ACT Government

# Discussion paper *Mental Health Act 2015* review

August 2026

## Acknowledgement of Country

The Health and Community Services Directorate acknowledges the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region.

We respect the Aboriginal and Torres Strait Islander people, particularly our Aboriginal and Torres Strait Islander staff, and their continuing culture and contribution they make to the Canberra region and the life of our city.

We acknowledge their enduring connection to Country, culture and Community, and the importance of self-determination in shaping health, and social and emotional wellbeing outcomes.

## Recognition of lived and living experience

The Health and Community Services Directorate recognises the contribution of individuals with lived and living experience to the work that we do together and the impacts of living with mental illness, suicidality, stigma and discrimination. We value their acquired expertise, both lived and learned, from these experiences.

We also recognise that that lived and living experience for Aboriginal and Torres Strait Islander peoples is culturally distinct and inseparable from connection to Country, kinship, Community and experiences of systemic inequity.



Produced by the Health and Community Services. Enquiries about this publication should be directed to the Health and Community Services.

GPO Box 158, Canberra City 2601
**act.gov.au**
Telephone: Access Canberra – 13 22 81

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## Content advisory

This document contains information that references mental health, mental illness, suicide, and family and domestic violence which some readers may find distressing.

If you are experiencing distress and need help, please contact one of the support services listed below.

Lifeline 13 11 14

Suicide Call Back Service 1300 659 467

Access Mental Health 1800 629 354

Beyond Blue 1300 22 4636

1800 RESPECT 1800 737 732

Kids Helpline 1800 551 800

13 Yarn 13 92 76

QLife 1800 184 527

MensLine Australia 1300 789 978

National Alcohol and Other Drug Hotline 1800 250 015

# Contents

# Background

## About the review

Section 271A of the *Mental Health Act 2015* requires certain sections of the Mental Health Act to be reviewed. This review involves asking members of the public about these sections to understand if they are working as intended.

The Minister for Mental Health must present a report on mental health orders and forensic mental health orders to the Legislative Assembly within two years after review starts. The Director-General must give a report on the other sections in the review to the Minister for Mental Health within two years after the review starts.

The Health and Community Services Directorate and the Justice and Community Safety Directorate are working together on the review as both directorates administer the sections in the review.

This public consultation discussion paper contains 15 sections which are part of the mandatory review and seven additional areas related to the Mental Health Act. There will also be one other issue that will be reviewed through targeted consultation with stakeholders due to the technical or specific nature of the issue.

Your feedback will help determine if any changes should be made to the sections to improve them. The additional areas have been included for consultation to consider whether part of the Mental Health Act should be updated to meet national or local commitments, or for best practice.

## *Mental Health Act 2015*

The Mental Health Act is the law that says when a person can be assessed, treated, cared for and supported if they have a mental illness or mental disorder. It is commonly used when a person cannot make their own decisions about treatment or if they do not want it, but still need treatment, care, or support.

The Mental Health Act came into effect in 2016 and replaced the *Mental Health (Treatment and Care) Act 1994*. The Mental Health Act is reviewed regularly to keep it up to date.

## Chief Psychiatrist Report

Following an incident at the Australian National University in 2023, the previous Chief Psychiatrist undertook a review. A report from this review was published in January 2024 (known as the Chief Psychiatrist Report). The ACT Government response to the report's recommendations was tabled in the Legislative Assembly in August 2024.

The Health and Community Services Directorate, the Justice and Community Safety Directorate and Canberra Health Services are working together to implement the recommendations from the report. Some of the sections included in the review of the Mental Health Act are also being considered as part of the implementation of recommendations from the Chief Psychiatrist Report.

# Feedback and comments

Please send your feedback or comments on this discussion paper to **mhactreview@act.gov.au**

Submissions must be received by close of business on **Friday 23 October 2026**.

Your feedback, comments or submissions on the discussion paper may be published unless you tell us that it is confidential. All requests for the content of submission to be treated as confidential will be respected and dealt with in accordance with relevant laws, including freedom of information legislation.

## How to use this discussion paper

This paper outlines the key issues that are part of the Mental Health Act review.

You are welcome to provide your feedback and comments on the questions included throughout the discussion paper or any other feedback you have on the Mental Health Act.

There is no requirement to respond to all questions in this discussion paper. You can provide a response to only the issues or questions you want to.

Alternatively, you are welcome to complete the survey questions instead of the questions in this discussion paper. The survey questions are available on the YourSay website.

Your feedback and comments will be used to help develop a final report from the review.

# Glossary

Table 1 below outlines terms used in the discussion paper. Some of these definitions are taken from the ACT Government 'important terms used in the Mental Health Act' webpage.

