require it, but that far too often health services ‘make a person involuntary without the necessary holistic, objective and factual information and assessment required to support them’. It supported

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40 ibid., p. 54.
41 ibid.
42 ibid., p. 56.
43 ibid., p. 17.
documented assessment, with no involuntary treatment unless a person has a mental illness, not just when they ‘appear’ to be mentally ill.\textsuperscript{45} Similarly, the Mental Health Legal Centre suggested that ‘appears to be mentally ill’ is not a strong enough criterion for subjecting a person to an involuntary order and that a staged system of orders, including an assessment order, should be introduced in order to diagnose a person with a mental illness before involuntary treatment occurs.\textsuperscript{46}

The Panel stated that provision for an assessment period as part of a staged orders scheme received community support.\textsuperscript{47} Alfred Psychiatry, Alfred Health described the separation of assessment and treatment stages in involuntary treatment orders as ‘a welcome development for practitioners in the field’, although it was concerned about restricting treatment in the assessment phase and argued that treatment decisions should be made on a case-by-case basis.\textsuperscript{48} The Mental Illness Fellowship Victoria supported a staged involuntary order system, as long as the assessment period was not too long (it recommended a maximum of 48 hours).\textsuperscript{49} The Health Services Commissioner similarly supported assessment periods, if they did not delay treatment.\textsuperscript{50} However, some clinicians were sceptical, with one warning against creating a ‘perception of greater protection for patients’ that in reality caused a burdensome ‘series of bureaucratic and administrative processes… which can potentially delay helpful interventions in the meantime’.\textsuperscript{51}

The Panel, supported by community views, also sought reform of the criterion that a person who has capacity and refuses treatment can be placed on an order. The Panel saw ‘merit’ in the inclusion of a ‘significant impairment’ test, as used in Scotland, where the criteria include that, ‘the person’s ability to make decisions about treatment is significantly impaired by their mental illness’.\textsuperscript{52}

\textsuperscript{45} ibid., p. 5.
\textsuperscript{47} ibid., p. 19.
External Review of Involuntary Orders

The community also identified deficiencies in the current system for external reviews of involuntary orders. External reviews are currently provided by the Mental Health Review Board within eight weeks of the order being imposed and annually thereafter. The Health Services Commissioner (previously President of the Mental Health Review Board) noted that the time between involuntary detention and a hearing with the Board was too protracted, but cautioned against hearings being conducted too soon after the person enters detention as ‘patients may be too unwell or disorganised to be able to participate in the hearing process’.\(^{53}\) Liberty Victoria was also critical of the length of time before compulsory review, while legal groups such as the Office of the Public Advocate, Public Interest Law Clearing House and the Human Rights Law Resource Centre raised multiple concerns in regard to the conduct of hearings.\(^{54}\)

The Panel stated that, ‘In our view it is unacceptable at present that, pursuant to the Act, a person can currently be treated involuntarily for a period of eight weeks before external review occurs’.\(^{55}\) The Panel also noted that a staged orders scheme, as used in some other jurisdictions, would provide orders of a limited duration with more frequent external reviews.\(^{56}\)

Monitoring and Promoting Patient Care, Wellbeing and Rights

Complaints Handling

The Panel reported that community consultations highlighted concerns with current complaint mechanisms. The report indicated that the current Act does not specify how complaints should be resolved or establish a particular body for this purpose. The Panel indicated that, in practice, complaints are handled by a range of organisations and people including mental health services, the Health Services Commissioner, the Chief Psychiatrist and the Office of the Public Advocate.\(^{57}\)

In their submission to the Panel, the Office of the Public Advocate expressed how difficult the different complaint pathways were for people to navigate when making a complaint about mental health services.\(^{58}\) This view was supported by other submissions, including a submission from Barrier Breakers Inc.\(^{59}\), which stated:

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\text{We agree that the – ‘present complaint system is confusing and inadequate’. Many of the complaint systems of Area Mental Health Services (hospitals) have no checks or balances and fail to properly address the real issue of the complaint; consequently, a}
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\(^{53}\) Health Services Commissioner (2009) op. cit., p. 3.
\(^{55}\) ibid., p. 28.
\(^{56}\) ibid., p. 29.
\(^{57}\) ibid., p. 61.
\(^{59}\) Barrier Breakers Inc. is an advocacy organisation for mental health in Gippsland.
number of serious shortcomings in the system remain unaddressed and the patient’s human rights continue to be ignored.60

The Office for the Public Advocate also noted that an inadequate response to a complaint could be more detrimental than the concern which prompted the complaint in the first place.61 Similarly in their submission, the Victorian Mental Illness Awareness Council emphasised the negative effect on complainants when authorities fail to objectively investigate their complaints, stating:

One of the most distressing issues for consumers is to experience a breach of the Act, Chief Psychiatrist guidelines, policy, professional standards, etc, make a complaint about it and experience a failure of those responsible under the Act to undertake an objective investigation. The loss of faith along with a sense of hopelessness and helplessness can be overwhelming for the individual.62

Other submissions to the Panel raised concerns that the Chief Psychiatrist’s complaints role was ineffective, as this position is situated within the Department of Health, and lacked independence from mental health services.63 The Alfred Psychiatry, Alfred Health submitted that the Chief Psychiatrist is ‘not sufficiently distant from mental health services to offer credible advocacy for patients’.64

There was support in many submissions from mental health and legal professionals for retaining local complaints processes within mental health services and regulating these further.65 However, in contrast, a small number of service providers expressed the view that legislation for local complaints management was not necessary.66 A submission by St Vincent’s Hospital noted that the Australian Standards for Healthcare Services guidelines for accreditation already required mental health services to maintain an effective complaints system.67

The Panel found ‘a significant amount of support for an independent, specialist and centralised body to address complaints’.68 The Victorian Mental Health Carer’s Network supported the creation of an independent complaints body in their submission to the Panel:

61 Office for the Public Advocate (2009) op. cit.
64 Alfred Psychiatry, Alfred Health (2009) op. cit., p. 11.
66 ibid.
Many people do not feel confident making a complaint directly to the organisation they wish to complain about. An independent body charged with handling complaints would help ensure that the service providers are subject to – and are seen to be subject to – appropriate oversight. The new Act must reflect an understanding of the importance of a complaints body: not only to address individual grievances, but as a means of improving service delivery and ensuring genuine accountability. In order to ensure efficacy, integrity and independence, the complaints body must be independent of both services and government, and must have decision-making authority.69

In their submission, the Disability Services Commissioner also supported the establishment of an independent body for mental health complaints, stating that:

Such a body needs to be independent of service providers and government and have broad ranging powers … The body needs to be able to receive complaints from family, friends, carers and others in addition to the patient themselves in recognition of the difficulties some people may face making a complaint.70

The Panel’s report did note a minority view that an independent mental health complaints body was not necessary.71 A submission by the Office of the Health Services Commissioner did not support the establishment of a new mental health complaints commissioner, stating that ‘our experience is that the complaint system is working well and that good outcomes are achieved for people’72. In their submission, the Victorian Branch of the Australian Nursing Federation supported a focus on greater expertise in mental health at the Office of the Health Services Commissioner and changes to processes, rather than creating a new complaints body.73

In their commentary, the Panel stated that the current process for handling complaints, in which the Department receives most of the complaints, lacked sufficient transparency or accountability.74 The Panel commented that the new Act could regulate local level complaint handling. If complaints could not be resolved at this level, then it was recommended that they be addressed through a centralised, independent system. Such an independent system could consist of either the creation of a mental health commissioner position or utilising the existing Health Services Commissioner with additional responsibilities and powers.75

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72 Health Services Commissioner (2009) op. cit., p. 8.


