Investigation into the mechanical restraint of a prison detainee while being treated in a mental health facility

A report of the
ACT Health Services Commissioner

March 2014

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ACT Health Services Commissioner

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HEALTH SERVICES COMMISSIONER
ACT Human Rights Commission

Mr Simon Corbell MLA
Attorney-General
Legislative Assembly for the ACT
CANBERRA ACT 2601

Dear Attorney-General

I present to you a report of my investigation into the mechanical restraint of an AMC detainee while being treated in the Adult Mental Health Unit.

This report is being given to you pursuant to s 87 of the *Human Rights Commission Act 2005*, which provides that you must present the report to the Legislative Assembly within six sitting days after the day that you receive the report.

I have made a range of recommendations aimed at improving service delivery and protecting the rights of service users, including that legislation be amended as a matter of priority.

Yours sincerely

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Health Services Commissioner

17 March 2014

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INVESTIGATION INTO THE MECHANICAL RESTRAINT OF A PRISON DETAINEE WHILE BEING TREATED IN A MENTAL HEALTH FACILITY

EXECUTIVE SUMMARY

On 1 November 2012, the Canberra Times published an article entitled "*Staff complain patient was shackled to bed"*. The article reported that "a patient at the new Adult Mental Health Unit was handcuffed to a bed for several days last month because he was a risk to the public and to health workers".

On 8 November 2012, the Health Services Commissioner advised the Health Directorate and the Justice and Community Safety Directorate that she had decided to conduct a Commission-initiated consideration of the matter, pursuant to section 48 of the *Human Rights Commission Act 2005*.

The purpose of the investigation was to determine whether the health service provided to the detainee was compromised by the presence of mechanical restraint; to examine the reasonableness of decisions to apply and maintain that restraint; and to examine the adequacy of legislative structures that govern decision making responsibility for detainees when they are transferred to mental health facilities.

The Commissioner concludes that, while the detainee may have been appropriately mechanically restrained during some periods of his interaction with the health system, serious questions arise about the length of time that he was handcuffed in the Adult Mental Health Unit. The Commissioner is of the view that:

- the powers vested in Corrective Services under the *Corrections Management Act 2007*, which provide for Corrective Services to maintain decision making about custody issues when a detainee is in a health facility, can lead to inconsistencies with the legal and ethical obligations that govern the delivery of services by health professionals;
- decisions relating to the treatment of prison detainees in a mental health facility should be made by clinicians, informed by advice from Corrective Services, rather than Corrective Services making decisions, informed by advice from clinicians;
- the decision to handcuff the patient for five days did not appear to be consistent with obligations to ensure that instruments of restraint are only to be used '*if other methods of control fail',* and that '*such instruments must not be applied for any longer time than is strictly necessary'*;
- the health service provided to the detainee was compromised by the presence of mechanical restraint (although no details will be provided for privacy reasons);
- decisions were not adequately documented, including the initial decision to restrain the detainee, as well as purported regular reviews of that decision;

- the *Corrections Management Act 2007* and the *Mental Health (Treatment and Care) Act 1994* are incompatible with each other and require amendment to better clarify roles and responsibilities.

RECOMMENDATIONS

The Commissioner makes the following recommendations.

Recommendation 1:

That consideration be given to amending the Corrections Management Act and/or the Mental Health Act to clarify their interaction, and in particular to clarify the authority of Mental Health ACT to detain a person and provide them with involuntary treatment under the Mental Health Act when that person is already a detainee under the Corrections Management Act.

Recommendation 2:

That the Mental Health (Care and Treatment Act) be amended to require Mental Health ACT to advise the Public Advocate when anyone being treated in the AMHU is mechanically restrained by order of Corrective Services ACT; and, prior to legislative authority, that Mental Health ACT undertake deidentified reporting as a matter of policy.

Recommendation 3:

That Corrective Services:

- *conduct individual risk assessments on each occasion that a detainee is to be escorted to a health facility, taking into account the individual circumstances relating to the particular facility, evidence in relation to potential flight risk, and the individual characteristics and medical/mental health condition of the detainee, as well as considering security classifications;*
- *conduct regular reviews of decisions to mechanically restrain a person under escort for more than two hours, to determine if the level of restraint remains appropriate, given that the individual circumstances relating to the particular facility, the flight risk, and the individual characteristics and medical/mental health condition of the detainee will change;*
- *amend its risk assessment documentation to require regular review of restraint decisions, taking the above factors into account;*
- *document all such decisions in a timely manner;*
- *take account of the views of, and strategies proposed by, mental health experts when considering custodial requirements in inpatient mental health situations, and document any reasons for rejecting those views.*

Recommendation 4:

That, pending any legislative amendments to enable transfer of custody from Corrective Services to Mental Health ACT for treatment outside the AMC, discussions about security requirements and the application of mechanical restraint should be conducted between Corrective Services management and the Chief Psychiatrist.

Recommendation 5:

That Corrective Services and ACT Health finalise their Memorandum of Understanding on transfer of detainees for treatment within 3 months of this report being tabled in the Legislative Assembly, and that the MOU adopts the process outlined in Recommendation 4.

Recommendation 6:

That the Corrections Management Act and/or the Mental Health Act be amended, as part of the imminent Mental Health Bill, to enable the transfer of custody from Corrective Services ACT to Mental Health ACT when a detainee is transferred from the AMC to an inpatient mental health facility. This recommendation is made regardless of the availability of a secure forensic mental health facility in the ACT, and should not be delayed pending the construction of such a facility.

Recommendation 7:

That the Health Directorate take steps, consistent with Principle 7(4) of the Health Records (Privacy and Access) Act 1994*, to restrict access to the misleading record of September 2012.*

Recommendation 8:

That Corrective Services take steps to reinforce with staff:

- *the need to refrain from relaying anecdotal information to health services on escort,*
- *to ensure that any information relayed is factual, and*
- *that information that is relayed, is limited to information that is relevant and necessary.*

This report has been prepared for the Government and Legislative Assembly with a view to amending legislation to better manage the mental health needs of detainees from the AMC when they are admitted to inpatient mental health facilities. In accordance with s 85 of the *Human Rights Commission Act 2005*, the Commissioner further ***recommends*** that the ACT Government respond to the recommendations in this report within three months of it being tabled in the Legislative Assembly by the Attorney-General.

INVESTIGATION

The Commissioner, under notice pursuant to section 73 of the Human Rights Commission Act, required the provision of various records, policies and procedures from Corrective Services, Mental Health ACT, the ACT Ambulance Service, and the Public Advocate of the ACT.

Interviews were held with a range of witnesses and decision makers. Interviewees included the Superintendent of the Alexander Maconochie Centre (now known as the General Manager, Custodial Operations, and referred to as the General Manager in this report), the Acting Chief Psychiatrist and the Chief Psychiatrist, the Team Leader of the Adult Mental Health Unit (AMHU), the Operational Director of Adult Mental Health Services, a number of Corrections officers, the attending ambulance officers, Official Visitors, the admitting nurse and the detainee.

Clinical advice was obtained from an interstate specialist forensic mental health expert. Information was provided by a range of interstate agencies and facilities.

This report was provided to relevant parties for comment prior to publication.

PRIVACY

Due to the public nature of this report, the detainee will be referred to as 'the detainee' to keep his identity anonymous. In a further effort to protect his identity, information regarding his specific actions, clinical presentation, offence history, and any other potentially identifying information will only be referred to in general terms where possible.

Details of some policies and procedures have been omitted because they contain sensitive security information.

WHAT HAPPENED

On 14 August 2012, a detainee in the ACT's prison, the Alexander Maconochie Centre (AMC), who was serving a sentence for a significant offence, engaged in a serious episode of self harm. The attempt at self harm was deliberate, rapid, sustained and had a very high potential to be lethal.

The episode of self harm was not reasonably foreseeable, or preventable, by Corrective Services officers. While the detainee’s emotional presentation had been noted by a senior Corrective Services officer and passed on to Health authorities, the episode occurred without advance notice and could not have been acted on in a more assertive or timely manner. The intervention of Corrective Services officers during and after the episode of self harm minimised the adverse consequences suffered by the detainee.

The detainee was assisted by Corrective Services officers and Justice Health staff in the immediate aftermath of the episode. He was then transported to hospital by ACT Ambulance Service officers,

with Corrective Services escorts. The detainee was medically assessed at the Canberra Hospital's Emergency Department and then taken to the Mental Health Assessment Unit, attached to the Emergency Department. He was later transferred to the Adult Mental Health Unit (AMHU), also on the hospital campus.

The detainee remained in the AMHU for a period of five days of containment, assessment and treatment. The detainee was in the lawful custody of Corrections, as well as simultaneously being detained (with the exception of a 13 hour period in the middle of his stay at the AMHU) under the emergency detention provisions of the Mental Health Act. On discharge from the AMHU, the detainee was returned to the AMC and placed in the Crisis Support Unit, a 10-bed unit for detainees assessed as being at high risk of self-harm, or of harm to others or from others, as the result of a mental illness or other mental condition.

During his absence from the AMC, the detainee was escorted by two Corrective Services officers at all times and subject to mechanical restraint on an ongoing basis, with few and brief exceptions. The devices used to restrain the detainee varied. While in bed, the detainee was handcuffed by his right arm to the bed with long chain cuffs. When escorted to the toilet or out of his bedroom, he was further restrained with normal handcuffs before the removal of the long chain cuffs. Corrective Services has advised that the use of long chain mechanical restraints in the place of regular handcuffs is a decision that seeks to minimise the use of force.

The mechanical restraint was instigated and maintained on the instructions of senior Corrective Services officers at the AMC, utilising the Director-General's delegated authority under the ACT's *Corrections Management Act 2007*. These instructions were the primary focus of this investigation.

LEGISLATIVE REGIME

Human Rights Act

ACT Health and Corrective Services are public authorities, as defined under the *Human Rights Act 2004*. As such, they must act consistently with human rights and give proper consideration to relevant human rights when making decisions. Section 40B(2) of the Human Rights Act allows public authorities to act incompatibly with human rights when such action is required by law. The human rights most concretely enlivened in this case are reflected in:

- section 10 (*Protection from torture and cruel, inhuman or degrading treatment*), which states, among other things, that “no-one may be … treated or punished in a cruel, inhuman or degrading way”;
- section 18 (*Right to liberty and security of person*), which states that everyone has the right to liberty and security of person and that no-one may be deprived of liberty, except on the grounds and in accordance with the procedures established by law; and

- section 19 (*Humane treatment when deprived of* liberty), which provides that "Anyone deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person".