*Table 1: terms used in the discussion paper*

| Term | Meaning |
|---|---|
| Affected person | An affected person is someone who has suffered harm because of a crime committed, or alleged to have been committed, by a person on, or who could be on, a forensic mental health order. An affected person may require support or protection and may be entitled to assistance as a victim of crime under the *Victims of Crime Act 1994*. |
| Apprehension | Apprehension is the legal holding and transportation of a person to an approved mental health facility by a police officer, authorised ambulance officer, doctor, or mental health officer if certain criteria are met. |
| Assessment order | An assessment order is an order that enables the psychiatric or psychological assessment of the person with the possible mental illness or mental disorder. |
| Carer | A carer is a person who provides care, support, or assistance to you. The *Carers Recognition Act 2021* recognises the role of unpaid carers. |
| Community-based sentence assessed under an assessment order | A community-based sentence is a sentence imposed by a court which allows the convicted person to serve their sentence outside of prison, under supervision and with specific conditions designed to rehabilitate the offender and benefit the community. |
| Decision-making capacity | Decision-making capacity is when you can make decisions for yourself about treatment, care, or support, for your mental illness or mental disorder, with help if needed. |
| Guardian | Guardians are given the power to make decisions on your behalf if you are unable to make decisions for yourself. |
| Mental illness | A mental illness is a condition that seriously impairs mental functioning of a person, either temporarily or permanently, in one or more areas of thought, mood, volition, perception, orientation or memory. The most common mental illnesses under the Mental Health Act are severe depression, bipolar disorder and schizophrenia. |
| Mental disorder | A mental disorder is a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion but does not include a condition that is a mental illness. Common |

| Term | Meaning |
|---|---|
| | causes include dementia, intellectual disability, acquired brain injury or other degenerative neurological conditions. |
| Nominated person | A nominated person is someone you can choose to ensure your rights and interests are respected if you need mental health treatment, care, or support. |
| Nominated term | A nominated term is a period of time which the Supreme Court or Magistrates Court would have imposed in a sentence of imprisonment, had normal criminal proceedings against a person occurred. |
| Release on licence | Chapter 13 of the *Crimes (Sentence Administration) Act 2005* provides for a person who was convicted of a criminal offence who is serving a sentence of life imprisonment and has served at least 10 years of that sentence to be released on licence. Release on licence is also usually subject to certain conditions. |
| Release on parole | The *Crimes (Sentencing) Act 2005* authorises a court to set a non-parole period when imposing a sentence of imprisonment. At the end of the non-parole period, the person may be released 'on parole'. Following release on parole, the person can return to the community. Release on parole is usually subject to certain conditions. |
| Required to accept supervision under bail | A person who has been charged with a criminal offence in the ACT may be released from custody subject to conditions under the *Bail Act 1992* (Bail Act). The Bail Act enables the decision maker to require a person released on bail to accept supervision, including a direction to comply with a mental health assessment of treatment order made by the ACT Civil and Administrative Tribunal (ACAT). |
| Treatment, care or support | Treatment, care or support are services provided by health professionals to promote recovery, remedy a mental disorder or mental illness, or lessen the effects or the pain or suffering it causes. This may include giving medication, counselling, training, therapeutic programs, care, or support. |
| Unfit to plead or not guilty due to mental impairment | Under the Part 13 of *Crimes Act 1900 (ACT)* (Crimes Act) and Part IB of the *Crimes Act 1914 (Cth)* (Commonwealth Crimes Act), the court may determine a person charged with a criminal offence is either unfit to plead to a charge or is not guilty due to mental impairment. In these circumstances, the court may make an order requiring the ACAT to consider whether to make a Conditional Release Order under section 180 of the Mental Health Act. |
| Young detainees and young offenders | A young detainee is defined in section 95 of the *Children and Young People Act 2008* as a child or young person who is in custody following arrest, remanded in custody, or in detention. A young detainee also includes a person who is at least 18 years old but under 21 years old in certain circumstances. |

# Mandatory review of sections in the *Mental Health Act 2015*

## About the review of these sections

The Health and Community Services Directorate and Justice and Community Safety Directorate are inviting feedback on 15 sections of the Mental Health Act as part of the public consultation process. These 15 sections must be reviewed through a public consultation process.

The directorates are seeking your feedback on these areas to understand whether they are operating as they are meant to. Your feedback will help determine if changes should be made to these sections to improve how they work. These sections cannot be removed from the Mental Health Act. They are an important part of how people with mental illness and mental disorder receive treatment, care or support for the safety of themselves, other people or the community.

### Human rights considerations

The Mental Health Act, and the provisions under review, engage a number of human rights under the *Human Rights Act 2004*, including the right to recognition and equality before the law, the right to privacy and reputation, the right to liberty and security of person and the right not to be subject to medical treatment without consent. Human rights may be limited where necessary to achieve an important purpose such as the safety of an individual or the public, but any limitations must be reasonable and demonstrably justifiable in a free and democratic society. It will be important for human rights impacts to be carefully considered in deciding what changes might be needed following the review.