75 Ibid., p. 64.
**Safeguards for Electroconvulsive Treatment**

The Panel also reviewed safeguards for the performance of electroconvulsive therapy (ECT). Electroconvulsive therapy is ‘a procedure performed under general anaesthesia and muscle relaxation in which modified seizures induced by the selective passage of an electrical current through the brain are used for therapeutic purposes’.76 Under the current Act, the authorised psychiatrist is required to seek informed consent from a person before performing ECT on them. If the person has the capacity but refuses, ECT can be performed only if it is urgently required.77

The views of stakeholders about ECT and its regulation were divided. Some argued that ECT was damaging and should either be prohibited or subject to strict safeguards. Others, mainly mental health professionals, supported the treatment’s use in certain circumstances.78 Reoccurring themes in the submissions related to the following areas: whether second opinions should be compulsory, whether treatment can be provided on a person who has capacity but refuses treatment, and whether ECT should be used on children.

Regarding second opinions and treating a person without their consent, a compulsory second psychiatric opinion was supported by St Vincent’s Hospital and in the ARAFEMI Consumer Group Forum.79 Similarly, the submission of Austin Health stated that ‘where a person cannot consent, it would be highly appropriate for a statutory second opinion doctor who is independent of the mental health service’ to be empowered to provide consent.80 In their submission, Mind, the leading provider of mental health services in Victoria, stated that the authorised psychiatrist should ‘respect any “advance statement”, consult with carers and family and other service providers’ and suggested that an appropriate and independent advocate should have the powers to ‘act in the best interests of the person concerned’.81 They noted that administering treatment without full consent does not sit comfortably with human rights and recovery approaches.82

The views expressed in the submissions of Monash University, Southern Health and the Victorian Mental Illness Awareness Council were that ECT should never be

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78 ibid., p. 73.
82 ibid.
permitted without the person’s consent. In particular, the Monash University submission quoted the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment stating that ECT ‘may constitute torture or ill-treatment’.

Regarding the use of ECT on young people, several stakeholders argued that ECT should never be used on children. The submission from the Office of the Public Advocate stated that in the case of interventions, such as ECT, an independent advocate should be appointed to represent the interests of the child. St Vincent’s Hospital stated that ECT should not be used in children less than 16 years and that ‘in any event that it is considered, there should be a requirement to have a second and third opinion’.

The Panel recommended that, in the new Act, it would be preferable for a mandatory safeguard (such as a second psychiatric opinion or Board decision) to be required prior to the performance of ECT. The report also stated that ECT should not be permitted on a person who has capacity but refuses treatment.

In relation to the use of ECT on young people and adolescents, the Panel commented that it would be desirable for the new Act to contain an additional mandatory safeguard.

**Labor Government’s Response and the Exposure Draft**

In July 2009, the (Labor) Government Response to the Community Consultation Report was released. In its response, the former government stated that it ‘accepts the broad thrust of the panel’s findings’.

Then, on 7 October 2010, the Labor Government released the Exposure Draft of its proposed new Mental Health Bill. The Bill incorporated many of the Community

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84 Monash University (2009) op. cit.
86 St Vincent’s Hospital (2009) op. cit.
88 ibid.
89 ibid.
91 ibid., p. 1.
Consultation Panel’s recommendations. Public comment was invited on the Exposure Draft with submissions due to close on 3 December 2010.

**Coalition Government’s Mental Health Priorities**

Following the Coalition’s election victory in November 2010, the new Minister for Mental Health, the Hon. Mary Wooldridge, extended the closing date for submissions about the Exposure Draft. By the extended closing date, the Department of Health had received a further 200 submissions about the draft Bill. In March 2011, following the receipt of submissions, the Department held roundtable discussions with consumers and carers about the exposure draft. In addition, the Department facilitated separate roundtable discussions about five topics covered in the draft legislation. The topics were: independent review and oversight of compulsory treatment; independent oversight of ECT for compulsory patients; patient information privacy and the provision, disclosure and collection of personal information; treatment of children and young people; and consent and capacity.

In 2013, the Coalition Government released *Victoria’s Priorities for Mental Health Reform 2013-15*. This document outlines the actions to be taken over the three year period to ensure the following: reform of Victoria’s mental health legislation; strengthening of clinical mental health services; improving community mental health support services; increasing connections between mental health services and other services; widening

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prevention and promotion; and building a stronger, more sustainable mental health workforce.\textsuperscript{101}

On 18 February 2014, the Minister for Mental Health introduced the Mental Health Bill 2014 into the Legislative Assembly.

**Stakeholders**

At the time of writing, key stakeholders had not made public comment on the new Mental Health Bill 2014, which might be attributed to the already lengthy and detailed stakeholder consultation processes since 2008. During the development of the Bill, extensive consultations with mental health consumers, families, carers, service providers, other government departments and the wider community were conducted with over 800 people attending public forums.\textsuperscript{102} There were more than 200 submissions received in response to the consultation paper (published in 2009) and another 200 submissions received on the exposure draft Mental Health Bill (released at the end of 2010).\textsuperscript{103} Furthermore, the Department of Health noted that following the submissions, round-table public meetings and targeted consultations were held to discuss issues identified in these submissions.

Nevertheless, assorted stakeholder views on key areas of potential reform canvassed in the 2009 Community Consultation Report have been summarised in the Background section of this paper, on pages 3 to 13.

\textsuperscript{101} ibid.
\textsuperscript{103} ibid.
2. Second Reading Speech

The Minister for Mental Health, the Hon. Mary Wooldridge, provided the Parliament with the second reading speech for the Mental Health Bill 2014 on 20 February 2014. The Minister began her speech by stating that ‘People with a mental illness and their families should be able to actively participate in decisions related to their care and have a range of choices about the types of support they need to achieve optimal wellbeing’. ¹⁰⁴

The Minister said that it is the Government’s objective to ‘deliver new mental health legislation that provides an effective and contemporary legal framework for the assessment, treatment and recovery of Victorians with severe mental illness’. ¹⁰⁵ She said that the current Mental Health Act is ‘over a generation old’ and is ‘tired, out of date and needs the major overhaul provided by this Bill’. ¹⁰⁶

The Minister explained that the production of the Bill has involved ‘comprehensive policy development over a period of more than five years’ and provided an overview of the process, including the review of the Mental Health Act, the release of the 2010 exposure draft, the further public meetings and consultations, and the release of the 2012 policy document titled A New Mental Health Act for Victoria – Summary of Proposed Reforms.¹⁰⁷

The Minister emphasised that the Government has engaged with the community and stakeholders throughout development and drafting of the Bill.¹⁰⁸

She said that the Bill responds to ‘the community’s expectations for contemporary mental health legislation that promotes supported decision-making partnerships between patients and practitioners and enables public sector clinicians and public mental health service providers to deliver quality mental health services’.¹⁰⁹

The Minister then went through key principles and provisions of the Bill in some detail. These included but were not limited to: the establishment of a recovery framework; supported decision making; the role of the nominated person; carers; advance statements; second psychiatric opinions; the Mental Health Tribunal; and treatment.¹¹⁰

¹⁰⁵ ibid., p. 471.
¹⁰⁶ ibid.
¹⁰⁷ ibid.
¹⁰⁸ ibid.
¹⁰⁹ ibid.
¹¹⁰ ibid.
¹¹¹ See pages 471-479 of the second reading speech for further detail.
3. The Bill

This section of the Research Brief summarises some of the key provisions of the Bill, in line with the subjects highlighted in the other sections of this paper. For an overview of the Bill in its entirety, readers are directed to the Explanatory Memorandum. The Bill consists of 17 Parts and one Schedule (containing consequential and transitional amendments). This section of the paper address the key provisions dealing with patient rights, compulsory treatment and restrictive interventions in Parts 1–6, as well as the new oversight bodies set up by Parts 8 and 10.

Part 1—Preliminary

The purpose of the Bill is set out in clause 1 as including: the provision of a ‘legislative scheme for the assessment of persons who appear to have a mental illness and for the treatment of persons with mental illness’, as well as to provide for the appointment of the chief psychiatrist, establishment of the Mental Health Tribunal and the Mental Health Complaints Commissioner, the continuation of the Victorian Institute of Forensic Mental Health, the appointment and functions of community visitors, the repeal of the existing Mental Health Act and other consequential amendments.