Section 28 provides that human rights may be subject to reasonable limitations set by law and provides:

> *In deciding whether a limit is reasonable, all relevant factors must be considered, including the following:*
>
> *(a) the nature of the right affected;*
>
> *(b) the importance of the purpose of the limitation;*
>
> *(c) the nature and extent of the limitation;*
>
> *(d) the relationship between the limitation and its purpose;*
>
> *(e) any less restrictive means reasonably available to achieve the purpose the limitation seeks to achieve.*

Section 30 provides that, as far as possible to do so with its purpose, ACT legislation is to be interpreted compatibly with human rights. Section 31 of the Human Rights Act sets out that, in interpreting human rights, other material may be considered including relevant international law and judgments.

The United Nations' *Standard Minimum Rules for the Treatment of Prisoners* addresses the use of *instruments of restraint*, including that instruments of restraint should only be used (relevantly) '*if other methods of control fail*', and that '*such instruments must not be applied for any longer time than is strictly necessary*'.

Consistent with these Rules, Australia's *Standard Guidelines for Corrections* note that instruments of restraint are to be used only where it is *'strictly necessary'*, *'applied for the minimum time necessary to control the prisoner'*, and *'removed during medical tests and procedures, provided this meets security and management requirements'*.

Finally, the United Nations' *Principles of Medical Ethics* offer concrete guidance to health professionals in two relevant principles:

Principle 1

> *Health personnel, particularly physicians, charged with the medical care of prisoners and detainees, have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.*

Principle 5

> *It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and it presents no hazard to his physical or mental health.*

Corrections Management Act

The *Corrections Management Act 2007* is the primary legislative regime guiding the actions of Corrective Services officers. In addition to the functional aspects of the Act, it sets out a range of principles underpinning the responsibilities that it creates. Many of those principles are relevant to the decisions being examined.

The *Preamble* to that Act states that

> *The inherent dignity of all human beings, whatever their personal or social status, is one of the fundamental values of a just and democratic society.*
>
> *The criminal justice system should respect and protect all human rights in accordance with the* Human Rights Act 2004 *and international law…*

Section 7 of the Act (*Main objects of Act*) sets out that the Act is to promote public safety and the maintenance of a just society, and section 8 (*Management of correctional services*) stipulates that:

> *Correctional services must be managed so as to achieve the main objects of this Act, particularly by—*
>
> *(a) ensuring that public safety is the paramount consideration in decision-making about the management of detainees; and*
>
> *(b) ensuring respect for the humanity of everyone involved in correctional services, including detainees, corrections officers and other people who work at or visit correctional centres; and*
>
> *(c) ensuring behaviour by corrections officers that recognises and respects the inherent dignity of detainees as individuals; and*
>
> *(d) ensuring that harm suffered by victims, and their need for protection, are considered appropriately in decision-making about the management of detainees.*

Section 9 (*Treatment of detainees generally*) dictates that functions must be exercised as follows:

> *(a) to respect and protect the detainee's human rights;*
>
> *(b) to ensure the detainee's decent, humane and just treatment;*
>
> *(c) to preclude torture or cruel, inhuman or degrading treatment;*
>
> *(d) to ensure the detainee is not subject to further punishment (in addition to deprivation of liberty) only because of the conditions of detention…*

Section 53 (*Health care)* obliges the Director General for Corrections to ensure that:

> *(a) detainees have a standard of health care equivalent to that available to other people in the ACT; and*
>
> *(b) arrangements are made to ensure the provision of appropriate health services for detainees; and*
>
> *(c) conditions in detention promote the health and wellbeing of detainees; and*
>
> *(d) as far as practicable, detainees are not exposed to risks of infection.*

In addition to those underpinning provisions, there are several functional aspects of the Corrections Management Act which were relevant to the circumstances investigated.

Transfer to health facilities

Section 54 of the Act provides that:

> *(1) The director-general may direct that a detainee be transferred to a health facility at a correctional centre, or outside a correctional centre, if the director-general believes, on reasonable grounds, that is necessary or desirable for the detainee to receive health services at the facility.*
>
> *(2) The director-general must have regard to the advice of a doctor appointed under section 21 (Doctors—health service appointments) when considering whether to make a direction under subsection (1).*
>
> *(3) The director-general may direct an escort officer to escort the detainee to or from the health facility, or while at the facility.*
>
> *(4) The detainee may be discharged from the health facility only if—*
>
> *(a) the health practitioner in charge of the detainee's care approves the discharge; or*
>
> *(b) the director-general directs that the detainee be removed from the facility.*

Use of force

Mechanical restraint is defined in Part 9.7 of the Corrections Management Act as a *Use of force*. Use of force is stipulated as a last resort able to be employed in a range of circumstances, including: to prevent escape, self harm or the commission of an offence, to compel compliance with a direction, and to defend a Corrective Services officer or someone else.

The use of force is only permitted when the officer believes, on reasonable grounds, that the purpose for which force may be used cannot be achieved in any other way. Further, there are obligations placed on a Corrective Services officer who uses force, including that the officer must use no more force than is necessary and reasonable in the circumstances.

Section 140 defines use of force as including restraint, and sets out specific requirements for the use of restraints or weapons. It states that the Director-General must ensure, as far as practicable, that the use of force involving a restraint or weapon is proportionate to the circumstances.

Ongoing custody

Section 217 of the Corrections Management Act provides that while a detainee is subject to a lawful temporary absence from a correctional centre (including transfer to a health facility, as was the case here), the detainee is still taken to be in the custody of the Director-General and, by delegation, Corrective Services.

Section 35 of the Act states:

> *(2) To remove any doubt—*

(a) the escort officer is authorised to have custody of the person for the purpose of escorting the person; and

(b) the person is also taken to be in the director-general's custody…

Section 35(2)(c) states that a Corrections officer acting as the escort officer may, for the purpose of escorting the person while outside a correctional facility, exercise any function under the Act that the officer may exercise in relation to a detainee admitted at a correctional centre.

Mental Health (Treatment and Care) Act

The *Mental Health (Treatment and Care) Act 1994* is the ACT's legislative instrument to oversee the provision of, amongst other things, involuntary mental health treatment.

Section 7 of the Mental Health Act sets out the objectives of the Act:

(a) to provide treatment, care, rehabilitation and protection for mentally dysfunctional or mentally ill persons in a manner that is least restrictive of their human rights;

(b) to provide for mentally dysfunctional or mentally ill persons to receive treatment, care, rehabilitation and protection voluntarily and, in certain circumstances, involuntarily;

(c) to protect the dignity and self-respect of mentally dysfunctional or mentally ill persons;

(d) to ensure that mentally dysfunctional or mentally ill persons have the right to receive treatment, care, rehabilitation and protection in an environment that is the least restrictive and intrusive, having regard to their needs and the need to protect other persons from physical and emotional harm;

(e) to facilitate access by mentally dysfunctional or mentally ill persons to services and facilities appropriate for the provision of treatment, care, rehabilitation and protection.

Section 9 (Maintenance of freedom, dignity and self-respect) stipulates that:

A person exercising a function under this Act, or under an ACAT order, in relation to a mentally dysfunctional or mentally ill person must endeavour to ensure that any restrictions on that person's personal freedom and any derogation of that person's dignity and self-respect are kept to the minimum necessary for the proper care and protection of the person and the protection of the public.

Involuntary detention and restraint under the Mental Health Act

Part 5 of the Mental Health Act deals with *Emergency detention and care* and sets out a detailed process whereby a person may be detained involuntarily in a mental health facility. This is separate to the process for the making of a mental health order by ACAT which may also result in involuntary detention and care (Part 4 of the Mental Health Act). Section 44 of the Act provides that a person may have treatment administered to them involuntarily. The Explanatory Memorandum makes it clear that '*The intention is that a person who is the subject of detention and care under [Part 5] should only be dealt with under this Part as an emergency measure until due processes are applied*'.

The Mental Health Act places a number of obligations on the 'person in charge' of the mental health facility, a phrase which is not defined, but which we have taken to be the Chief Psychiatrist or their

delegate. These include that they are to ensure that a proper physical and psychiatric examination of a person detained under the emergency provisions is carried out within 24 hours.

Importantly, the Chief Psychiatrist also has obligations to ensure that the custody, confinement, restraint or treatment to which the person is subjected "*is the minimum necessary to prevent any immediate and substantial risk of the person detained causing harm to himself or herself or to another person*".

There are also obligations to report instances of involuntary detention to the ACT Civil and Administrative Tribunal and to the Public Advocate of the ACT. This provides an oversight regime in relation to the appropriateness and duration of involuntary mental health treatment.

Finally, the Chief Psychiatrist has a duty to release the person if an order for release is made by the ACAT or if the period of detention has expired. The examining doctor, Chief Psychiatrist or the ACAT may order the release of the person before the period of detention ends if they are satisfied that the detention is no longer justified.

Crimes Act

In addition to being responsible to ensure the ongoing detention of people subject to the ordinary provisions of the Mental Health Act, Mental Health has a role stemming from the *Crimes Act 1900*. Section 309 of that Act allows for the Magistrates Court to send a person who appears to need immediate treatment or care because of mental impairment, to an approved health facility for assessment. The Mental Health Act then allows for such people to be involuntarily detained in line with similar provisions that exist for those not before the Court.

A person to whom s 309 of the Crimes Act applies is to be released into the custody of a police officer once any detention under the Mental Health Act ceases.

LEGISLATIVE INCOMPATIBILITY

There is a question as to whether the Mental Health Act, and the protections contained in that Act, apply at all to detainees under the Corrections Management Act.

While it is without doubt that a detainee continues to be in the custody of Corrective Services, even when they are not physically held in the AMC, the drafting of the current Mental Health Act is not clearly set up to acknowledge the potential for concurrent detention under both the Corrections and Mental Health legislation. A number of ambiguities arise that pose actual and potential difficulties in interpretation and decision making under the Acts. These ambiguities are set out in detail in Attachment A.