## Mental Health Orders

### Psychiatric treatment order (section 58)

Psychiatric treatment orders (also known as PTOs) are a type of mental health order. PTOs are made by the ACT Civil and Administrative Tribunal (ACAT). PTOs authorise the involuntary treatment, care or support of a person with a mental illness.

PTOs include information about the person's treatment, including where and when the treatment is to be provided, the types of treatment provided, and who will provide the treatment.

A PTO may be made for any period up to six months. A PTO can only be made if a person has a mental illness, not a mental disorder.

Section 58 of the Mental Health Act outlines who PTOs may apply to. It also specifies the criteria to be met before the order can be made.

PTOs under section 58 of the Mental Health Act apply to a person who:

- has undergone a psychiatric or psychological assessment under an assessment order
- an application for a mental health order has been made
- an application for a forensic mental health order has been made (this includes people released on parole, people released on a licence, young detainees or offenders, and people released on bail); or

- is required by a court to submit to the jurisdiction of the ACAT because they are unfit to plead or not guilty due to mental impairment for a criminal offence.

The ACAT may make a PTO if a person has a mental illness and either:

- the person does not have decision-making capacity to consent to the treatment, care or support and refuses to receive treatment, care or support; or
- the person has decision-making capacity to consent to the treatment, care or support but does not consent to treatment.

The ACAT may only make a PTO if the following are also met:

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

If an application for a forensic mental health order (explained further on page 9) has been made in relation to the person, ACAT has the power to make a PTO instead.

## Question

1. Do you have any feedback based on your experience or knowledge of psychiatric treatment orders? What do you think is working or not working?

### Community care orders (section 66)

A community care order (also known as a CCO) is a type of mental health order. CCOs authorise the involuntary treatment, care or support of someone with mental disorder, rather than a mental illness.

CCOs under section 66 of the Mental Health Act apply to a person who:

- has undergone a psychiatric or psychological assessment under an assessment order
- an application for a mental health order has been made
- an application for a forensic mental health order has been made (this includes people released on parole, people released on a licence, young detainees or offenders, and people released on bail); or
- is required by a court to submit to the jurisdiction of the ACAT because they are unfit to plead or have been found not guilty due to mental impairment for a criminal offence.

The ACAT may make a CCO if a person has a mental disorder and either:

- the person does not have decision-making capacity to consent to the treatment, care or support and refuses to receive treatment, care or support; or
- the person has decision-making capacity to consent to the treatment, care or support but does not consent to treatment.

The ACAT may only make a CCO if the following are also met:

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

A CCO may be made for any period up to six months.

If an application for a forensic mental health order has been made in relation to the person, section 66 gives ACAT the power to make a CCO instead.

The key differences between PTOs and CCOs are that PTOs apply to people with a mental illness and CCOs apply to people with a mental disorder.

## Question

2. Do you have any feedback based on your experience or knowledge of community care orders? What do you think is working or not working?

### What ACAT must take into account – mental health order (section 56)

Section 56 of the Mental Health Act outlines what the ACAT must consider when making a mental health order. Mental health orders include psychiatric treatment orders, community care orders and restriction orders.

When making a mental health order ACAT must consider the following:

- the plan for the proposed treatment, care or support
- whether the person consents, refuses to consent or has the decision-making capacity to consent
- any statement by a registered affected person (if applicable)
- that any restrictions placed on the person are the minimum necessary for the safe and effective care
- any alternative treatment, care and support available
- any relevant medical history

- details of the alleged offence and risk to safety only if a person is required by a court to submit to the jurisdiction of the ACAT because they are unfit to plead or not guilty due to mental impairment for a criminal offence.

The ACAT must also consider the views of the following people:

- the person who the ACAT is considering making an order for
- people who provide the person with day-to-day care
- people appearing at the proceeding
- people who ACAT must consult under section 54 of the Mental Health Act, such as a guardian, attorney, nominated person, each person with parental responsibility, or the Director-General of the Justice and Community Safety Directorate.

## Question

3. Based on your knowledge or experience, do you have any feedback on what the ACAT should consider in a mental health order? What do you think is working or not working?

### Contravention of mental health order (section 77)

A person who refuses the treatment, carer or support in their mental health order has contravened the order.

Section 77 of the Mental Health Act relates to circumstances where a person does not comply with the requirements of their order. It does not relate to a person leaving the facility without approval (this is outlined in section 78).

Following the identification of non-compliance, the person must be given an opportunity to engage in treatment care or support prior to a contravention occurring.

A relevant official or a mental health officer must take all reasonable steps to tell a person that failure to comply with an order may result in them being apprehended and taken to an approved facility.