The Bill commences on 1 July 2014, with the exception of sections 456 and 457, which make consequential amendments to references to the Victoria Police Act 2013 and the Legal Profession Uniform Law Application Act 2014 and do not come into operation until those Acts have commenced.

Clause 3 sets out the definitions of relevance to the Bill, which are largely new definitions not included in the current Act. Specific sections provide for definitions of mental illness (clause 4), treatment criteria (clause 5), treatment (clause 6), and medical treatment (clause 7) for the purposes of the Bill.

For example, the definition of treatment has been altered from the current Act whereby it means ‘things done in the course of the exercise of professional skills’ to remedy, or lessen the ill effects of, a mental disorder (section 3). The new definition of treatment includes ‘if things are done to the person in course of the exercise of professional skills’ to remedy, alleviate the symptoms of, or reduce the ill effects of a mental illness (clause 6).

Part 2—Objectives and Mental Health Principles

Part 2 of the current Mental Health Act sets out the objects of the Act and principles of treatment and care, as well as the objectives of the Department and the functions of the Secretary. The proposed Part 2 of the new Act consists of two sections detailing eight objectives (clause 10) and 12 mental health principles (clause 11) which provide a focus on the rights of the patient, least restrictive and recovery-oriented treatment, involvement of the patient in decision making, and recognition of the role of carers. Persons performing any duty or function, or exercising any power, under the proposed Act must have regard for these principles (clause 11(3)).
Part 3—Protection of Rights

Part 3 of the Bill makes provisions for a person’s rights regarding mental illness and treatment, including a statement of rights, the right to communicate, advance statements and nominated persons. This section of the paper focuses on Divisions 3 and 4 – advance statements and nominated persons.

Division 3—Advance Statements

The Bill introduces advance statements under Division 3 of Part 3. An advance statement is a document in which a person can record their treatment preferences in the event that they become unwell and need compulsory treatment in the future (clause 19). Current Victorian mental health legislation does not provide for a person to set out how they would like to be treated for a future condition.

Making an Advance Statement

Clause 20 sets out when and how an advance statement can be made. An advance statement can be made at any time and must be in writing. The advance statement must be signed and dated by the person making the statement, and witnessing requirements apply. An authorised witness must witness the advance statement. The advance statement must also include a signed statement by the authorised witness, stating that:

- in their opinion, the person making the advance statement understands the document and its consequences;
- they observed the person making the advance statement sign the statement; and
- they are an authorised witness (clause 20(d)).

An advance statement is effective from the time it is made until a new advance statement or a written revocation is made. The form that the revocation must take and the witnessing requirements are set out in clause 21(2). This includes the requirement for a revocation to have a signed statement from an authorised witness, stating that they believe the person understands the consequences of revoking the advance statement.

Advance Statements must not be Amended

Clause 22 prohibits any amendment to an advance statement. If a person wants to change the preferences regarding treatment which they have set out in their advance statement, they must make a new advance statement under clause 20.

When Advance Statements must be Taken into Account

The Bill sets out several circumstances in which an advance statement must be taken into account. These include:

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111 An ‘authorised witness’ means a registered medical practitioner, a mental health practitioner or a person who can witness the signing of a statutory declaration under section 107A of the Evidence (Miscellaneous Provisions) Act 1958 (see clause 3).
when an authorised psychiatrist is determining a temporary treatment order (clause 48(2)(b));
when the Tribunal is making a treatment order (clause 55(2)(b));
when an authorised psychiatrist is granting leave of absence for a person subject to an assessment order or treatment order (clause 64(3)(b));
when an authorised psychiatrist or chief psychiatrist is varying an assessment order or treatment order (clause 65(4)(b));
when a patient does not give consent to treatment (clause 71(4)(b));
when a psychiatrist is giving a second opinion and decides to recommend changes to the treatment (clause 82(d)(i)(B));
when the chief psychiatrist is recommending changes to treatment (clause 88(3));
when an authorised psychiatrist is making an application to the Tribunal to perform electroconvulsive treatment (clauses 93(2)(b) and 94(3)(b));
when an authorised psychiatrist is transferring a security patient or a forensic patient to another mental health service (clauses 291(2)(b) and 307(3)(b));
when the Tribunal is transferring a patient to an interstate mental health service (clause 321(3)(b)); and
when disclosing a patient's health information (clause 346(2)).

In these circumstances, the advance statement may be considered along with the views of people relevant to the person, which include the person’s nominated person, guardian, carer (if it directly affects the carer and the care relationship), parent (if the person is under 16 years of age) or the Secretary of the Department of Human Services (if the person is under the custody or guardianship of the Secretary).

**When Advance Statements may be Overridden**

Clause 73(1) provides for circumstances where an authorised psychiatrist may override a person’s advance statement. An advance statement can be overridden when the patient’s preferred treatment:

(a) is not clinically appropriate; or
(b) is not a treatment ordinarily provided by the designated mental health service.

If an authorised psychiatrist does override the patient’s preferences in their advance statement, they must inform the patient and give reasons for this decision. The patient can request the reasons in writing, which the authorised psychiatrist must provide to them within ten business days (clause 73(2) and 73(3)).

**Division 4—Nominated Persons**

The Bill establishes the role of the nominated person in Division 4 of Part 3. Under clause 23, the role of the nominated person is to provide support and represent the interests of the patient, to receive information about the patient and be consulted on
the patient’s treatment, as well as to help the patient exercise their rights. However, the nominated person cannot make treatment decisions on behalf of the patient.112

Making a Nomination

The nomination must be in writing, signed and dated by the person making the nomination, and include the name and contact details of the nominated person (clause 24). The nomination must also include a signed statement by the nominated person, indicating that they agree to act as the nominated person. Witnessing requirements apply, including a signed statement by the authorised witness stating that they believe the person making the nomination understands the document and its consequences. Clause 24(3) stipulates that a nominated person cannot also act as witness for the nomination.

A nomination comes into effect as soon as it is made and remains effective until a new nomination or a written revocation is made, or the nominated person declines to continue acting as the nominated person (clause 25).

A person can revoke the nomination they have made at any time. Clause 26(2) sets out how a revocation of a nomination can be made. This includes witnessing requirements and a signed statement by the authorised witness stating that they believe the person understands the revocation and its consequences.

Clause 26(3) states that the person who revokes a nomination must take ‘reasonable steps to inform the nominated person of the revocation’ or, if the person making the revocation is a patient, they must inform the authorised psychiatrist.

Nominated Person May Decline

A nominated person can decide not to continue in that role at any time, under clause 27(1). The nominated person must take ‘reasonable steps’ to inform the person who nominated them that they have decided not to continue being the nominated person. If the person who nominated them is a patient, the nominated person must inform the authorised psychiatrist of their decision.

Part 4—Compulsory Patients

Part 4 sets out provisions for compulsory patients and replaces the current involuntary treatment orders with a staged system of assessment orders, temporary treatment orders and treatment orders.

Division 1—Assessment Orders

Proposed section 28 provides for two types of assessment orders to be made by a registered medical or mental health practitioner: Community Assessment Orders that enable a person to be compulsorily examined by an authorised psychiatrist to

determine whether the treatment criteria for a Temporary Treatment Order apply (clause 28 (1)(a)); and Inpatient Assessment Orders which enable a person to be compulsorily 'taken to, and detained in, a designated mental health service and examined there by an authorised psychiatrist' to determine whether the treatment criteria for a Temporary Treatment Order apply (clause 28 (1)(b)).

Under the definition in clause 5, the treatment criteria for a Temporary Treatment Order or Treatment Order are that the person has a mental illness, and because of that mental illness the person needs immediate treatment to prevent either 'serious deterioration in the person's mental or physical health' or 'serious harm to the person or another person'. Further, immediate treatment must be provided to the person and there must be no less restrictive means available to enable the person to receive immediate treatment.

Similarly, either of the Assessment Orders can be made if it appears that such criteria apply (clause 29). Such an order can only be made if that person can be assessed under the order and 'there is no less restrictive means reasonably available to enable the person to be assessed' (clause 29(d)).