There is clear potential for the powers and duties under the Corrections Management Act in relation to a detainee to be exercised inconsistently with the powers and duties of the person in charge of a health facility in relation to a person detained under the Mental Health Act. For example, a

Corrective Services officer may hold a reasonable belief that use of force (including restraint) is necessary for the purpose of containing the person, but the person in charge of the mental health facility may consider that this goes beyond the minimum necessary for the safety of the person and others.

As a matter of legal interpretation, two options are available to resolve this inconsistency if this matter were to be considered by a court. One is that one Act overrides the other i.e. that the provisions in the Mental Health Act cease to operate at all when a detainee, held under the Corrections Management Act, is in a mental health facility. The alternative interpretation is that the Acts can operate concurrently. This means that, even though Corrective Services retains the right to make custodial decisions about a detainee, including decisions to apply restraint, the Mental Health Act provisions around treatment and oversight continue to apply.

In the circumstances of this matter, the agencies operated as if both Acts continued to apply to the detainee. The records indicate that the detainee was formally detained under the Mental Health Act for the majority of his time in the AMHU, even though it could be argued that decisions made under the Mental Health Act were invalid because it ceased to apply when decisions were made under the Corrections Management Act.

The courts are generally slow to find that legislative provisions made by the same legislature are inconsistent, and will strive to allow sections to operate concurrently where possible. Ultimately, however, in order to read the provisions together, either the powers of the Director-General and escort officers must be subject to decisions made by the person in charge of the health facility, or *vice versa*. On balance, it appears that the detention provisions contained in the Mental Health Act would be read as subject to the relevant powers of Corrective Services under the Corrections Management Act. This conclusion is consistent with the principle that a later Act overrides an earlier Act to the extent of any inconsistency: the Corrections Management Act is the later Act.

If the two Acts can be read together and concurrent detention can occur, the protections in the Mental Health Act would apply to detainees. It seems on such a reading, however, that the obligation on the Chief Psychiatrist to ensure that any custody, confinement, restraint or treatment is the minimum necessary, is overridden by Corrective Services' authority to direct that a person be restrained pursuant to powers under the Corrections Management Act.

This interpretation of the legislation leads to a situation where, as occurred in this case, the views of mental health experts around the counter-therapeutic impacts of mechanical restraint of a mentally unwell person, are overridden by the authority of Corrective Services officers under the Corrections Management Act.

The question of the interaction between the Corrections Management Act and the Mental Health Act gives rise to considerable uncertainty. It would seem desirable to consider amending either or both of the Acts to clarify their interaction.

Recommendation 1:

That consideration be given to amending the Corrections Management Act and/or the Mental Health Act to clarify their interaction, and in particular to clarify the authority of Mental Health ACT to detain a person and provide them with involuntary treatment under the Mental Health Act when that person is already a detainee under the Corrections Management Act.

STANDARDS AND POLICIES

Corrective Services

Corrective Services provided a range of policies relevant to the detainee's circumstances. As previously stated, some documents are protected for security reasons and will not be specifically named or described here.

The policy in relation to the use of force (which includes mechanical restraint) is robust from a philosophical perspective. The policy allows for the use of force in both situational and planned circumstances, and sets out reporting requirements. Corrective Services policy also sets out security classifications for detainees, differentiating various classes of detainee based on risk. Security classification has been highlighted by Corrective Services as *the* significant factor in decision making regarding mechanical restraint on escort.

The policy in relation to mechanical restraint within the AMC is dealt with separately to the escort restraint policy. Detainees being escorted are not mechanically restrained as a matter of course – this is subject to specific instruction. The written approval of the General Manager is required to authorise mechanical restraint in excess of two hours in escort situations.

Explicit consideration is given in the escort policy to potential or actual conflict between security considerations and any requirements conveyed by medical personnel. The relevant policy allows for negotiation between corrections and health personnel if issues are raised by health personnel, with a view to reaching agreement, while noting that the security of the escort should not be compromised.

Since the incident that prompted this investigation, further work has been undertaken by Corrective Services to formalise risk assessment processes and decision making regarding mechanical restraint.

Mental Health

Mental Health ACT has a range of policies and procedures that relate to risk assessment, restraint and confinement. In the current case, the relevance of some of these policies was diluted as a result of accepting Corrective Services' decision making primacy in relation to maintenance of custody.

Risk assessments are carried out in accordance with MHACT's *Clinical Risk Assessment and Observations* policy. This policy and its associated procedures determine the level of supervision required for each person, which in turn influences staffing levels.

A Standard Operating Procedure exists for *Prisoners/Detainees as Patients* which sets out principles and practicalities in relation to detainees on Health Directorate premises.

A Standard Operating Procedure exists in relation to *Seclusion and Confinement of Consumers*. It stipulates that seclusion and confinement is a last resort, and is only to continue as long as is required for safety. The policy is predicated on the failure of attempts to de-escalate violent behaviours.

Restraint of Patients is also covered in a Standard Operating Procedure. A robust philosophical context is provided to guide the guarded use of interventions such as mechanical restraint. It should be noted that, prior to this incident, mechanical restraint under the Mental Health Act has never been resorted to within the current Adult Mental Health Unit and on only one occasion (in radically different circumstances) in approximately the past ten years in the former Psychiatric Services Unit.

Medical ethics

Clinical personnel working in a mental health environment are subject to codes of conduct set by regulatory authorities and are also guided by ethical considerations established by their professions.

The Australian Medical Association recently published a position paper on *Medical Ethics in Custodial Settings*, which highlights a range of considerations that reflect the principles adopted in the Human Rights Act, the Corrective Services Act and the Mental Health Act.

The paper notes that '*doctors require reasonable professional autonomy and clinical independence without undue influence from correctional facility management'* and that '*Corrections authorities should afford doctors the freedom to exercise their professional judgement in the care and treatment'.*

The position paper goes on to state that '*Medical personnel should never proceed with medical acts on restrained people, except for those with potential for immediate and serious risk for themselves and others*'. Additionally, it states that '*Doctors have a duty to speak out to appropriate authorities when the health care services or environment within correctional facilities are inadequate or pose a potential threat to health*'.

While it is recognised that the detainee in the current circumstances was not in the AMC but was detained in a mental health facility, such ethical considerations were significant in the minds of health authorities when struggling with the concept of restraint.

THE TENSIONS BETWEEN CUSTODIAL AND HEALTH/MENTAL HEALTH PRACTICES

This case brings to focus the stark and deliberate gulf between accepted custodial practice, and contemporary mental health service delivery.

Both the custodial and mental health systems make provision for the lawful use of mechanical restraint. Custodial systems are more content to use mechanical restraint than mental health services are. Mental health services have evolved significantly in recent decades, away from a similar level of comfort with the use of mechanical devices (to lessen risk of harm and risk of escape), and towards a stronger focus on balancing the counter-therapeutic effects of mechanical restraint against the additional security and assurance that mechanical restraint provides.

Any disquiet experienced by Corrective Services regarding Mental Health's capacity to ensure ongoing custody, appears to have been precisely mirrored by Mental Health's disquiet regarding Corrective Services' capacity to adequately allow therapeutic intervention and recovery to be facilitated. Mechanical restraint as a mechanism to ensure custody and reduce risk of harm is visible and obvious. The harm done to a therapeutic environment by the presence of mechanical restraint is understandably more difficult to comprehend and appreciate for people not operating in that space and trained in the nuances of mental health inpatient care.

Counter-therapeutic effects of restraint

Mechanical restraint in a mental health facility is, in almost all circumstances, intrinsically counter-therapeutic. This is a basic premise widely accepted in the inpatient mental health community, and is a fact not well understood by Corrective Services. This lack of understanding was demonstrated in the management of the matter at hand and persists following discussions on a draft of this report.

It is easy to describe and understand the ways in which mechanical restraints can interfere with physical medical interventions. It is harder to describe and understand the more conceptual counter-therapeutic effect of mechanical restraint in the mental health sphere, where impacts are less able to be visually observed. This is one reason why the expertise of mental health professionals should be generally preferred, where possible, to the extent that this can safely occur.

Mental health treatment and support are both reliant on the building and maintaining of professional and therapeutic rapport, which is hampered by the altered dynamic of custodial practices. Best practice mental health service is focussed on recovery principles, which are already finely balanced against the other forms of intrusion that come with hospitalisation. Inpatient mental health treatment is a package of intervention, which can include containment, trained supervision, targeted de-escalation strategies, medication, and quietude.

Being mechanically restrained is not conducive to the environment or manner in which this intervention is delivered by mental health professionals. Restrictive practices also have a high potential to be traumatising (or re-traumatising) – particularly in relation to a person whose mental health has degraded to the extent that they make a serious and dramatic effort to self-harm.

Advances in inpatient mental health service delivery have essentially stamped out the use of mechanical restraint because of this counter-therapeutic effect. In combination with issues of dignity, respect, and the legislative requirement for least restrictive practice, this recognition has been one of the primary drivers away from outdated methods of service delivery which were previously considered to be acceptable. These advances have also been highly successful in reducing the incidence of other intrusive mental health interventions such as seclusion, the use of which has reduced dramatically in recent years.

The admitting psychiatrist's first ward round on the morning of 16 August concluded with the following entry in the management plan: '*To liaise with prison authority to take off handcuff from him*'. This illustrates the immediate importance in the mind of the physician that handcuffs were inappropriate when addressing a person's mental health issues. The psychiatrist has confirmed that they wished to have the handcuffs removed. The detainee's clinical records contain many similar references from health professionals in relation to the presence of the handcuffs.

The Commission obtained advice from an independent interstate forensic mental health expert. The advice stated that the application of mechanical restraint to an involuntary patient under the Mental Health Act, in accordance with routine Corrections procedure is troubling. The advice noted "*If it was deemed to be clinically indicated by the treating psychiatrist then the clinical merits of that would have to be examined. Even if thought clinically appropriate, the fact that the restraints are applied by prison officers, presumably in accordance with prison protocol, would make it even more difficult than usual for the patient to view the restraints as a clinical intervention with their own mental health welfare as the purpose of it*."

The expert further noted that, even if the patient was not involuntary, *"the use of mechanical restraint is inimical to good mental health care"* and questioned the clinical impact of prolonged mechanical restraint on the mental state of the patient.