The relevant official may be the Chief Psychiatrist, the Care Coordinator or their delegate.

A mental health officer can be a nurse, nurse practitioner, psychologist, occupational therapist or social worker appointed by the Chief Psychiatrist.

A delegate for the Chief Psychiatrist could be a psychiatrist at the hospital, and the delegate of the Care Coordinator could be anyone with the training, experience and personal qualities necessary to exercise the functions of the role.

This process must be done within seven days of the contravention.

If the contravention continues, the relevant official or mental health officer may require the person to be detained at a facility to ensure compliance with a mental health order. If this is required, a police officer, authorised ambulance paramedic, mental health officer or doctor may apprehend the person and take the person to an approved facility.

The relevant officer or a mental health officer must notify the ACAT and the Public Advocate within 24 hours if the person has been detained in relation to a contravention.

A person can comply with their order (and avoid being taken to a mental health facility), if they consent to receiving treatment at a place which a relevant official or mental health officer believes is suitable for treatment. This may be a place such as the person's home, as long as it is appropriate and suitable.

## Question

4. Do you have any feedback based on your experience or knowledge about contravention of mental health orders? What do you think is working or not working?

## Forensic Mental Health Orders

### Forensic psychiatric treatment order (section 101)

Forensic psychiatric treatment orders (also known as a FPTOs) are a type of forensic mental health order. A FPTO may be made by ACAT where a person with a mental illness is involved with the criminal justice system.

Under section 117, a FPTO may only be made for a maximum of three months. Sometimes a FPTO can be made for up to one year, if consecutive forensic mental health orders have been in force in for a person for one year or more.

The ACAT may make a FPTO where the person with a mental illness is either:

- a detainee or a person serving a community-based sentence assessed under an assessment order
- a person referred to the ACAT for a forensic mental health order (this includes people released on parole, people released on a licence, young detainees and young offenders, and people released on bail); or
- a person required by a court to submit to the jurisdiction of the ACAT because they are unfit to plead or not guilty due to mental impairment for a criminal offence.

The ACAT may make a FPTO for a person if the person has a mental illness. The ACAT is not required to consider the person's decision-making capacity when making a FPTO.

The ACAT may only make a FPTO for a person if the following are also met:

- the ACAT believes on reasonable grounds that, because of the mental illness, the person is doing, or is likely to do, serious harm to themself or someone else, or is suffering, or is likely to suffer, serious mental or physical deterioration
- the ACAT believes on reasonable grounds that, because of the mental illness, the person has seriously endangered, is seriously endangering, or is likely to seriously endanger, public safety
- the ACAT is satisfied that psychiatric treatment, care or support is likely to reduce the harm, deterioration or endangerment, or the likelihood of harm, deterioration or endangerment, or result in an improvement in the person's psychiatric condition
- the ACAT is satisfied that, in the circumstances, a mental health order (such as a PTO) should not be made; and
- the ACAT is satisfied that the treatment, care or support to be provided under the forensic psychiatric treatment order cannot be adequately provided in another way

that would involve less restriction of the freedom of choice and movement of the person.

The key differences between a PTO and a FPTO are:

- A person's decision-making capacity is not part of the criteria for making a FPTO.
- The ACAT must be satisfied that the person presents a risk of serious endangerment to the community to be placed on a FPTO.

The ACAT has an additional important and active role in decisions about the person's care and support arrangements under a FPTO. This includes decisions about whether a person will be detained or released from a mental health facility. It also includes whether a person will be given leave from a mental health facility.

A person who was harmed by the person on a FPTO is entitled to certain information about the order. The person receiving the information is known as the 'affected person' (see section below about the affected persons register for more information).[1]

## Question

5. Do you have any feedback based on your experience or knowledge about forensic psychiatric treatment orders? What do you think is working or not working?

### Content of forensic psychiatric treatment order (section 102)

Section 102 outlines what might be included in a forensic psychiatric treatment order (FPTO). The FPTO must state that the person needs to comply with any determination made by the Chief Psychiatrist about their care, such as whether the person needs to be admitted to an approved mental health facility. The FPTO must also be accompanied by a statement about how the person meets the criteria for a FPTO.

A FPTO may include:

- the facility that the person is to be admitted to
- what a person must do such as undergoing as psychiatrist treatment and/or undertake a counselling, training, therapeutic or rehabilitation program
- whether the Chief Psychiatrist can place temporary restrictions on the person's communication with other people
- where the person must live or state if they are detained in an approved facility; and
- any people or places that the person must not approach or any activities that the person must not undertake.