**Examination by a Medical or Mental Health Practitioner**

Under proposed section 30, the registered medical practitioner or mental health practitioner\(^{113}\) must inform the person that they will be examined, explain the purpose of the examination, and then examine the person before an Assessment Order is made. The order must then be made within 24 hours of the examination.

A copy of the order must be given to the relevant authorised psychiatrist and, where it is reasonable in the circumstances, a copy must also be given to the person who is the subject of the order, as well as a statement of rights. The authorised psychiatrist must then inform the people of relevance to the person and supply them with a copy of the order and statement of rights (proposed section 32). The same people must be informed if an order is varied (clause 35(4)), or is revoked or expires (clause 37(3)).

In the case of an Inpatient Assessment Order, the person must be taken to a designated mental health service within 72 hours of the order being made (proposed section 33). An Inpatient Assessment Order remains in force for the shorter period of 24 hours after the person has been received at a designated mental health service or 72 hours after the order has been made if the person is not received at a designated mental health service (proposed section 34(1)(b)). Community Assessment Orders are valid for a period of 24 hours. The duration of both orders can be extended by 24 hours, twice, if after examining the person the authorised psychiatrist is not able to determine whether the treatment criteria apply (proposed section 34). The Assessment Orders expire at the end of these periods, or if the person is made subject to a Temporary Treatment Order.

\(^{113}\) A mental health practitioner is defined as a registered psychologist, registered nurse, social worker or registered occupational therapist who is employed or engaged by a designated mental health service (clause 3).
Assessment Orders can be varied from either category by a medical or mental health practitioner before the authorised psychiatrist completes the assessment, under proposed section 35. However, a Community Assessment Order may only be varied to an Inpatient Assessment order if the practitioner is satisfied that the person cannot be assessed in the community (clause 35(2)), and that person must then be taken to the designated mental health service as soon as practicable (clause 35(5)).

**Examination by an Authorised Psychiatrist**

Under proposed section 36, an authorised psychiatrist must examine a person as soon as practicable after the order is made or the person is received at a designated mental health service. Further, the authorised psychiatrist must explain to the person, to the extent that is reasonable in the circumstances, the purpose of the examination before starting each examination in the course of the assessment. The authorised psychiatrist must then make a determination on whether the treatment criteria for a Temporary Treatment Order apply before the Assessment Order expires.

If the treatment criteria do not apply to the person, the Assessment Order must be immediately revoked by the authorised psychiatrist (clause 37). The person must be informed when they are no longer subject to an Assessment Order and the effects of the revocation or expiry of an order.

Under proposed section 38, a person subject to an Assessment Order must not be given treatment, unless they give informed consent to the treatment, or a registered medical practitioner employed or engaged by the designated mental health services is satisfied that urgent treatment is necessary to prevent ‘serious deterioration in the mental or physical health of the person’ or ‘serious harm to the person or to another person’ (clause 38).

**Division 3—Temporary Treatment Orders**

Similar to the Assessment Orders set out in Division 1 of Part 4, there are two types of Temporary Treatment Orders provided for in Division 3 of Part 4: a Community Temporary Treatment Order and an Inpatient Temporary Treatment Order. These orders can be made by an authorised psychiatrist after assessment has been conducted under an Assessment Order and enable a person to be compulsorily treated in either the community or in a designated mental health service (clause 45). An Inpatient Temporary Treatment Order can only be made if the authorised psychiatrist is satisfied that the person cannot be treated within the community (proposed section 48(3)).

In determining whether the treatment criteria apply to the person, the authorised psychiatrist must take into account the ‘person’s views and preferences about treatment of his or her mental illness and the reasons for those views and preferences, including any recovery outcomes that the person would like to achieve’ as well as the views and preferences set out in the person’s advance statement and those of the people relevant to the person (proposed section 46(2)).

These views must also be taken into consideration by the authorised psychiatrist when determining whether the order will be a Community Temporary Treatment Order or
an Inpatient Temporary Treatment Order (proposed section 48). These views must also be considered by the Mental Health Tribunal (established by Part 8 of the Bill) when conducting a hearing as to whether a Treatment Order should be made under Division 4 of Part 4 (clause 55).

Under section 47, the same authorised psychiatrist who made an Assessment Order in relation to a person cannot make the person subject to a Temporary Treatment Order. Information requirements for a Temporary Treatment Order are similar to those for an Assessment Order, although as well as notifying those people of relevance to the person, the authorised psychiatrist must also notify the Mental Health Tribunal of the Order (clause 50).

Temporary Treatment Orders remain in force for 28 days, unless it is revoked, or otherwise expires upon the creation of a Treatment Order (clause 51). Variation to the temporary order cannot extend its duration.

**Division 4—Treatment Orders**

A Treatment Order enables a person to be compulsorily treated in the community (a Community Treatment Order) or in a designated mental health service (Inpatient Treatment Order) (clause 52) and can only be made by the Mental Health Tribunal after conducting a hearing before the expiry of a Temporary Treatment Order (clause 53). For people currently subject to a Treatment Order, an authorised psychiatrist may apply to the Tribunal for a Treatment Order within 10 business days of the order expiring, if they have examined the person and are satisfied that the treatment criteria apply (clause 54).

The duration of the order, and whether the treatment will be in the community or in a designated mental health service, must be determined by the Tribunal, and stated in the order (clause 55). Community Treatment Orders may be made for a maximum period of 12 months, and Inpatient Treatment Orders may be made for a maximum period of six months, unless the person is under the age of 18 in which case both types of orders can only be made for a maximum of three months (clause 57).

**Part 5—Treatment**

Part 5 consists of five Parts. This section will deal with the major provisions in Division 1, Division 4 and Division 5 dealing with capacity to give informed consent, second psychiatric opinions, and ECT.

**Division 1—Capacity and Informed Consent**

The Bill sets out four factors that determine whether a person has the capacity to give informed consent, including that the person 'understands the information he or she is given that is relevant to the decision', is able to remember that information, can use or weigh relevant information and is able to communicate the decision 'by speech, gestures or any other means' (proposed section 68).
Any person required to determine whether a person has the capacity to give informed consent can be guided by principles set out in proposed section 68(2) including that a person’s capacity is linked to the specific decision they have to make, their capacity may change over time, an unwise decision made by a person is not the same as not having capacity to give informed consent, and reasonable steps should be taken to conduct an assessment of a person’s capacity at a time and location where that capacity can be assessed most accurately. Further, a person should not be assumed to not have capacity based only on age, appearance, condition or a particular aspect of their behaviour (clause 68(2)(c)).

Capacity is just one aspect of giving informed consent; for a person to give informed consent they must also have been given adequate information to make an informed decision, been given a reasonable opportunity to make the decision, given consent freely without undue pressure or coercion, and not withdrawn or indicated an intention to withdraw consent (clause 69). Requirements for adequate information and circumstances constituting a reasonable opportunity to make a decision are laid out in subsection (2) and (3) or proposed section 69.

Under proposed section 70, informed consent of a person must be sought before treatment or medical treatment is administered to a person and capacity to give informed consent should be presumed. However, consent does not need to be sought if the person required to seek consent forms the opinion that the other person does not have the capacity to give informed consent at the time that consent would be sought (proposed section 70(3)).

If a patient does not have the capacity to give informed consent to treatment proposed by the authorised psychiatrist, or has capacity to give informed consent and does not give it, the authorised psychiatrist may make a treatment decision for the patient if they are satisfied there is no less restrictive way for the patient to be treated (but this treatment cannot include electroconvulsive treatment or neurosurgery, which are covered by other provisions) (clause 71). In deciding whether to treat a patient without consent, the authorised psychiatrist must have regard to the patient’s views and preferences about treatment of their mental illness and any beneficial alternative treatments that are reasonably available, as well as the reasons for those views and preferences and the recovery outcomes the patient would like to achieve (clause 71(4)(a)). Further, the authorised psychiatrist must consider the views and preferences expressed by the patient in their advance statement, as well as the views of people of relevance to the person including, but not limited to, the patient’s nominated person, guardian, carer and parent. The likely consequences for the patient if the proposed treatment is not performed, and any second psychiatric opinion that has been given to the authorised psychiatrist, must also be taken into account.