The expert noted that if restraint is a routine scenario then it raises concerns about a systemic inadequacy of appropriate resources for treatment of severely mentally ill patients. The expert noted that in their forensic mental health facility, restraint is limited to the following circumstances:

1. *High risk escorts outside of the hospital for medical purposes eg. to a general hospital. It is not routine that all patients on external medical leave have mechanical restraint (handcuffs/if in an ambulance, velcro restraints);*

2. *Leave to attend court: the patient is escorted in handcuffs to court by the health service on behalf of Corrections; and*

3. *Brief application of a blanket wrap around the torso of certain highly disturbed patients in seclusion to facilitate safe exit of staff from the room. This, although we are required to report it as an episode of mechanical restraint, is fundamentally different from the more common forms of mechanical restraint such as handcuffs and leg restraints. The patient can remove the blanket themselves and it usually is applied for no more than a minute or so.*

In summary, the independent expert noted *"There are sound clinical, ethical, legal and human rights reasons for ensuring that involuntary psychiatric treatment is kept at a distance from the application of correctional protocols. This is not intended as a criticism of corrections in any way but the functions of mental health services and corrections should never be confused."*

These concerns were shared by Mental Health ACT clinicians and staff when interviewed by the Commissioner.

Relative expertise in managing risk

Corrective Services is expert in providing custodial containment. Their culture focuses on this important primary aim. They are assisted by legislative powers to use force, as a last resort, to achieve this aim. They have the advantage of generally operating within a purpose-built facility designed to prevent escape, but also are experienced in managing risk when dealing with offenders under escort, including in hospital and at funerals, as well as in the courts.

They also have obligations to protect the wellbeing of detainees, under law and in accordance with human rights. Corrective Services staff are not experts in the provision of therapeutic inpatient mental health interventions. Additionally, there is a significant gulf between the expertise and actions required to protect the health and safety of individuals as a result of a detainee's criminogenic motivations, and those required to protect the health and safety of individuals posed by psychiatric illness.

Mental Health is, among other things, expert in providing involuntary therapeutic treatment, and containment to the extent that their facilities allow (noting that, from time to time, a mental health consumer may present greater risk than can be managed locally, although that was not considered by the health professionals to be the case in this matter). Their culture focuses on minimising the extent to which their treatment involves containment and deprivation of liberty, but accepts its necessity. The AMHU is a semi secure facility that does not aim to meet the same containment standards as the AMC. However, it is routinely used to ensure the ongoing detention of people subject to the Mental Health Act, including those referred by the Magistrates Court under the Crimes Act. The risk of harm to self and/or others presented by such people is not greatly different to that potentially posed by a remandee or a sentenced detainee, regardless of the source of their motivation (criminogenic or illness-related).

While not directly on point in this case, legislative provisions such as s 309 of the Crimes Act, which provides for the detention of persons who have allegedly committed crimes but who need treatment because of a mental impairment, indicate that the Territory recognises the relevant skill, expertise, resources and facilities possessed and controlled by Mental Health ACT. When a person is taken to the AMHU pursuant to s 309, maintaining custody is in the hands of the mental health authorities.

It arguably makes little sense that a person who is alleged to have committed a criminal offence can be considered safely containable by mental health authorities at one point in time, yet that same person after sentencing may potentially be in the same facility in identical clinical circumstances and

be subject to counter-therapeutic interventions directed by Corrective Services. While the Commissioner acknowledges that there may be a greater risk associated with motivations to escape once someone has been sentenced, the question arises as to why Mental Health ACT's resources, and the philosophies that drive their use, can be considered adequate for this task on some occasions yet not on others.

Mental Health's obligations

Mental Health's legislation, policies, protocols and culture, combine to create an overarching philosophy that is very different to that of Corrective Services. Mental Health's approach can lead (and did in this case), to starkly different decisions than those made by Corrective Services regarding the treatment of a person experiencing a mental health crisis.

During the time the detainee was in the AMHU, the Chief Psychiatrist also held direct decision making responsibility for his treatment and welfare. It is clear that if decisions relating to the detainee were solely made under the Mental Health Act, the detainee would not have been mechanically restrained. Indeed, for a 13 hour period of time when he was a voluntary patient, Mental Health would not have had the authority to restrain him in any case, restraint only being available to mental health authorities in involuntary treatment situations. During the time that he was voluntarily receiving treatment, he could only be the subject of restraint by order of Corrective Services.

Even when a detainee is subject to involuntary detention under the Mental Health Act, it is unlikely that mechanical restraint would emerge as one of the options in making decisions about the least intrusive way in which to maintain custody. In the judgement of the Mental Health clinicians, it was not necessary, appropriate or justifiable to mechanically restrain the detainee in this case. While the Mental Health Act authorises mechanical restraint in certain circumstances, the AMHU does not use mechanical restraints and does not have any on site.

If Mental Health had been responsible for custody decisions, those decisions would have been made in accordance with the *Clinical Risk Assessment and Observations* policy. The risk assessment would need to have included consideration of advice from Corrective Services. Based on their risk assessment, staffing levels would have been adjusted accordingly to ensure proportionate monitoring of the detainee, and the ability to respond to any incidents that may arise. In the event that incidents eventuated, Mental Health's *Seclusion and Confinement of Consumers* Standard Operating Procedure could have been activated if appropriate. The *Restraint of Patients* Standard Operating Procedure may have also been called into use. Seclusion and physical (body) restraint may be applied as a last resort and after attempts at de-escalation. As noted earlier, inpatient mental health treatment is a package of intervention, which can include containment, trained supervision, targeted de-escalation strategies, medication, and quietude.

By having decisions regarding custody and restraint removed from them, Mental Health clinicians arguably became involuntarily complicit in the ongoing mechanical restraint of the detainee while in their treatment facility. The situation effectively caused (notwithstanding their wishes to the contrary) a contravention of the medical ethics under which they operate, including Principle 5 in

the United Nations' *Principles of Medical Ethics* – it is "*a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria...".*

Reasonable efforts were made by Mental Health staff to express dissatisfaction with the arrangements in place, consistent with the UN's *Principles of Medical Ethics.* Those efforts were escalated to an appropriately senior level, but remained ineffectual.

Based on Corrective Services' assessment of risk and decision to mechanically restrain, clinical staff were unable to meet the aspirations of their profession. While not unlawful, this is clearly undesirable from a clinical and professional perspective. Further, a health practitioner who is complicit in the ongoing mechanical restraint of mental health patients runs the risk that such concerns could form the basis of a report to the Australian Health Practitioner Regulation Agency regarding an alleged failure in their duty of care to their patients.

These considerations leave Mental Health practitioners in an unenviable position regarding whether they accept patients in the AMHU, or refuse to taken them, if they are to be mechanically restrained. Clearly, if they are of the view that inpatient mental health treatment is required, they have little option but to admit the person for treatment. The AMC (including the Crisis Support Unit) is not an alternative to the AMHU when inpatient mental health treatment is required.

The ambiguities in the legislation discussed earlier mean that there is some uncertainty as to whether or not the custody provisions in the Corrections Management Act and the involuntary treatment provisions in the Mental Health Act operate concurrently. Nonetheless, Mental Health clearly operated on the basis that they had the power to involuntarily detain the detainee under the Mental Health Act and purported to invoke the powers and procedures under that Act in relation to the detainee.

When a person is detained under the Mental Health Act, there is a requirement under s 42 of the legislation that certain persons be notified about the detention. This includes notifying the Public Advocate of the ACT and the ACT Civil and Administrative Tribunal. There is a further obligation on Mental Health to ensure that the detainee has adequate opportunity to notify a relative or friend of their detention.

These notifications ensure that there can be external oversight of detention and treatment decisions. Following such a notification the Public Advocate is, for example, able to visit the person in detention to satisfy themself that the conditions of that detention, including restraint, are appropriate.

If one accepted the argument that the legislative incompatibility means that provisions in the Mental Health Act have no application when someone is already detained under the Corrections Management Act, there was a potential for none of these things to have occurred in this case. If none of the triggering factors for the detainee's detention under the Mental Health Act had applied, the oversight mechanisms may also not have been activated. Mental Health, however, acted on the

basis that he was detained under the Mental Health Act, and staff reported the matter to the Public Advocate.

If a person is not detained under the Mental Health Act, reporting obligations in relation to restraint ordered by another party do not arise. The Commissioner is of the view that all instances of restraint in mental health facilities need to be advised to the Public Advocate. This would not require naming a person, and therefore potentially breaching their privacy, but could simply be advised in a de-identified manner. This would then allow the Public Advocate to visit the facility and determine whether there are any matters of concern.

> ***Recommendation 2:***
>
> *That the Mental Health (Care and Treatment Act) be amended to require Mental Health ACT to advise the Public Advocate when anyone being treated in the AMHU is mechanically restrained by order of Corrective Services ACT; and, prior to legislative authority, that Mental Health ACT undertake deidentified reporting as a matter of policy.*

Corrective Services' obligations

A simple interpretation of the Corrections Management Act (custody remains with the Director-General) is that Corrective Services' decision making authority was not in any way diluted by the fact that the detainee was away from the AMC, or by the fact that he was, for two periods of time, involuntarily detained under the Mental Health Act. The earlier discussion in this report around the legislative regime would indicate that Corrective Services' role may be read as concurrently operating with that of Mental Health services. Nonetheless, it appears that Corrective Services' decisions regarding whether or not to apply restraint will prevail.

At the time, Corrective Services clarified with Mental Health its view that all decisions regarding the maintenance of custody, and consequently the use of restraint, were the responsibility of Corrective Services. This view was the confirmed by the General Manager when interviewed by the Commissioner.

This interpretation of Corrective Services' ongoing responsibility was clearly not understood or accepted by Mental Health at the outset of the detainee's admission, particularly when the issue of mechanical restraint arose as a significant concern for Mental Health staff. It was later accepted by Mental Health following discussions between Corrective Services and Health Directorate management.

In the circumstances, it was appropriate at the time for Mental Health to accept Corrective Services' assertion of its ongoing right to make unilateral custodial decisions. It is clear that decision making under the Corrections Management Act, however, requires a careful balancing of potentially competing priorities. Most relevantly, a tension exists between the rights of a detainee, the rights of the public, and the responsibilities of decision makers under the Act. While the Act provides that "*public safety is the paramount consideration in decision-making about the management of*

detainees", the degree to which this requires use of force in any given situation can reasonably be subject to differing views. Further, the Act requires that use of force is always a last resort.