A FPTO cannot state that a person must undergo electroconvulsive therapy or psychiatric surgery as part of their requirement to undergo psychiatric treatment, care or support. Electroconvulsive therapy, which is a therapeutic medical procedure used for the treatment

[1] ACT Government, Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS) *Plain Language Guide for the Mental Health Act (Australian Capital Territory)*, February 2016 <https://actmhcn.org.au/wp-content/uploads/2023/02/Handout-02-Plain-Language-Guide_MH-ACT.pdf>.

of severe psychiatric disorders, can only be ordered by way of an electroconvulsive therapy order or emergency electroconvulsive therapy order.

## Question

6. Do you have any feedback based on your experience or knowledge about the content of forensic psychiatric treatment orders? What do you think is working or not working?

### Forensic community care order (section 108)

A forensic community care order (FCCO) can only be made by ACAT in relation to a person with a mental disorder who is involved with the criminal justice system.[2] FCCOs only apply to people who are:

- a detainee or person serving a community-based sentence assessed under an assessment order
- a person referred to the ACAT for a forensic mental health order; or
- a person required by a court to submit to the jurisdiction of the ACAT because they are unfit to plead or not guilty due to mental impairment for a criminal offence).

The ACAT may make a FCCO for a person who has a mental disorder. The ACAT is not required to consider the person's decision-making capacity. The ACAT must be satisfied that the person could place the community at serious risk to be placed on a forensic mental health order.

The ACAT may make a FCCO for a person if they meet the following requirements:

- there are reasonable grounds for ACAT to believe that because of the mental disorder, the person is doing, or is likely to do, serious harm to themselves or someone else, or that they are suffering, or likely to suffer, serious mental or physical deterioration
- there are reasonable grounds for ACAT to believe that because of the mental disorder, the person has seriously endangered, is or is likely to seriously endanger, public safety
- the ACAT is satisfied that:
    - treatment, care or support is likely to reduce the harm, deterioration or endangerment
    - in the circumstances, a forensic psychiatric treatment order should not be made
    - in the circumstances, a mental health order should not be made, and the treatment, care or support to be provided under the forensic community care order cannot be adequately provided in another way that would involve less restriction of the freedom of choice and movement of the person.

[2] ACT Government, Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS) *Plain Language Guide for the Mental Health Act (Australian Capital Territory*, February 2016 <https://actmhcn.org.au/wp-content/uploads/2023/02/Handout-02-Plain-Language-Guide_MH-ACT.pdf>.

## Question

7. Do you have any feedback based on your experience or knowledge of forensic community care orders? What do you think is working or not working?

# Apprehension

## Apprehension (section 80)

Section 80 outlines the criteria for when a police officer or an authorised ambulance paramedic may apprehend a person. This section also outlines the criteria for when a mental health officer or doctor may apprehend a person. It allows for a person to be taken to an approved mental health or community care facility in emergency situations.

A police officer or an authorised ambulance paramedic may apprehend a person with a mental disorder or mental illness if they believe on reasonable grounds that:

- the person has a mental disorder or mental illness
- the person has attempted or is likely to attempt suicide or inflict serious harm on themselves or another person; and
- the person requires immediate examination by a doctor and does not agree to be examined immediately.

In forming a belief about the person, the police officer and paramedic are not required to make a medical assessment or clinical judgment.

A doctor or mental health officer may apprehend a person if they believe on reasonable grounds that:

- the person has a mental disorder or mental illness
- the person requires immediate treatment, care or support or their condition will deteriorate within three days to such an extent that they would require immediate treatment, care or support
- the person has refused the treatment, care or support
- detention is necessary for the person's health or safety, social or financial wellbeing, or for the protection of someone else or the public; and
- adequate treatment, care or support cannot be provided in a less restrictive environment.

The apprehended person may be taken to an approved mental health facility by:

- police officer or authorised ambulance paramedic; or
- the original doctor or mental health officer who apprehended the person; or
- another doctor, mental health officer, police officer or paramedic at the request of the original doctor or mental health officer.

The ACAT must, on application, review the following decisions within two working days after the application is made:

- a decision of a police officer or ambulance paramedic to apprehend a person; or

- a decision of a doctor or mental health officer about whether the person's condition will deteriorate within three days to such an extent that the person would require immediate treatment.

## Question

8. Do you have any feedback based on your experience or knowledge about apprehension? What do you think is working or not working?

## Conditional Release Orders

Work is already underway to review and reform Conditional Release Orders in response to the Chief Psychiatrist's Report.

### Review of detention under court order (section 180)

The court can order a person with either a *mental illness* or a *mental disorder* who has been found unfit to plead or not guilty due to mental impairment to be detained in custody under Part 13 of the Crimes Act for review by the ACAT.

Under section 180 of the Mental Health Act, the ACAT is required to review the detention of the person as soon as possible and no later than seven days after the court ordered the detention, and decide whether to:

- release the person subject to conditions (also known as a Conditional Release Order or CRO)
- release the person unconditionally, or
- not release the person.