**Division 4—Second Psychiatric Opinions**

Division 4 sets out the provisions in relation to second psychiatric opinions. Under proposed section 79, a patient on a Temporary Treatment Order or Treatment Order, or who is a security or forensic patient, can seek a second psychiatric opinion at any time. Further, any person on the request of that person, or the person’s guardian, parent (if the person is under 16 years of age), or Secretary (if the person is
under the custody or guardianship of the Secretary) may seek a second psychiatric opinion. If assistance is requested, the authorised psychiatrist must take reasonable steps to assist the patient in getting a second psychiatric opinion (clause 79(3)).

A psychiatrist giving a second psychiatric opinion has the powers to examine the patient, access the health information relevant to the patient’s treatment held by the health service treating the patient, and consult the authorised psychiatrist and other staff of the mental health service in order to prepare a report detailing their opinion as to whether the treatment criteria for the relevant Order apply to the patient and to review the treatment provided to the patient under the relevant Order (clauses 81, 82 and 84). The second opinion psychiatrist can be any psychiatrist (clause 80) and must have regard to the same views and preferences required to be considered by the authorised psychiatrist (clause 82(d)). While the second opinion psychiatrist may recommend changes to the treatment of the patient, they cannot override the treatment prescribed by the authorised psychiatrist (clause 81).

Upon receiving a report from a second opinion psychiatrist which either expresses the opinion that the criteria for the relevant Order do not apply (clause 85) or that recommends changes to the patient’s current treatment (clause 86), the authorised psychiatrist must examine the entitled patient (clause 85(1)) or review their treatment (clause 86(1)) and determine whether to accept the second psychiatrist’s opinion. If the authorised psychiatrist does not agree with the second psychiatrist’s opinion, they must provide an explanation of their reasons to the patient and inform the patient that they are entitled to apply to the Tribunal to revoke the order (in the case of the application of criteria) (clause 85(2)) or to the chief psychiatrist to review their treatment (in the case of recommendations for treatment) (clause 86(3)).

Specifically, a patient or any person entitled to seek a second psychiatric opinion on behalf of the patient, may apply to the chief psychiatrist to review their treatment if the authorised psychiatrist decides to adopt none or only some of the second opinion psychiatrist’s recommendations (clause 87). This review must be conducted within 10 business days of receiving the application to review (clause 88), and the authorised psychiatrist can continue to treat the patient during this time (clause 87). Following the review, the chief psychiatrist can direct the authorised psychiatrist to change the treatment of the patient, and is not limited to those recommendations put forward by the second opinion psychiatrist (clause 88).

**Division 5—Electroconvulsive Treatment**

Division 5 regulates the use of electroconvulsive treatment (ECT) for adult patients and young people (persons under the age of 18). Proposed section 91 defines ‘a course of ECT’ as one not exceeding 12 treatments performed within a period not exceeding six months. ECT can be performed on an adult patient if they have given informed consent in writing or the Tribunal has approved the use of ECT for a patient that does not have capacity to give informed consent and there is no less restrictive way for the patient to be treated (proposed sections 92 and 93). All ECT for young people must be approved by the Tribunal, upon application from the authorised psychiatrist (proposed sections 92 and 94).
The views and preferences of the patient, and the guardian/carers/parents relevant to that patient must be taken into account by the Tribunal (proposed sections 93 and 94). The Tribunal must complete a hearing of an ECT application within five business days of receiving the application, although an urgent hearing may be requested if the ECT is considered necessary as a matter of urgency to save the life of the patient, prevent serious damage to the health of the patient or to prevent the patient from suffering or continuing to suffer from significant pain or distress (clause 95). Patients who have the capacity to give informed consent, or who develop the capacity during the course of ECT, can withdraw their consent during the treatment (clause 98).

**Part 6—Restrictive Interventions**

Part 6 of the Bill regulates the use of restrictive interventions, defined in proposed section 3 as seclusion and bodily restraint. Bodily restraint is listed in the definitions as ‘a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person’s ability to get off the furniture’ (clause 3). Seclusion is defined as ‘the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave’ (clause 3).

**Division 1—General**

Under clause 105, restrictive interventions may only be used:

on a person receiving mental health services in a designated mental health service after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.

The nominated person, guardian, carer (if it will affect the carer and care relationship), parent (if the person is under 16 years of age) and the Secretary (if the person is under the custody or guardianship of the Secretary) must be notified when restrictive intervention is used (clause 107), and the Chief Psychiatrist must also receive a written report (clause 108). Immediate steps to release the person from restrictive intervention must be taken by a person who can authorise the use of restrictive intervention when they are satisfied that the continued use of intervention is no longer necessary (clause 109).

**Division 2—Seclusion**

Under proposed section 110, seclusion may only be used if it is necessary to prevent imminent and serious harm to the person or to another person. It can only be authorised by an authorised psychiatrist, unless an authorised psychiatrist is not immediately available in which case a registered medical practitioner or the senior registered nurse on duty may authorise the seclusion and an authorised psychiatrist must be notified as soon as possible (clause 111). An authorised psychiatrist must then examine a person secluded by a registered medical practitioner or senior registered nurse (or ensure a registered medical practitioner examines the person) and determine whether the continued use of seclusion on the person is necessary.
Persons in seclusion must be clinically observed by a registered nurse or medical practitioner at least every 15 minutes, and examined by an authorised psychiatrist at least every four hours (clause 112).

**Division 3—Bodily Restraint**

Bodily restraint may be used on a person to prevent imminent and serious harm to the person or other person, or to administer treatment to the person (clause 112). The same authorisation conditions as those required for seclusion apply (clause 114). However, a registered nurse may approve the use of physical restraint (not mechanical) if ‘it is necessary as a matter of urgency to prevent imminent and serious harm to the person or another person’ and an authorised psychiatrist, registered medical practitioner or the senior registered nurse on duty are not available (clause 115).

A person subject to bodily restraint must be under continuous observation by a registered medical practitioner or registered nurse, and clinically reviewed at least every 15 minutes (clause 116). An authorised psychiatrist must also examine the person at least every four hours.

**Part 8—Mental Health Tribunal**

Part 8 of the Bill establishes the Mental Health Tribunal (‘the Tribunal’) and details its membership, administration, divisions, procedures and the establishment of a rules committee.

The Tribunal replaces the Mental Health Review Board and the Psychosurgery Review Board established under the Mental Health Act 1986. The Mental Health Review Board functioned as a place of review regarding orders and treatment plans involving involuntary patients and to hear appeals against decisions. The Psychosurgery Review Board dealt with matters relating to the performance of psychosurgery.

**Functions of the Tribunal**

The functions of the new Tribunal are set out under clause 153. Some of the Tribunal’s functions include hearing and determining:

- matters relating to whether a treatment order should be made;
- applications to revoke a temporary treatment order or treatment order;
- applications involving the transfer of treatment for compulsory patients to another mental health service;
- applications to perform electroconvulsive treatment on a person under 18 years or a patient who doesn’t have the capacity to give informed consent; and
- applications to perform neurosurgery for mental illness.
Membership of the Tribunal

Membership of the Tribunal is specified under clause 156 and comprises the President, the Deputy President, senior members and ordinary members. All members of the Tribunal are appointed by the Governor in Council on the recommendation of the Minister. The President and the Deputy President must have at least five years’ experience as Australian lawyers to be eligible for appointment (clauses 157(1), 158(1) and 160).

Tribunal divisions

Division 4 of Part 8 includes provisions for the divisions of the Tribunal, the Tribunal’s constitution and presiding member. Clause 178 specifies two different divisions of the Tribunal:

- the general division - deals with all matters except those relating to electroconvulsive treatment and neurosurgery for mental illness; and
- the special division - deals with applications for the performance of electroconvulsive treatment and neurosurgery for mental illness.