Corrective Services' policy allows for negotiation between corrections and mental health personnel if issues are raised by health personnel, with a view to reaching agreement, while noting that the security of the escort should not be compromised. As noted earlier, Health Directorate management raised concerns with Corrective Services and were advised that mechanical restraint would be maintained.

The General Manager made it clear to the Commissioner in interview, that the primary and predominant consideration in making a decision to mechanically restrain is the detainee's security classification, and that the issue of potential escape was critical. Other considerations included the health and wellbeing of the detainee; the safety of the community; the security and good order of the environment; the wellbeing of people in the hospital including hospital staff, patients and members of the public; the fact that AMHU is not a secure environment in the way that the AMC is; and that, in the event of an incident, he could not rely on hospital staff to intervene in the same way that Corrections staff would.

The General Manager was of the view that for a maximum security detainee, and generally a medium security detainee, it would be very difficult to find sufficient grounds to lower security away from a baseline decision to restrain, even if a detainee was compliant. He considered that compliance in hospital for two, three or four days would not lead to a decision to reduce restraint. This would be one factor to consider, but not relied on to the extent that it would prompt the removal of restraints in and of itself.

Further to this, it was also made clear that any decision to alter a classification-based restraint decision would generally be in the direction of imposing greater restriction or intervention, rather than lesser. This position was contributed to by concerns about the potential for hospital admissions to be considered a soft target for escape attempts, and that it is by no means without precedent for a detainee to manufacture circumstances to prompt admission to hospital, with a direct view to an easier attempt at escape.

The General Manager advised that in his assessment, if the handcuffs were removed the detainee posed a very high risk to all, and to the integrity of the escort. He was not convinced that the detainee would not try to escape.

The General Manager advised that his ongoing assessment included consideration of reports of concerning behaviour coming from Corrections staff on an ongoing basis, in addition to the initial incident, the detainee's presentation on transfer from the Assessment Unit to the AMHU, and the detainee's irrational behaviour on the night of 18 August leading to an incident on the 19th. It is noted that such reports are not reflected in the records of either Corrective Services or Mental Health. The Commission spoke with a number of Corrective Services staff who were rostered on with the detainee when he was in the Adult Mental Health Unit. None of those staff indicated that there were ongoing incidents of concerning behaviour.

The Human Rights Act requires that any limitation on the rights of the detainee is reasonable and proportionate. Relevant international human rights considerations would indicate that instruments of restraint should only be used (relevantly) '*if other methods of control fail*', and that '*such instruments must not be applied for any longer time than is strictly necessary*'[1]; instruments of restraint are to be used only where it is *'strictly necessary'*, *'applied for the minimum time necessary to control the prisoner'*, and *'removed during medical tests and procedures, provided this meets security and management requirements'*[2].

The Commissioner does not consider that an approach based, in effect, on security classification is consistent with these aims. The Commission raised concerns about similar 'routine' restraint of young people in custody in its 2011 Review of the Youth Justice System Report. In that Report the Commission noted that young people on remand were routinely restrained for medical appointments outside the custodial environment. The Commission had concerns that such a use of force was not subject to thorough risk assessment processes and recommended that an assessment be taken in relation to every individual before restraint was used.

Justification for mechanical restraint

Even if one were to accept that Corrective Services maintained all decision making authority regarding what was required to maintain custody and protect the detainee and others from harm, the question remains whether it was, in fact, necessary to mechanically restrain him at all relevant times.

The General Manager indicated that, in general, maximum and medium classification detainees would be subject to mechanical restraint on medical escort in order to maintain safe custody. Decision making for minimum security detainees would lean more towards considering a non-restraint arrangement while on escort.

In this case, it is relevant that the detainee was, prior to the self-harm incident, classified as a maximum security detainee. This classification was based on a range of factors, significant amongst them the nature of the detainee's most recent offence.

Additionally, the General Manager advised the Commissioner that the detainee may have had a heightened risk of escape, and that this was taken into consideration in the decision making process. This suspicion was based on an undocumented report of comments allegedly made by the detainee to a custodial officer at some time after the self harm incident, indicating that he had previously attempted to evade Police custody. There is no written evidence contained within the Corrective Services record to support this comment having been made (although the Commission accepts that it was verbally reported to the General Manager). The alleged comment was not tested by Corrective Services, or the Commission, although it is noted that this would not have been a factor in the original decision to restrain, as it was not known at that time.

[1] United Nations' *Standard Minimum Rules for the Treatment of Prisoners*
[2] Australia's *Standard Guidelines for Corrections*

Ambulance transport
During transit from the AMC to the Canberra Hospital, the detainee was voluntarily mute but cooperative and not displaying any signs of aggression, uncooperativeness or unpredictability.

The Justice and Community Safety Directorate's response to the Commission stated that "*During transport to hospital and while in hospital, (the detainee) remained aggressive and non-compliant*". This statement was not borne out in interview with ambulance officers or in other documentation. As discussed elsewhere, there were two incidents involving the detainee following his removal from the AMC but for the remainder of his time in the health system the documentation of both organisations indicates that he was compliant.

The presence of mechanical restraint in transit did not interfere with Ambulance officers' ability to provide assessment, treatment and monitoring, and was consistent with routine practice. Ambulance officers were confident that an appropriate outcome would have been successfully negotiated if clinical circumstances required flexibility (such as changing restraints to a different limb). In light of the very recent episode of self harm and the detainee's unpredictable behaviour, no particular reassurance of safety would have been available at that time. In any event, given the less-controlled nature of the ambulance environment, Corrective Services' maintenance of mechanical restraint during transport appears to have been prudent at that stage.

Emergency Department
As with the transport, in light of the detainee's recent highly unpredictable and dangerous behaviour, Corrective Services' maintenance of mechanical restraint during the period in which the detainee was in the Emergency Department appeared reasonable.

Mental Health Assessment Unit
At the Mental Health Assessment Unit, the early part of the detainee's presentation did not indicate any additional or ongoing risk. The detainee was described in Health records as "*pleasant and warm*" towards nursing staff. In preparation for transport to the Adult Mental Health Unit, the detainee was handcuffed prior to the removal of chain restraints. His presentation was then described by hospital staff as "*very irritable and aggressive towards correctional and nursing staff*" and "*intimidating in his stare and approach to staff*". This appeared to Health and Corrective Services staff to be directly related to the addition of the handcuffs. Again, restraint appears to have been appropriate for the purposes of transport.

Adult Mental Health Unit (AMHU)
During the detainee's five day stay in the AMHU, there was no particular indication of concerning behaviour, increased risk or inappropriate actions throughout the first four days. The justification for mechanical restraint on the basis of immediate risk of harm to self or others (as opposed to the maintenance of custody) arguably became less strong as those days passed, particularly as it relates to the concept of '*last resort*'.

Late on the night of 18 August and into the early morning of 19 August, the detainee began exhibiting irrational behaviour. This included banging his head against a wall, vocalising unusual sounds, engaging for the first time in elevated verbal altercations with staff, and collapsing to the

floor without any clear precipitating cause. A further incident occurred approximately 40 minutes later, which soon escalated to a violent altercation.

It appears from the records that the direct trigger for the incident becoming physically violent (acknowledging that the detainee had already initiated a verbally aggressive confrontation which included threats of violence) was the forced removal of a lit cigarette from the detainee's mouth. Records indicate that the lit cigarette was knocked out of the detainee's mouth with a towel by a Corrective Services officer. While not in any way condoning the subsequent actions of the detainee, it is not surprising that a person already engaged in a volatile verbally aggressive and threatening altercation would react poorly to such an action. The only direct or immediate benefit to this action was the cigarette being extinguished, rather than finished. The act of smoking was not inherently in need of forcible intervention from a safety perspective. The flow-on effect of the ensuing escalation was aggressive physical contact with custodial and mental health staff (resulting in minor injury to a custodial officer), involuntary seclusion of the detainee, the forced injection of several medications, and the re-introduction of emergency mental health detention.

This incident does not appear to have been managed in the least intrusive way possible. This is not to suggest that the remainder of the detainee's stay would have necessarily been uneventful or that the verbal aggression and threats would have been successfully de-escalated, although it is possible they could have been.

While this outcome was not the intended result of the removal of the cigarette, on retrospective examination the action appears to have been disproportionate to the potential for harm presented by the detainee's actions at the time. The additional risks posed by smoking one cigarette indoors while already being directly monitored by multiple staff, even in circumstances where he was already verbally aggressive and threatening, were minimal.

It is somewhat ironic that the strongest validation of Corrective Services' perceived need to continuously mechanically restrain the detainee when in the AMHU, was provided by an incident that, in the Commissioner's view, was escalated by Corrective Services' actions. Incidents of verbal aggression and the flouting of rules occur regularly in the AMHU and are managed by Mental Health staff without recourse to mechanical restraint.

Corrective Services stands by its officers' actions in this regard, considering that failure to intervene in the way that they did would be to accept or condone 'non-compliance' and give weight to a detainee's notion that they have the right to do what they want. This notion, in the Commissioner's view, illustrates the difference between a corrections viewpoint that challenging behaviours exhibited by a detainee must necessarily be a form of 'acting out' and an alternative view that such behaviours may be a manifestation of a person's mental illness. In the latter case, the situation could be handled in a manner that is different to exerting authority. The Commissioner does not form a view on this issue regarding the detainee's motivations or actions in the particular circumstances.

Corrective Services notes that in a custodial context security decision making may be informed by increased risk very quickly but will not be influenced by decreased risk except over time. In their

view the detainee's spontaneously aggressive behaviour on this occasion shows that his risk profile remained high.

Was the use of force the least intrusive option available?

The detainee was at all times accompanied by two Corrective Services officers as well as being mechanically restrained. The question arises whether these or additional staffing resources would have been sufficient to contain the detainee, without the need to resort to continuous mechanical restraint. The application of Mental Health's policy in the same circumstances would have seen additional staff allocated to monitor the detainee and no use of mechanical restraint. Such a situation may also have led to customised variations to day to day activities, such as heightened awareness of the detainee's location when opening doors, ensuring particular staffing levels in particular areas, and creating response plans to various circumstances. While it is unknown how many additional staff would have been rostered on by Mental Health, it is apparent that a decision around some appropriate staffing level would have been reached.