In making its decision, the ACAT must have regard to a number of key matters, including:

- that detention in custody is to be regarded as a last resort
- that detention should be ordered only in exceptional circumstances
- the nature and extent of the person's mental disorder or mental illness
- the effect the person's mental disorder or mental illness it is likely to have on the person's behaviour in the future
- the risk to the person's health and safety if the person was released
- the risk that the person would do serious harm to others if released
- if relevant, any statement by the registered affected person and the views of the Victims of Crime Commissioner
- the nominated term
- any information the Chief Psychiatrist or Director-General has given to the ACAT about the treatment, care or support the person requires, including that the person should be admitted to a particular approved mental health facility or approved community care facility; and
- following amendments to the Mental Health Act made in April 2026, any information the Chief Psychiatrist or Director-General has given to the ACAT about the person's compliance with any orders made under the Mental Health Act.

Where the ACAT decides to release the person subject to conditions (on a CRO), the person may be required to reside at a specified mental health facility and may be required to comply

with other conditions under a mental health order or a forensic mental health order designed to manage any risk of harm the person poses.

Where the ACAT decides to release the person without imposing any conditions, the person is free to return to the community. In practice, the ACAT will only release a person unconditionally if the person does not pose a risk of harm to themselves or the community.

Where the ACAT decides not to release the person, the ACAT must review the detention and consider the release of the person at least monthly. The ACAT must consider all the matters listed above each time it reviews the person's detention. The ACAT may also vary a mental health or forensic mental health order that applies to the person or impose a new mental health or forensic mental health order on the person while they person is detained. In addition, the ACAT must advise a number of individuals and entities if the ACAT does not order the release of the person, including the Public Advocate, the Chief Psychiatrist, and the ACT Human Rights Commission.

## Question

9. Do you have any feedback on the operation of section 180 or your experiences regarding review of detention under a court order?

   This may include consideration around who should receive information under this section or if the ACAT should consider any other information when making an order to release a person.

### Review of conditions of release (section 182)

Where the ACAT has imposed a CRO on a person, the ACAT must review the conditions imposed by the CRO at least every six months while the order is in force.

There is a requirement to notify the ACAT if a person contravenes a condition of their CRO. The ACAT must review each condition within 72 hours after the ACAT receiving notice.

The ACAT may conduct the review without a hearing. This is necessary for a number of reasons, including that the person may not be able to be located or may refuse to participate in a hearing.

When reviewing the conditions of the CRO, the ACAT must consider any statement by a registered affected person (victim who is on the register) and the views of the Victims of Crime Commissioner.

After completing a review, the ACAT can:

- amend or revoke any existing condition in the CRO
- impose new conditions on the person as part of the CRO; or

Additionally, if a person has breached a condition of their release, ACAT may order that the person be detained in custody until the ACAT orders otherwise.

## Question

10. Do you have any feedback on the operation of section 182 or your experiences regarding review of conditions of release?
    This may include how often ACAT should review orders or hold hearings.

## ACAT Procedural Matters

### Definitions – definition of forensic patient (section 127)

A forensic patient is a person who:

- is subject to a forensic mental health order
- could be made subject to a forensic mental health order; or
- has been found unfit to plead or not guilty due to mental impairment under either the ACT Crimes Act or the Commonwealth Crimes Act.

This definition is relevant only to disclosures to registered affected people (explained in the section below).

## Question

11. Do you have any feedback on how forensic patient is defined in section 127?

### Disclosures to registered affected people (section 134)

Registered affected persons are persons who suffered harm as a result of the conduct of a forensic patient (as defined above) and who are on the 'register'. This includes a person with parental responsibility for the registered affected person if they are under 15 years old.

The Director-General of the Justice and Community Safety Directorate (DG JACS) must notify each registered affected person when an application for a forensic mental health order has been made in relation to the forensic patient.

If a forensic mental health order is made in relation to the forensic patient, the DG JACS must also notify each registered affected person:

- that a forensic mental health order is in force in relation to the forensic patient
- that the forensic patient must submit to ACAT or is subject to a review by ACAT
- about any relevant decisions or orders by ACAT in relation to the forensic patient
- if the forensic patient has absconded from a mental health facility or community care facility
- if the forensic patient has failed to return a mental health facility or community care facility after approved leave
- if the forensic patient is transferred to or from another jurisdiction; and
- if the patient is released from a mental health facility or community care facility.

In addition, the DG JACS can disclose any other information about the forensic patient to a registered affected person that the DG JACS considers necessary for the safety and wellbeing of the registered affected person.

However, where the forensic patient is a child or was a child at the time of the conduct, the DG JACS must not disclose information to a registered affected person unless the conduct involved personal violence and the DG JACS believes the registered affected person or their family members may come into contact with the forensic patient.

To protect the privacy of forensic patients, the DG JACS must notify each registered affected person that they must not publish information disclosed to them, that publishing the information could be a criminal offence, and that publishing the information could result in them being removed from the register of affected people.