Under clause 179, each division of the Tribunal consists of three members. The general division consists of a legal member, a psychiatrist or medical practitioner, and a community member. The special division comprises a legal member, a psychiatrist and a community member. The President and Deputy President are legal members under clause 179.

Part 10—Mental Health Complaints Commissioner

Part 10 of the Bill establishes the Mental Health Complaints Commissioner (‘the Commissioner’) and includes provisions for complaints management, conciliation, investigations, and compliance notices, as well as general provisions.

The Commissioner is appointed by the Governor in Council, on recommendation by the Minister. The Commissioner may hold office for a term of up to 5 years, and can be reappointed (clause 226). Clause 228 sets out the functions of the Commissioner. These functions include:

- Complaints management – accepting, managing, investigating and resolving complaints relating to mental health service providers;
- Education and advice – publishing materials about the complaints procedure, providing information, education and advice to mental health service providers about their responsibilities in managing complaints;

114 Senior members and ordinary members comprise legal, psychiatrist, medical practitioner and community members, see clause 159(1). As many senior members and ordinary members as required can be appointed (clause 159(5)).

115 A ‘community member’ means a person who has special interest or experience in mental illness, or knowledge or experience relevant to the role of community member of the Tribunal (clause 163).
Policy assistance – assisting mental health service providers to develop or improve complaint management procedures; and

Quality review – identifying, analysing and reviewing quality, safety and other issues arising from complaints and making recommendations to mental health service providers, the chief psychiatrist, the Secretary of the Department of Health and the Minister.

Further to these provisions, there is provision for the establishment of local complaint mechanisms under clause 266 of Part 10. A mental health service provider is required to establish procedures whereby complaints are received, managed and resolved. In addition, a mental health service provider must provide a biannual report to the Commissioner specifying the number of complaints received and the outcomes of the complaints (clause 267).
4. Other Jurisdictions

This final section of the Research Brief provides information on aspects of mental health legislation in the other Australian states. It looks firstly at Tasmania which has a new mental health Act – the *Mental Health Act 2013* (Tas) - following a major review. It then looks at New South Wales’ *Mental Health Act 2007* and South Australia’s *Mental Health Act 2009*, before concluding with an overview of Queensland’s *Mental Health Act 2000*.116

The aspects of mental health legislation considered for Tasmania, New South Wales, South Australia and Queensland include: the making of involuntary orders; the significance of a patient’s capacity to give informed consent to treatment; the use of advance statements; the ability to nominate a person to receive information about the patient’s treatment; safeguards surrounding electroconvulsive therapy; and complaints handling.

As mentioned earlier in this Research Brief, there is a movement in mental health law towards emphasising the rights of people with mental illness to have their autonomy respected and to be treated on an equal basis with others. Each jurisdiction covered takes its own approach in implementing some measures towards this goal. For example, although Tasmania has recently undergone a review of its mental health legislation and made human rights-based changes, it has not opted to implement advance statements.

Although not covered in detail in this Research Brief, Western Australia has conducted a review of its mental health legislation and introduced a Bill for a new Act on 23 October 2013. Some brief information on the Western Australian Bill is provided at the end of the Other Jurisdictions section.

**Tasmania**

The key legislation regarding mental health in Tasmania is the *Mental Health Act 2013*, which commenced operation on 17 February 2014. This new Act replaced the *Mental Health Act 1996* (Tas) and places more emphasis on the protection of rights of people with mental illness than the previous legislation.117

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116 In Western Australia, a Bill for a new Mental Health Act was introduced to the WA Parliament in October 2013. If passed, that Bill will repeal and replace the Mental Health Act 1996 (WA). Due to length restrictions, the Territories will not be covered in this paper.

**Involuntary Orders**

**Assessment Orders**
The Tasmanian Department of Health and Human Services explains that ‘An Assessment Order is a short term Order enabling a person to be assessed, without informed consent to determine the state of their mental health and to identify treatment options. This may require the person to be detained in an approved hospital for a short period of time, for the purposes of assessment’.  

The Tasmanian Mental Health Act provides that an assessment order can be sought when the applicant is satisfied that a person may have a mental illness; and that a reasonable attempt to have the person assessed, with informed consent, has failed or that it would be futile or inappropriate to make such an attempt (section 23). An assessment order can be made by a medical practitioner who has examined the person within 72 hours of having received the application (section 24).

The assessment criteria are that the person has, or appears to have, a mental illness that requires (or is likely to require) treatment for – the person’s health or safety; or the safety of other persons; and the person can only be assessed under the authority of the assessment order; and the person does not have decision-making capacity (section 25). The assessment order provides the authority for the patient to be assessed by an approved medical practitioner and determine if the patient also meets the treatment criteria. However, the assessment order is not authority for the patient to be given any treatment (section 27).

The assessment order takes effect when it is signed by the medical practitioner who makes it and lasts for 24 hours unless it is discharged sooner (sections 28 and 30). An approved medical practitioner can also affirm the assessment order and extend its operation, once, for a further period up to 72 hours (section 32).

**Treatment Orders**
Notably, the Tasmanian Mental Health Act establishes a new Mental Health Tribunal which has the sole responsibility for making treatment orders (section 36). As the Tasmanian Department of Health and Human Services explains, the Tribunal has ‘responsibility for decisions about the type of treatment and the setting in which it will be given (e.g. in hospital or in the community)’. The Tribunal can only make a treatment order if the person meets the treatment criteria set out in section 40 of the Act.  

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119 Tasmania, Department of Health and Human Services (2014) ‘Overview of the Mental Health Act 2013’, op. cit. Section 167 of the Tasmanian Mental Health Act establishes the Tribunal. See also section 40 which sets out the treatment criteria.

120 Section 40 of the Act provides that The Tribunal can only make a treatment order if: (a) the person has a mental illness; and (b) without treatment, the mental illness will, or is likely to, seriously harm – (i) the person’s health or safety; or (ii) the safety of other persons; and (c) the treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1); and (d) the treatment
An approved medical practitioner can make an application to the Tribunal for a treatment order for a person not subject to an assessment order, if a second approved medical practitioner has also assessed the person (within the preceding seven days) and is also satisfied that the person meets the treatment criteria set out in section 40 of the Act (section 37). Section 38 of the Act provides for the making of interim treatment orders.

Treatment orders made by the Tribunal can be for up to six months (section 44). A treatment order can be renewed for another six months if it has not been previously renewed or, in any other case, a period not exceeding 12 months (section 48).

The Tribunal must review a treatment order within 30 days after it is made if it is still in effect (section 181). The Tribunal must further review the order at intervals of 90 days so long as it is in effect. If a patient is admitted to hospital (under section 42 of the Act which deals with the effects of treatment orders) then the controlling authority needs to notify the Tribunal of the patients admission and the Tribunal must then review the order within three days (section 181).

**Capacity and Informed Consent**

Significantly, the new Tasmanian Mental Health Act provides that a person can only be treated non-consensually if they lack the decision-making capacity to refuse treatment. Capacity is defined in section 7(1) of the Act by the same four criteria used in the Victorian Bill.

Section 7(2) of the Tasmanian Act provides that a child’s capacity is assessed by the same criteria, except that the child must be sufficiently mature to make the decision.

**Advance Statements**

The Tasmanian Mental Health Act does not provide for advance statements.

**Nominated Persons**

The Tasmanian Mental Health Act does not provide for nominated persons in the same way that the Victorian Mental Health Bill does. However, the Tasmanian Act does provide that a patient can have a ‘representative’. Section 3(1) of the Tasmanian Act states that a ‘representative’ of a patient or prospective patient means – (a) the patient’s guardian; or (b) the patient’s lawyer; or (c) if the patient is a child and raises cannot be given except under a treatment order; and (e) the person does not have decision-making capacity. 

Section 40(e) states that the Tribunal can only make a Treatment Order if the person does not have decision-making capacity. See Callaghan & Ryan (2012) op. cit., p. 614.