The fact that two escorts were chosen by Corrective Services was a conscious decision regarding the level of human resources considered appropriate to ensure the detainee's ongoing custody and safety. Would additional escorts have precluded the need for mechanical restraint? Was mechanical restraint a 'last resort' and the least intrusive option available in the circumstances?

Human rights considerations

Corrective Services and ACT Health, as public authorities, have obligations to act consistently with human rights and to take human rights into account in decision making. Failure to do so is unlawful under s 40B of the Human Rights Act. A defence is available if a public authority is required by law to act inconsistently with human rights.

Public authority obligations under s 40B are subject to s 28 of the Act, which allows rights to be subject to reasonable limits, authorised by law, that are justifiable in a free and democratic society. It is necessary to determine whether these limits were set by laws and justifiable under s 28, which provides, amongst other things, that in deciding whether a limit is reasonable, all relevant factors must be considered, including whether there are "…*any less restrictive means reasonably available to achieve the purpose the limitation seeks to achieve".*

In this situation, a key issue is whether there were any less restrictive means reasonably available to achieve the purpose of ensuring the security of the detainee and protecting public safety, including staff, patients, visitors and the general public. The Commissioner accepts that there will be exceptional situations where the risk profile of a particular detainee will mean that mechanical restraints are the only means reasonably available to ensure safety and security at a particular time. The Commissioner also acknowledges that these are difficult decisions to make, and that Corrective Services and ACT Health have serious responsibilities to ensure safety and to prevent a detainee from escaping. The Human Rights Act gives public authorities room to exercise professional judgement to discharge that responsibility, within the scope of the authorising law and policy.

Nevertheless, in this case, after the detainee was stabilised in the mental health unit, it is not clear that his individual risk at that time (and the Commissioner acknowledges that Corrective Services disagrees with this view) made ongoing mechanical restraint the only means reasonably available, and more particularly, *the last resort* to achieve these aims. It could be argued that the presence of an appropriate number of escort officers monitoring the detainee, and of other staff in the unit who are trained to manage involuntary consumers, may have obviated the need for mechanical restraint. There were a suite of options available in between no restraint to continuous handcuffing but it appears they were not explored. The removal of restraints at least for limited periods of time would have allowed the detainee respite from the discomfort of ongoing restraint, reduced counter-therapeutic impacts, and enhanced the decision makers' ability to assess ongoing risk.

The approach discussed by Corrective Services, that as a general rule mechanical restraints will be used for detainees on maximum or medium security classifications raises particular concern. In the Commissioner's view this apparent blanket approach does not appear to be consistent with the use of restraint as a last resort, nor with the concept of the least restrictive means available. An approach that further recognises factors such as the condition for which the detainee is being treated, the changes to the risk posed over the course of treatment, the intrinsic counter-therapeutic effects of mechanical restraint or the increasing discomfort that will be experienced by a detainee as a period of restraint progresses, appears warranted.

The Commissioner does not form a view on whether the approach taken by Corrective Services in these circumstances may have been inconsistent with human rights, and thus give rise to potential concerns of unlawful conduct under s 40B of the Human Rights Act. The issue of whether or not the detainee's human rights were breached is not one for the Commissioner to determine. This would ultimately be a matter for a Court.

Response from Corrective Services

A draft of this report was provided to Corrective Services for comment. In discussions that followed with Corrective Services and JACS, the Commissioner was advised that decisions to restrain are based on a range of considerations, the detainee's security classification is only one of those considerations, and that decisions are the subject of ongoing review. Corrective Services noted that unless there are mitigating factors, the general approach will be that restraint will be applied in cases where a person under escort is maximum or medium security. Corrective Services noted that they will consider removing restraint but if there is no identified need to remove handcuffs, they will be left on. Further, on 29 July 2013 the Executive Director, ACT Corrective Services, wrote to the office of the Health Services Commissioner in relation to another matter where a detainee was handcuffed and stated *"In line with Mr [X's] security classification as a medium security detainee, he was handcuffed during escort. This is normal practice for a detainee that is classified as medium security."*

A second draft of the report was provided to JACS and further comment was received from JACS/Corrective Services. That response noted that *"the General Manager would [not] without complex consideration of the issues use a detainee's classification alone as the basis for detainee*

management decisions through the aftermath of a serious incident… While the General Manager stated to you in interview that a classification is a starting point for management decisions a classification, itself a risk based instrument, is carefully applied in dynamic circumstances having regard to a broad range of matters that might be relevant."

The response stated that the detainee's behaviour was throughout the relevant period unpredictable, unusual and at times violent. The response also noted that *"the short passage of purportedly uneventful days between 14 and 18 August are insufficient to have dramatically reduced the detainee's risk profile in context of his custody outside of a secure environment. During the period of the detainee's custody in the AMHU the General Manager was in periodic contact with appropriately senior executives at both the Justice and Community Safety and Health Directorates, as well as frequent contact with corrections officers, regarding the decision to maintain mechanical restraint of the detainee. Risk assessment, although perhaps inadequately documented, was intrinsic to the ongoing decision to restrain."*

As noted earlier, the Commissioner could find no evidence of the purported behavioural issues throughout the relevant period, and there was no documentary evidence of the conversations that took place. The Commissioner accepts that conversations occurred.

The Commissioner remains concerned that the approach taken in this case does not appear to be consistent with the use of restraint as *a last resort*, nor with the concept of the least restrictive means available.

Documentation of decisions

On review of the material provided to the Commission by Corrective Services, it became apparent that the records did not include any documentation formalising the transfer of the detainee to hospital, or containing instructions regarding the conditions of the escort (such as the level of supervision and any restraint to be applied). When this apparent omission was queried, an unsigned Removal Order was provided, with an indication that this had been extracted from the electronic records. The Commissioner made a request for the original to be located, given its significance. A signed copy was unable to be located.

Post-incident policy response

Since the incident that prompted this investigation, collaborative work has been undertaken by Corrective Services and Mental Health management to ensure better operation of transfer processes, including a more formalised risk assessment by Corrective Services, informed by Mental Health input.

Mental Health has developed a Standard Operating Procedure for the transfer of detainees, superseding the pre-existing procedure entitled *Prisoners/Detainees as Patients*. This Procedure creates a three step process which includes:

- a formal referral from Mental Health to Corrective Services where a transfer is considered appropriate;

- an accompanying risk assessment by Mental Health (prompting collaboration between Mental Health and Corrective Services regarding how the person will be managed by Corrective Services on transfer, and including a requirement for daily information exchange between them); and

- a *Security and Risk Assessment of Detainee Report* by Corrective Services, taking account of the above information, an assessment of risk factors from Corrective Services' standpoint leading to specific recommendations, and a confirmed Corrective Services decision regarding conditions of escort (including any restraint to be applied).

While the new approach provides certainty for all parties, the Commissioner remains concerned that the *Security and Risk Assessment of Detainee Report* does not incorporate provision for review of decisions at appropriate intervals, nor take into account all of the factors that need to be considered, as recommended in this report.

Conclusion

In the Commissioner's view the decisions made by Corrective Services, while unquestionably made for the right reasons from their perspective, were made without sufficient regard to competing policy and human rights considerations. In particular:

- the decision to mechanically restrain the detainee for the duration of his interactions with the health system was effectively based primarily on his security classification, which overrode other criteria, and Corrective Services has indicated that such decisions would be made in the same way in the future;

- there is no documented evidence that an additional risk assessment was undertaken (acknowledging that a security classification is a risk assessment process in itself), including whether the detainee presented an actual flight risk;

- the decision to transfer the detainee to hospital and provide instructions regarding the conditions of the escort (such as the level of supervision and any restraint to be applied), was not documented in accordance with policy;

- no formal review of the decision occurred in light of the detainee's presentation at different stages of his detention in the AMHU to consider whether restraint was being applied for the minimum time necessary to control the detainee, when two Corrections officers were permanently present in addition to Mental Health staff, other than to reaffirm the decision to restrain after the incident of 19 August; and

- little weight appears to have been given to the views of mental health clinicians regarding alternative means of securing custody.

It is acknowledged that in a practical context the requirement for an escort can emerge without notice and in such circumstances it is appropriate to rely in the first instance on a detainee's security classification. However, it would be appropriate to re-assess the situation without delay, as well as

formally on an ongoing basis, to determine the extent to which restraint may be required as circumstances change.

Recommendation 3:

That Corrective Services:

- *conduct individual risk assessments on each occasion that a detainee is to be escorted to a health facility, taking into account the individual circumstances relating to the particular facility, evidence in relation to potential flight risk, and the individual characteristics and medical/mental health condition of the detainee, as well as considering security classifications;*
- *conduct regular reviews of decisions to mechanically restrain a person under escort for more than two hours, to determine if the level of restraint remains appropriate, given that the individual circumstances relating to the particular facility, the flight risk, and the individual characteristics and medical/mental health condition of the detainee will change;*
- *amend its risk assessment documentation to require regular review of restraint decisions, taking the above factors into account;*
- *document all such decisions in a timely manner;*
- *take account of the views of, and strategies proposed by, mental health experts when considering custodial requirements in inpatient mental health situations, and document any reasons for rejecting those views.*

Ultimately, the Commissioner considers that decisions about the custody and management of patients in mental health facilities must be made by clinicians, in the best interests of managing the person's mental health. When those patients are detainees, such decisions clearly need to be informed by advice from Corrective Services. This view is canvassed in more detail below and the Commissioner is of the view that the legislation requires amendment to enable this to occur.

In the meantime, the Commissioner is concerned that discussions between Corrective Services and Mental Health need to be aimed at finding the right balance between clinical and custodial considerations. The Commissioner is of the view that the Chief Psychiatrist, in conjunction with the treating team, is the person best placed to make such decisions on clinical grounds. On the same basis that the Commissioner does not consider it appropriate for Corrective Services to be making the final decisions about how a person in a mental health facility is to be managed, as they are not mental health clinicians, the Commissioner does not consider that such decisions should ultimately be made by non-clinical managers in the Health Directorate. This of course does not preclude consultation with all appropriate stakeholders and taking those views into account.

The Commissioner welcomes the advice provided in response to a draft of this report, that ACT Health will seek to finalise a Memorandum of Understanding with ACT Corrective Services to clarify how the two services will operate collaboratively now that both the AMHU and AMC exist.