Victim Support ACT (part of the ACT Human Rights Commission) administers the ACT Victims Registers. This includes the Affected Persons Register.[3]

## Question

12. Do you have any feedback on the operation of section 134 or your experiences regarding disclosures to registered affected people?

### Notice of hearing (section 188)

Section 188 of the Mental Health Act sets out the requirements for giving notice of a hearing in relation to matters under the Mental Health Act, including the matters referred to above.

In particular, section 188 identifies:

- the individuals and entities who must receive notice; and
- the circumstances in which notice is not required.

## Question

13. Do you have any feedback on the operation of section 188 or your experiences regarding notice of hearings?

### Appearance (section 190)

Section 190 of the Mental Health Act identifies the individuals and entities who can appear and give evidence at an ACAT hearing. A hearing may be for any proceedings under the Mental Health Act including for an assessment order, a mental health order, for the removal of an order, for an electroconvulsive therapy order, or for a review of an order.

Section 190 notes that individuals and entities not listed may also appear and give evidence at a hearing with the permission of the ACAT.

Section 190 does not prevent a person from making a written submission to the ACAT in relation to a proceeding. This means that if a person is not listed in this section or given

[3] ACT Human Rights Commission, *Victims Registers* <https://www.hrc.act.gov.au/victim-support/victims-register>.

permission by the ACAT to give evidence at the hearing, they can still make a written submission to ACAT.

## Question

14. Do you have any feedback on the operation of section 190 or your experiences about appearance at hearings before the ACAT?

## Supporting people who have a function under the Mental Health Act

### Chief Psychiatrist may make guidelines (section 198A)

The Chief Psychiatrist may make guidelines for a mental health facility, mental health professional or anyone else exercising a function under the Mental Health Act. This power to make guidelines sits with the Chief Psychiatrist and cannot be delegated.

To date, guidelines have been made in relation to the following:

- contravention of mental health orders
- use of restraint; and
- use of seclusion

A guideline is required to include a statement about how it is consistent with the objects and principles of the Mental Health Act and human rights.

It outlines consultation requirements when making certain guidelines, specifically those relating to a function exercised by a police officer or an authorised ambulance paramedic. It also states who is required to comply with the content of certain guidelines.

## Question

15. Do you have any feedback on the operation of section 198A regarding the power of the Chief Psychiatrist to make guidelines under the Mental Health Act?

# Additional areas for review related to the *Mental Health Act 2015*

The Health and Community Services Directorate is inviting feedback on additional issues relating to the Mental Health Act to determine whether any changes should be made. These relate to national or local commitments, ensure best practice, or help the ACT align with other Australian states and territories.

## Emergency detention

The Health and Community Services Directorate is inviting feedback on the process for the assessment of consumers by doctors when they have been taken to hospital.

There are situations where a person with a mental illness or mental disorder may be required to stay in hospital to ensure their own safety or the safety of other people. This is called emergency detention in the Mental Health Act.

The Health and Community Services Directorate is seeking feedback on whether the emergency detention sections of the Mental Health Act should be changed to ensure they are operating in a consumer-centred way and in accordance with best practice. The directorate is seeking feedback on whether the number of assessments under emergency detention sections are appropriate.

Once a person has been detained at an approved mental health facility under the emergency detention framework they must undergo an assessment process. The assessment process requires two examinations within a four-hour period, with the first examination by a psychiatrist or another doctor in consultation with a psychiatrist, as well as a second examination by a second doctor.

If the person continues to be detained after the four-hour period, then the Chief Psychiatrist has a further two hours to arrange for the assessment process, following which the person should be released.

The person may be detained for a maximum period of three days if the two doctors undertaking the assessment process agree that there are reasonable grounds for believing that:

- the person requires immediate treatment, care or support
- the person has refused to receive that treatment, care or support
- detention is necessary for the person's health or safety, social or financial wellbeing, or for the protection of someone else or the public; and
- adequate treatment, care or support cannot be provided in a less restrictive environment.

A person detained at an approved mental health facility must then have medical examination (physical and psychiatric) within 24 hours of being detained. This examination must not be conducted by the same doctor who conducted the initial examination.

Principle 16 of the United Nations *Principles for the protection of persons with mental illness and the improvement of mental health care* provides guidance in relation to involuntary

admission to a mental health facility as a patient.[4] It notes that two mental health practitioners need to be consulted in relation to the involuntary admission or retention of a patient, and that the admission should not take place until the second mental health practitioner agrees with the first assessment.

The United Nations principles outlined that a mental health practitioner (rather than just a doctor) should be consulted in relation to involuntary detention. This may be medical doctor, psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care.[5]

## Question

16. Based on your knowledge or experience, do you have any feedback on the process of emergency detention? What do you think is working or is not working?
17. Do you think the emergency detention sections under sections 84, 85 and 86 of the Mental Health Act should be changed to be more consumer and carer centred? Do you have suggestions on what should be changed?