Section 7(1) of the Act provides that an adult is taken to have decision-making capacity (about their own assessment and treatment) unless he or she is unable to make the decision because of an impairment or disturbance of mental functioning, and they are unable to: understand the information relevant to the decision; or retain information relevant to the decision; or use or weigh information relevant to the decision; or communicate the decision (whether by speech, gesture or other means).
no objection, a parent of the patient; or (d) any other person nominated by the patient to represent his or her interests.\textsuperscript{124}

\textbf{ECT}

The Tasmanian Mental Health Act does not specifically refer to ECT as it falls within the general definition of treatment provided by the Act.\textsuperscript{125} Sections 122-128 of the Act provide for ‘special psychiatric treatment’ which means ‘psychosurgery’ or ‘any treatment that the regulations declare to be special psychiatric treatment’.

\textbf{Complaints Handling}

Tasmania does not have a Mental Health Complaints Commissioner like the one proposed in the Victorian Bill. The Tasmanian Mental Health Act provides, however, that any patient is entitled to make a complaint to an Official Visitor (section 161). Each approved facility is to be visited by an Official Visitor at least once a month (section 160(1)). Official Visitors then refer complaints to the Principal Official Visitor (section 157). The Principal Official Visitor assesses and conducts preliminary inquiries into complaints by patients, and refers suspected contraventions of the Act, or other matters that require investigation, to the Health Complaints Commissioner or Ombudsman (section 156).

\textbf{New South Wales}

The key legislation regarding mental health in New South Wales is the Mental Health Act 2007.

\textbf{Assessment Criteria}

For the purpose of the Act, a person is mentally ill or mentally disordered if they satisfy the criteria under sections 14 and 15.

A person is a mentally ill person if they suffer from a mental illness, and because of that illness there are reasonable grounds to believe that care, treatment and control of the person is necessary for the their own protection and the protection of others from serious harm. Consideration must also be given to the continuing condition of the person and likely deterioration (section 14).

A person, whether or not suffering from a mental illness, is a mentally disordered person, if their behaviour at the time is so irrational as to justify the conclusion on reasonable grounds that temporary care, treatment and control of the person is necessary for their own protection and the protection of others from harm (section 15).

\textsuperscript{124} Also see section 10 of the Tasmanian Mental Health Act.  
\textsuperscript{125} Personal Communication with Tasmanian Department of Health and Human Services, 6 March 2014.
**Involuntary Orders**

The New South Wales Mental Health Act provides that a person may be taken and detained in a declared mental health facility for a number of reasons, one of them being on the basis of a certificate being issued by a medical practitioner or accredited person (section 19). A person must be examined by an authorised medical officer within 12 hours of the person’s arrival at the facility. On issue of a certificate by the officer that the person is either mentally ill or mentally disordered, the person must be examined by a second medical practitioner – a psychiatrist if the authorised medical officer is not a psychiatrist. If a person is found to be mentally ill or mentally disordered by two of the practitioners, the person must be brought before the New South Wales Mental Health Tribunal as soon as practicable for a mental health inquiry (section 27).

If the Mental Health Tribunal is satisfied that an assessable person is mentally ill, the Tribunal can make: an order that the person be discharged into the care of the person’s primary carer; make a community treatment order; or an order that the person be detained in or admitted and detained in a specified mental health facility for further observation and/or treatment as an involuntary patient for a specified period of up to three months (section 35). The community treatment order made by the Mental Health Tribunal for compulsory treatment in the community can be for a specified period, but must not exceed 12 months (section 56).

**Capacity and Informed Consent**

Capacity to consent under the New South Wales Mental Health Act is only considered in the absence of decision-making capacity for Other Medical Treatments (section 98) which include emergency surgery. Consent in these circumstances can be given by an authorised medical officer, Director-General or the New South Wales Mental Health Tribunal (sections 99-103). Consent by these people on behalf of the patient has the same effect as if the patient had the capacity to consent (section 104). Informed consent is required for persons other than involuntary patients for the administration of ECT (section 91).

**Advance Statements**

The New South Wales Mental Health Act does not provide for Advance Statements.

**Nominated Persons**

Under section 72 of the New South Wales Mental Health Act, a person with a mental illness may nominate a person to be their primary carer for the purpose of the Act. The nomination remains in force for the period prescribed by regulations or until revoked in writing.

**ECT**

Section 89(a) of the New South Wales Mental Health Act states that ECT may be administered to voluntary patients only if all the requirements for informed consent are met under section 91, and the person gives free voluntary and written consent.
Section 89(b) specifies that ECT can only be administered to involuntary patients after an ECT determination by the New South Wales Mental Health Tribunal at an ECT inquiry.

**Complaints Handling**

New South Wales does not have a Mental Health Complaints Commissioner. Section 128 of the New South Wales Mental Health Act stipulates that the function of the ‘Principal Official Visitor’, appointed by the Minister, is to act as an advocate to the Minister for consumers of mental health care. An ‘Official Visitor’ under this Act has the function to act as an advocate for patients to promote the proper resolution of issues arising in the mental health system, including issues raised by the primary carer of a patient or person detained under the Act (section 129).

**South Australia**

The key mental health legislation in South Australia is the *Mental Health Act 2009*. The Act includes a requirement for a review to be undertaken four years after its commencement. SA Health conducted a two month public consultation, to inform their review of the Act, which closed on 31 October 2013. A report and recommendations will be developed by SA Health and tabled by 30 June 2014.\(^{126}\)

**Assessment Criteria**

The South Australian legislation defines mental illness as ‘any illness or disorder of the mind’ (section 3), and describes a range of conduct that may not indicate mental illness (Schedule 1). A person may be placed on a treatment order if, after being examined by a medical practitioner or authorised health professional, they appear to have a mental illness and require treatment for their own protection, or for the protection of others from harm. There must be facilities and services available for their treatment and there must be ‘no less restrictive means’ than the treatment order to ensure appropriate treatment of the person’s illness (section 10).

**Involuntary Orders**

**Inpatient**

Involuntary inpatient orders in South Australia are divided into three levels. Under section 21 of the South Australian Mental Health Act, a level 1 inpatient treatment order, which expires after seven days, can be made on assessment by a medical practitioner or authorised health professional. A level 1 order must be confirmed by a psychiatrist or authorised medical practitioner within 24 hours of the order being made. Before a level 1 order expires a psychiatrist or authorised medical practitioner,\(^{126}\)

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following further examination, may make a level 2 inpatient treatment order for treatment of the patient in an approved treatment centre (section 25(1)).

A level 2 order may last for a maximum of 42 days. All level 2 orders must be notified to the Guardianship Board (‘the Board’) and the Chief Psychiatrist. A level 3 inpatient treatment order, which can last for up to 12 months (for adult patients), may only be determined by the Board. An application for a level 3 order can be made in respect of a person to whom a level 2 or level 3 inpatient treatment order already applies.

All level 1 and 2 orders must be notified to the Guardianship Board and the Chief Psychiatrist (section 22). The Board must also report level 3 orders to the Chief Psychiatrist (section 30). Treatment for mental illness or other illnesses can be given during all levels of order despite the refusal of consent to the treatment by the patient (section 24).

**Community**

Under the South Australian Mental Health Act community treatment orders are divided into two levels. A level 1 community treatment order, which lasts for a maximum of 28 days, may be made by a medical practitioner or authorised health professional after an examination of the person. If the order is not made by a psychiatrist or authorised medical practitioner, a psychiatrist or authorised medical practitioner must examine the patient within 24 hours or as soon as is practicable to confirm the order. The Board must review a level 1 order as soon as practicable after receiving notice of the order (section 15).

Level 2 community treatment orders, lasting not longer than 12 months (adults), can only be made by the Board (section 16(1)). The Chief Psychiatrist must be notified of all community treatment orders. Treatment for the person’s mental illness may be given on a community treatment order despite the person’s absence or refusal of consent to the treatment (section 18).

**Capacity and Informed Consent**

The issues of capacity and informed consent for medical treatment are not given a great deal of coverage in the Mental Health Act 2009. The South Australian Consent to Medical Treatment and Palliative Care Act 1995 allows for emergency medical treatment to be administered if the patient is incapable of consenting, has not refused consent, and the medical practitioner believes that the treatment is necessary to meet an imminent risk to the life or health of the patient (section 13). The Guardianship and Administration Act 1993 allows for the appointment of guardians for persons with mental incapacity (section 29) and provides for consent being given for the treatment of ‘mentally incapacitated persons’ by the appropriate authority (section 59).