Recommendation 4:

> *That, pending any legislative amendments to enable transfer of custody from Corrective Services to Mental Health ACT, discussions about security requirements and the application of mechanical restraint should be conducted between Corrective Services management and the Chief Psychiatrist.*

Recommendation 5:

> *That Corrective Services and ACT Health finalise their Memorandum of Understanding on transfer of detainees for treatment within 3 months of this report being tabled in the Legislative Assembly, and that the MOU adopts the process outlined in Recommendation 4.*

WHO SHOULD BE MAKING DECISIONS IN MENTAL HEALTH FACILITIES?

While it appears that the legislative regime currently provides for Corrective Services to prevail in making custody decisions when a detainee is transferred from a custodial setting to a mental health facility, this is not the only option available. Amendments to the legislation could provide for a transfer of custody from Corrective Services to Mental Health when a detainee requires inpatient mental health treatment, and back again when treatment is completed.

While the ACT does not currently have a secure forensic mental health facility (and it is not planned to construct a high security facility), the question arises whether this is a necessary pre-requisite for the transfer of custody to mental health authorities. Consideration of the options available in other jurisdictions appears relevant.

Interstate regimes for maintaining custody in mental health services

Jurisdictions vary in relation to how custody is maintained, or transferred, when a detainee requires inpatient mental health treatment. In some instances these variations are related to the availability of secure forensic units, although this is not universal. The following summaries are based on an examination of corrections and mental health legislation in each of the jurisdictions.

Queensland

Queensland's *Mental Health Act 2000* provides for a detainee to become a *classified patient* and, when a transfer from a corrections facility is agreed upon, the administrator of an authorised mental health service assumes legal custody to detain the patient within the health service facility. These provisions allow transfer to mainstream facilities as well as secure facilities. Provisions exist for the return of custody to the authority of Corrective Services under the *Corrective Services Act 2006* when the person no longer meets the criteria to be a *classified patient*.

This scheme is in direct contrast to the system in place in the ACT.

Victoria

Victoria's *Corrections Act 1986* allows for transfers to mental health services that are approved under the *Mental Health Act 1986*, and stipulates that custody is transferred to persons specified under the Act, or to the authorised psychiatrist of the service. When treatment is no longer required, provisions exist to return responsibility to decision makers under the Corrections Act. The Commission understands that, while provisions exist for transfer of responsibility in relation to a detainee who goes to a non-secure facility, this does not occur in practice – transfer to a secure facility is arranged.

This scheme is in direct contrast to the system in place in the ACT, noting the altered dynamic of having available secure mental health facilities, which allows those facilities to be utilised as the favoured option.

Northern Territory

The Northern Territory's *Mental Health and Related Services Act* allows for both voluntary and involuntary transfer from a custodial facility to an approved treatment facility. The detainee is taken to be in lawful custody during this time, under either scenario.

Both the *Prisons (Correctional Services) Act* and the Mental Health and Related Services Act oblige the officer in charge of a prison to make arrangements with the person in charge of the hospital to ensure the security and good order of the detainee while they are in the hospital. However, both Acts appear silent on any explicit transfer of authority except in relation to a handover of authority when a health treatment facility or agency is interstate.

This scheme appears to be similar to the system in place in the ACT, although it appears that there may be more scope for the involvement of the person in charge of the hospital in ensuring security and good order. The Commission is not aware of whether or not this occurs in practice.

New South Wales

The *Crimes (Administration of Sentences) Act 1999* allows for transfer to hospital, and indicates that the relevant Commissioner within Corrections "may direct a correctional officer to take charge of the inmate". Both that Act and the *Mental Health Act 2007* are silent on any transfer of authority. This scheme appears to be largely consistent with the system in place in the ACT, although the use of the word 'may' appears to indicate there may be a greater level of discretion regarding ongoing custody by Corrective Services. Again, the Commission is unaware of whether or not this occurs in practice.

South Australia

The *Correctional Services Act 1992* indicates that the Chief Executive has the custody of a detainee regardless of where they are held. The Chief Executive may grant a leave of absence for mental health or other treatment, subject to any conditions the Chief Executive thinks appropriate, including that the detainee be in the custody and supervision of correctional officers. The *Mental*

Health Act 2009 is silent on corrections-specific issues and the receipt of patients under a leave of absence from a correctional facility. This scheme is consistent with the system in place in the ACT.

Western Australia

The *Prisons Act 1981* allows for a permit of absence, and stipulates that a detainee is deemed to be in the custody of the Chief Executive Officer for as long as they continue to be a detainee, while subject to such a permit. The *Mental Health Act 1996* is silent in relation to relevant or related provisions. In practice, inpatient mental health treatment only occurs through transfer to the State's secure mental health facility, where the practical effect of a permit is that custodial authorities cease to have a role or presence until the permit ceases. This scheme is in direct contrast to the system in place in the ACT, noting the altered dynamic of having an available secure unit.

Tasmania

The *Corrections Act 1997* allows the Director responsible for Corrections to direct a detainee to be removed from a prison to a hospital or an institution, other than a secure mental health unit. Custody remains with the Director in such circumstances. Transfer to a secure mental health unit can occur if the Director and Chief Forensic Psychiatrist agree that this should occur, and custody ceases to be held by the Director while the detainee is within the secure unit. This scheme is in contrast to the situation in the ACT, in that the availability of a secure mental health unit allows the transfer of custody and decision making to mental health authorities.

Conclusion

If a secure forensic mental health facility were currently available in the ACT, the issue of transfer of custody from Corrective Services to Mental Health Services would in all likelihood be indisputable. Whether or not such an approach should be deferred until a forensic mental health facility is available, is a more difficult question. A further complication is that the planned secure mental health facility will not treat all detainees from the AMC. The Commissioner understands that, under the proposed model of care for the new facility, some detainees will continue to be treated in the Adult Mental Health Unit after it is built.

The brief analysis above indicates that transfer of custody from correctional authorities to mental health authorities is available in other jurisdictions, and in some circumstances, regardless of the availability of secure forensic mental health facilities.

It would be a regrettable outcome from this investigation if the threshold for transfer of a detainee to an appropriate mental health facility were to be raised because of any criticisms in this report. While the Commissioner accepts the current General Manager's view that this would not happen, it remains a potential concern for the future if the issues are not resolved. Similarly, it would be a regrettable outcome if mental health staff were to conclude that they could not ethically accept patients from the AMC if they were to be subject to continuous restraint. Access to a properly therapeutic inpatient mental health environment, which simply cannot be (and is not) provided in

the AMC, is an important aspect of ensuring equivalence in health care provision, and of promoting mental health recovery outcomes.

As noted earlier, Mental Health ACT already deals with people who are detained and referred by the Magistrates Court for assessment, and potentially inpatient treatment, pursuant to s 309 of the Crimes Act. Mental Health staff pointed out that they have successfully assessed, treated and maintained the custody of people under s 309 with serious charges, including murder, who present significant risk to themselves and/or others, without resorting to mechanical restraint or the presence of police or corrections officers.

Mental Health maintains that it has the capacity and experience to deal with the majority of situations where a detainee requires inpatient mental health treatment. In circumstances where they consider that a person requires treatment in a more secure facility than is currently available, they would recommend interstate inpatient treatment in a secure forensic mental health facility.

On balance, the Commissioner considers that ACT legislation requires amendment to enable the transfer of custody to Mental Health authorities when a detainee in the AMC requires inpatient mental health treatment. Such an amendment should not, in the Commissioner's view, be dependent upon the existence of a secure mental health facility. The current review of the Mental Health Act provides an opportunity for introducing further amendments and providing a legislative response to this issue.

The Commissioner is aware that a proposed Mental Health Bill is in the final stages of drafting, following years of rigorous consultation, and is soon to be presented to the Legislative Assembly. In the Commissioner's view it would be regrettable if an amendment could not be made to the Bill as a matter of urgency, rather than delaying any amendment until further legislation is prepared to accompany the commissioning of the secure mental health facility. The construction of the secure facility is likely to be some years away and such a delay would be unwarranted.

Implementing such legislative amendments does not preclude Corrective Services from maintaining a significant and appropriate level of input into decisions regarding security and management of custody. It is entirely appropriate that Corrective Services advise Mental Health of concerns around maintenance of security and what threats particular detainees may present. Decisions relating to the treatment and management of patients in a mental health facility should, however, ultimately be made by clinicians in the best interests of treating mental health conditions. Such decisions should be informed by advice from Corrective Services, rather than Corrective Services making decisions, informed by advice from clinicians. This does not preclude Mental Health from deciding to put a substantial range of security measures around a detainee who is admitted for inpatient treatment, based on Corrective Services' assessment of risk.

Recommendation 6:

> *That the Corrections Management Act and/or the Mental Health Act be amended, as part of the imminent Mental Health Bill, to enable the transfer of custody from Corrective Services ACT to Mental Health ACT when a detainee is transferred from the AMC to an inpatient*

mental health facility. This recommendation is made regardless of the availability of a secure forensic mental health facility in the ACT, and should not be delayed pending the construction of such a facility.

This recommendation expands on Recommendation 1. In the Commissioner's view, amendments to clarify the interaction between the two pieces of legislation should be drafted to enable the transfer of custody from Corrective Services to Mental Health ACT.

OTHER ISSUES

Record keeping

The Commissioner notes with concern a number of indications that the detainee's offence history, and also the details of the self harm incident, were inaccurately portrayed, inaccurately understood and/or inaccurately documented in various records. The potential that inaccurate information will subsequently be relied upon as fact, for risk assessment and decision making purposes, is high.

For example, the records relating to a subsequent hospital assessment in September 2012 includes a statement by a hospital Registrar that purports to be informed by 'police'. It is more likely that this is an erroneous reference to information provided by escorting Corrective Services officers. It is not possible to describe this statement without specific reference to the detainee's offence but it directly refers to apparent advice from the source, which indicates that the detainee was a serial offender in relation to the charge for which he was found guilty. There is no evidence that this is the case. The nature of this statement is highly prejudicial and likely to influence future risk assessments and decisions based on such assessments, if referred to over the passage of time.

It is acknowledged that information about risk should not necessarily be withheld merely because it has not been confirmed as factual, and that the relaying of concerns to proper authorities is appropriate so that the veracity of information can be tested. The Commissioner does not, however, consider that the scenario described above reflected reasonable and considered mitigation of risk. If the information was in fact communicated in the way that it was documented, it was more akin to gossip than the appropriate exchange of information.