**Advance Statements**

The Advance Care Directives Act 2013 passed the South Australian Parliament on 8 April 2013 but does not commence operation until 1 July 2014. Under the Act a person can record their wishes and instructions for future health care and other matters in an Advance Care Directive. They can appoint one or more substitute decision makers to
make decisions on their behalf. An Advance Care Directive does not permit the refusal of mandatory medical treatment, such as a community treatment order or an inpatient order under the Mental Health Act 2009 (section 12).

**Nominated Person**

Patients are entitled to have another person’s support wherever practicable (section 47).

**ECT**

ECT can only be administered when it has been authorised for treatment of the illness by a psychiatrist who has examined the patient, and with the written consent of the patient or on behalf of the patient. If an adult patient does not have capacity to give informed consent to ECT, written consent may be given by a medical agent, guardian, or the Board. An application for the Board’s consent may be made by a medical practitioner or mental health clinician. If the patient is under 16 years of age, consent is required from a parent or guardian, or from the Board (section 42(1)). Consent to a course of ECT must be limited to a maximum of 12 episodes and a maximum period of three months (section 42(2)).

**Complaints Handling**

South Australia does not have a Mental Health Complaints Commissioner. Individuals with complaints are directed in the first instance to speak to a Patient Advisor or a Complaints Officer at the hospital or health service. The Chief Psychiatrist is also able to receive consumer complaints. Otherwise, complaints are dealt with by the Health and Community Services Complaints Commissioner.127

**Queensland**

The key legislation regarding mental health in Queensland is the *Mental Health Act 2000.*

**Assessment Criteria**

The Queensland Mental Health Act provides that a recommendation for assessment of a person can only be made by a doctor or authorised mental health practitioner if they are satisfied that the assessment criteria applies to the person (section 20).

A person is assessed if they appear to have a mental illness; they require immediate assessment; assessment can be made properly at an authorised mental health service;

that they are at risk of causing harm to themselves or someone else; or at risk of suffering serious mental or physical deterioration; and there is no less restrictive way of ensuring the person is assessed (section 13).

**Involuntary Orders**

The Queensland Mental Health Act provides that a person for whom ‘Assessment Documents’ are in force can be detained in an authorised mental health service pending an assessment for an ‘Assessment Period’ which is initially not longer than 24 hours (section 44). A person becomes an involuntary patient at commencement of the assessment period and all relevant persons are informed, including the patient’s allied person\(^{128}\) (section 45). As soon as practicable, the patient must be assessed by an authorised doctor (section 46). The assessment period may be extended by the authorised doctor for a further 24 hours, but the patient must not be detained for more than 72 hours (section 47).

If an authorised doctor – not a psychiatrist who made the recommendation for assessment – is satisfied that a treatment criteria following initial assessment applies, the doctor may make an ‘Involuntary Treatment Order’ (section 108). The doctor decides the category of order – for inpatient or community care (section 109); ensures a treatment plan is prepared (section 110); and tells the patient about the treatment plan (section 111). If the authorised doctor is not a psychiatrist, the patient must be examined by a psychiatrist within 72 hours to confirm the order (section 112).

An involuntary treatment order continues in force until it is revoked by an authorised doctor or on a review or appeal against a review decision; or if the patient does not receive treatment under the order for six months (section 118). The Queensland Mental Health Tribunal must review the application of the ‘Treatment Criteria’ (section 14) to a patient for whom an involuntary treatment order is in force within six weeks of the initial order being made, and afterwards at intervals of not more than six months (section 187).

**Capacity and Informed Consent**

The Queensland Mental Health Act states that ‘Assessment Criteria’ for a person under involuntary assessment (Chapter 2) includes the lack of capacity to consent to be assessed or having unreasonably refused to be assessed (section 13(2)). ‘Treatment Criteria’ for a person who has been assessed as having a mental illness includes a lack of capacity to consent to be treated for the illness or has unreasonably refused treatment for the illness (section 14(1)(f)). Regulated treatments – ECT and Psychosurgery – are conditional on all requirements for informed consent being met (section 133). This includes the capacity to give informed consent (section 134); that consent is written (section 135); given freely and voluntarily (section 136); and a full explanation provided of purpose, risks and alternative treatments available in form and language that the person is able to understand (section 137).

\(^{128}\) For ‘allied person’ see section on ‘Nominated Persons’.
**Advance Statements**

In Queensland, ‘Advance Health Directives’ can be made under the *Powers of Attorney Act 1998* (Qld) (Chapter 3, Part 3). Patients’ treatment plans under the Mental Health Act (section 124(4)(a)) must take into account the patient’s advance health directive under the Powers of Attorney Act. An advance health directive must also be considered for patients who are not involuntary patients in regard to ECT, should they indicate that they object to such treatment (section 139). An allied person may be stated in a patient’s advance health directive in the event the patient does not have the capacity to choose such a person (section 342(2)).

**Nominated Persons**

Under section 340 of the Queensland Mental Health Act, an ‘Allied Person’ for an involuntary patient can help represent the patient’s views, wishes and interests relating to the patient’s assessment, detention, treatment and care under this Act. An Allied Person may be chosen by the patient (section 341) or should the patient not have capacity, chosen by the administrator at the treating health service, or be the stated person in the patient’s advance health directive (section 342).

**ECT**

ECT may be performed on a person only if the person has given informed consent or with approval of the Queensland Mental Health Tribunal (s 139).

**Complaints Handling**

Queensland does not have a Mental Health Complaints Commissioner. As part of the ‘Rights of Patients’, under Chapter 9, section 344 of the Queensland Mental Health Act, the ‘Statement of Rights’ of involuntary patients must be prepared by the director and contain information about the rights of patients to make a complaint about the service provided at an authorised mental health service and how a complaint can be made. Currently complaints are made to the Health Quality and Complaints Commission under the *Health Quality and Complaints Commission Act 2006* (Qld), which will be repealed and replaced by the *Health Ombudsman Act 2013* (Qld) as of 1 July 2014.

**Western Australia**

As stated earlier, Western Australia introduced the Mental Health Bill 2013 on 23 October 2013. If this Bill is passed, it will replace the *Mental Health Act 1996* (WA).

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The Western Australian Bill provides a Charter of Mental Health Care Principles that would be a Schedule to the proposed Act. In the second reading speech for the Bill, the Western Australian Minister for Mental Health, the Hon. Kim Hames, said that the ‘Principles provide an important framework for the way in which service providers are expected to deliver mental health services’. Other rights provided by the Western Australian Bill include the right to request an independent further opinion about treatment and the right to nominate another person to receive information and be involved in decision-making.

The Western Australian Bill provides that involuntary treatment orders can only be made by psychiatrists (proposed section 24) and that the criteria for making a person an involuntary patient includes that the person does not have the capacity to consent or is ‘unreasonably refusing treatment’ (proposed section 25). The Western Australian Mental Health Commission has stated that in response to stakeholder feedback the Minister for Health is proposing to table amendments to the Bill primarily relating to proposed section 25. The Commission stated that: ‘The proposed amendment is to delete reference to unreasonable refusal. The consequence of this is that a person will only be able to be made an involuntary patient if they do not have capacity to make a treatment decision, in addition to meeting the other criteria for an involuntary treatment order’.

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130 Western Australia, Legislative Assembly (2013) Debates, 23 October, pp. 5382b-5386a.
131 ibid. See proposed sections 182-183 for further opinions and proposed sections 263-279 for nominated persons.
References

Relevant Legislation

Mental Health Act 1986 (Vic)
Evidence (Miscellaneous Provisions) Act 1958 (Vic)
Mental Health Act 2013 (Tas)
Mental Health Act 2007 (NSW)
Mental Health Act 2009 (SA)
Mental Health Act 2000 (Qld)
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