Recommendation 7

That the Health Directorate take steps, consistent with Principle 7(4) of the Health Records (Privacy and Access) Act 1994*, to restrict access to the misleading record of September 2012.*

Recommendation 8

That Corrective Services take steps to reinforce with staff:

- *the need to refrain from relaying anecdotal information to health services on escort,*

- *to ensure that any information relayed is factual, and*
- *that information that is relayed, is limited to information that is relevant and necessary.*

Restraint in health services generally

While, in this matter, the Commissioner has taken the view that the decision to restrain the detainee appeared to be reasonable during transport to hospital and in the Emergency Department, this should not be read as a general endorsement of mechanically restraining a person when being transported or in the Emergency Department, or indeed in other areas of the health system. An allegation that a person was mechanically restrained in the Emergency Department is the subject of a current complaint to the Commissioner, which will be considered in the context of the rationale outlined in this report – whether an individual risk assessment was undertaken and whether the mechanical restraint was a last resort in the relevant circumstances.

PUBLIC ADVOCATE

Section 11 of the *Public Advocate Act 2005* provides for the Public Advocate to investigate complaints and allegations about matters in relation to which the Public Advocate has a function. While the Public Advocate did not conduct an investigation into this matter, she raised concerns about the management of the case with the Health Directorate in a meeting on 24 October 2012. A recommendation from that meeting was that Mental Health ACT needed to develop clearer guidelines as to restraint and seclusion practices for all consumers in AMHU, including forensic patients.

While those guidelines have been developed, the issue remains that Corrective Services has the authority to direct that a forensic patient be restrained regardless of Mental Health's own guidelines. The issue is clearly one of greater systemic concern, which could not be resolved by policy changes in one Directorate alone.

Section 11(2) of the Public Advocate Act requires that the Public Advocate must refer systemic matters relating to people with a disability, which includes mental health conditions, to the Commission for consideration. No referral to the Commission was made on this occasion. Indeed, the Commissioner only became aware of the matter when the article in the *Canberra Times* was drawn to her attention.

Since this matter came to light, the Public Advocate and the Commission have signed a Memorandum of Understanding relating to when matters will be referred between them. This will enable an appropriate exchange of information between the two offices, recognizing the different and distinct roles that each play in servicing the community.

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LEGISLATIVE INCOMPATIBILITY

There is a question whether the Mental Health Act and the protections contained in that Act, apply at all to detainees under the Corrections Management Act.

While it is without doubt that a detainee continues to be in the custody of Corrective Services, even when they are not physically held in the AMC, the drafting of the current Mental Health Act is not clearly set up to acknowledge the potential for concurrent detention under both the Corrections and Mental Health legislation. A number of ambiguities arise that pose actual and potential difficulties in interpretation and decision making under the Acts.

The Mental Health Act's emergency provisions generally presuppose that a person who may need to be apprehended for involuntary treatment is either free in the community, or attends a health facility voluntarily. While the detainee may be said to have attended voluntarily in this case, in that he did not object to leaving the AMC in an ambulance, his attendance at the hospital would have occurred whether he agreed with this or not.

There is no direct trigger for Mental Health Act assessment, and therefore involuntary detention and care, where a person is transferred to a health facility under the Corrections Management Act against their will. There may, therefore, be no way in which the emergency detention provisions of s 41 could begin to apply to such a detainee. The protections in the Mental Health Act that provide for ACAT oversight of emergency detention and treatment, and reporting to the Public Advocate, may therefore not also apply.

Even if, prior to a transfer being made, a doctor at the correctional centre held a reasonable belief that emergency apprehension under the Mental Health Act was warranted (which did not occur in this case) and the Director-General ordered a transfer under s 54 of the Corrections Management Act, the provisions for review of the doctor's decision by the ACT Civil and Administrative Tribunal (ACAT) do not appear to sit comfortably with the Director-General's ongoing exercise of power under the Corrections Management Act.

The roles of custodians

There is clear potential for the powers and duties under the Corrections Management Act in relation to a detainee to be exercised inconsistently with the powers and duties of the person in charge of a health facility in relation to a person detained under the Mental Health Act.

For example, the Director-General could give a direction that the detainee is to be escorted by two or more corrections officers for the entire duration of their stay at a mental health facility, whereas the person in charge of the mental health facility may consider that this is beyond the minimum necessary to prevent any immediate and substantial risk of the person detained causing harm to himself or herself or to another person. Similarly, a Corrective Services officer may hold a reasonable belief that use of force (including restraint) is necessary for the purpose of containing the person but the person in charge of the mental health facility may consider that this goes beyond the minimum

necessary for the safety of the person and others. Use of force as a last resort, as required in the Corrections Management Act, may at times be consistent with the duty under the Mental Health Act. Sometimes the use of force might equate to what is the minimum necessary to prevent immediate and substantial risk, but this may not always be the case.

Other potentially inconsistent provisions

The provisions in the Mental Health Act relating to release from involuntary detention also do not sit comfortably with circumstances in which a person is already detained under the Corrections Management Act. For example, under the Mental Health Act, a person may be released before a period of detention expires if the doctor who examined the person, or the Chief Psychiatrist, or ACAT is satisfied that the detention of the person is no longer justified. However, under the Corrections Management Act, 'early' removal may also be ordered by Corrective Services without the agreement of anyone else. It is noted that Corrective Services does not utilise this provision in practice.

Similarly, the provision in Part 4 of the Mental Health Act for mental health orders by ACAT does not envisage persons in detention and does not sit well with the powers of Corrective Services under the Corrections Management Act. For example, ACAT can direct the person to attend the facility and, if necessary, stay there; ACAT can specify the mental health facility in which an assessment is to be conducted, before making a mental health order; ACAT must consult various people, including for example a guardian under the *Guardianship and Management of Property Act 1991*, but the Director-General under the Corrections Management Act is not mentioned; and the matters which ACAT must take into account in making a mental health order include that the person's rights should not be interfered with except to the least extent necessary.

Provision for persons already detained – s 309 of the Crimes Act

The regime for detention of persons transferred from the AMC is in contrast to transfer by order of a court under s 309 of the Crimes Act. That Act provides for a seamless handover of custody of a person who is already detained in the court system, to mental health authorities. The Mental Health Act acknowledges that a person to whom s 309 applies, does not need to be first apprehended under the Mental Health Act. Instead it provides for examination under detention, and then involuntary detention for care if necessary. Similarly, a clear process allows transfer back to relevant authorities, in this case the police, following treatment. No confusion arises regarding treatment and custody decisions because there is no concurrent detention by mental health authorities and police.

Concurrent application of the Acts?

Sections 54 and 140 of the Corrections Management Act make some provision for medical treatment of detainees, including involuntary treatment and restraint. There is, therefore, no absolute necessity for the Mental Health Act to apply to detainees to ensure that involuntary treatment can be administered if appropriate. However, the fact that the Corrections Management Act authorises involuntary medical treatment of a detainee, does not necessarily imply that the Mental Health Act regime was not intended to also apply to a detainee. Similarly, the provisions in the Corrections

Management Act were not envisaged to provide for inpatient mental health treatment and care. The general health provisions under the Corrections Management Act are not as comprehensive as the Mental Health Act, and do not provide the same level of protection provided by the Mental Health Act for people with mental health issues.

On the face of it, the Mental Health Act applies to detainees, and in the current circumstances the parties acted in accordance with such a presumption. The detainee was involuntarily detained under the Mental Health Act for the majority of his time in the AMHU, albeit that the power for such a detention is ambiguous.

As discussed above, the Corrections Management Act and the Mental Health Act are incompatible in a range of ways. The courts, however, are generally slow to find that legislative provisions made by the same legislature are inconsistent, and will strive to allow sections to operate concurrently where possible. There is a reasonable argument that the Corrections Management Act and the Mental Health Act can be read together so that the Mental Health Act applies to detainees.

- First, there is nothing express in the Corrections Management Act or the Mental Act which would preclude application of the Mental Health Act to a Corrections Management Act detainee.

- Secondly, the triggers for treatment under the Mental Health Act could probably be interpreted somewhat flexibly to allow for their application to detainees (as appears to have been done in this case).

- Thirdly, the roles of the Director-General/escort officer and the Chief Psychiatrist could generally be exercised compatibly, just as the roles of the Director-General and a health practitioner appointed under the Corrections Management Act are clearly intended to be exercised compatibly.

Ultimately, however, in order to read the provisions together, either the powers of the Director-General and escort officers must be subject to the oversight of the person in charge of the health facility, or the oversight of the person in charge of the health facility must not extend to the exercise of powers by the Director-General and escort officers. On balance, it appears that s 44 of the Mental Health Act would be read as subject to the relevant powers of Corrective Services under the Corrections Management Act. If Corrective Services officers are given powers which, on their face, can be exercised in a health facility, it does not appear that s 44 was intended to override them. This conclusion is consistent with the principle that a later Act overrides an earlier Act to the extent of any inconsistency: the Corrections Management Act is the later Act.

Conclusion

In summary, it is not absolutely certain that a person can be detained for involuntary treatment under the Mental Health Act if they are already a detainee under the Corrections Management Act. One interpretation of the legislation is that Mental Health authorities have no power to detain a person under the Mental Health Act, as the Act only envisages apprehension and detention in

circumstances where a person is free in the community, or if they are transferred to a mental health facility pursuant to an order under s 309 of the Crimes Act. On this interpretation the protective provisions in the Mental Health Act that apply to emergency detention and restraint would not apply to persons detained under the Corrections Management Act.

If the two Acts can be read together and concurrent detention can occur, the protections in the Mental Health Act e.g. reporting and oversight obligations, would apply to detainees. It seems on such a reading, however, that the obligation on the Chief Psychiatrist to ensure that any custody, confinement, restraint or treatment is the minimum necessary, is overridden by Corrective Services' authority to direct that a person be restrained pursuant to powers under the Corrections Management Act.

This interpretation of the legislation leads to a situation where, as occurred in this case, the views of mental health experts around the counter-therapeutic impacts of mechanical restraint of a mentally unwell person, are overridden by the authority of Corrective Services officers under the Corrections Management Act.

The question of the interaction between the Corrections Management Act and the Mental Health Act gives rise to considerable uncertainty. It would seem desirable to give consideration to amending either or both of the Acts to clarify their interaction.