## Information sharing

The Health and Community Services Directorate is seeking feedback on whether the information sharing sections in the Mental Health Act should be updated to include requirements for information sharing between health services and carers.

The Mental Health Act does not currently include any requirements for information sharing between health services and carers in relation to treatment, care or support. However, carers are recognised or involved in a number of sections within the Mental Health Act. Carers and care relationships are also recognised by the *Carers Recognition Act 2021*.

Several recent ACT coronial cases have highlighted the issue of information sharing with carers in relation to mental health.[6] The ACT Government committed to review this issue in response to a recommendation following a coronial inquest in 2023.[7]

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[4] United Nations Human Rights Office of the High Commissioner, Universal Instrument, *Principles for the protection of persons with mental illness and the improvement of mental health care*, adopted 17 December 1991 GA Res 46/119, principle 16 <https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-protection-persons-mental-illness-and-improvement>.

[5] United Nations Human Rights Office of the High Commissioner, Universal Instrument, *Principles for the protection of persons with mental illness and the improvement of mental health care*, GA Res 46/119 (adopted 17 December 1991) principle 16 <https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-protection-persons-mental-illness-and-improvement>.

[6] Inquest into the death of Mark Jollife [2015] ACTCD 2, Inquest into the death of Adrian Pitman [2019] ACTCD 13; Inquest into the death of Kaitlin McGill [2020] ACTCD 7; An inquest into the death of Peter Zovak [2015] ACTCD 1.

[7] Inquest into the death of Joshua [2023] ACTCD 2 <https://www.parliament.act.gov.au/__data/assets/pdf_file/0010/2267074/3_Inquest-into-the-death-of-Joshua-Coroners-report.PDF>; the Legislative Assembly for the Australian Capital Territory, 10th Assembly, *Coronial Inquest into the death of Joshua, Government Response* <https://www.parliament.act.gov.au/__data/assets/pdf_file/0008/2267072/3_Inquest-into-the-death-of-Joshua-Government-Response.pdf>.

In addition to information sharing with carers, work has been progressing at a national level on information sharing between states and territories. This work is known as the mutual recognition of mental health orders. The mutual recognition of orders would involve states and territories recognising mental health orders that have been made in other states and territories. The Health and Community Services Directorate is continuing to work on implementing mutual recognition of mental health orders in the ACT.

Additionally, the Australian Health Ministers and Mental Health Ministers agreed to develop a National Mental Health Information Sharing Framework (national framework) to improve information sharing between jurisdictions to better support patients receiving mental health care and treatment. The ACT is a signatory to the national framework.

The national framework sets out five guiding principles for health service providers in relation to information sharing. These principles are that jurisdictions should:

- Provide a high-level commitment to information sharing to support the continued care for a mental health consumer when moving between jurisdictions
- Ensure there are no legislative barriers to information sharing
- Consider a consumer's human rights when sharing information, including their right to privacy
- Balance the safety and privacy of consumers and others while enabling mental health care and support
- Facilitate continuing collaboration between jurisdictions and ensure mental health information, where required, is shared responsibly and appropriately across jurisdictional boundaries.

## Questions

18. Do you have any thoughts on how information sharing can be improved for carers to help support them in their caring role?
19. Do you have any thoughts on how information sharing with carers can also balance the rights and protections of privacy for consumers?
20. Do you have any thoughts on potential protections or safeguards for consumers related to information sharing with family members, partners or carers in situations with potential family and domestic violence or coercive control?
21. Do you have any feedback on the proposal to strengthen information sharing across jurisdictions in line with the national framework?

## Sexual safety of consumers

The Health and Community Services Directorate is seeking feedback on how to improve the Mental Health Act to support sexual safety for consumers.

Sexual safety is about ensuring consumers feel safe and are free of unwanted sexual behaviour.[8] Incidents involving sexual safety may include sexual assault and sexual harassment as well as sexually disinhibited behaviour.[9] Consensual and non-consensual sexual activity is not permitted in public mental health facilities operated by Canberra Health Services.[10]

The Health and Community Services Directorate is considering whether to include the following within the Mental Health Act:

- A sexual safety principle within the objects of the Mental Health Act.
- A requirement which allows sexual safety incidents to be reported to the Chief Psychiatrist.

These proposals aim to ensure the safety and quality of health services and prevent harm to consumers who are covered under the Mental Health Act. These proposals would align with national work as well as jurisdictions such as New South Wales, South Australia, Victoria and Western Australia which have developed guidelines for sexual safety within mental health services.

Further policy work in this space will explore intersections with mandatory reporting requirements and obligations under other ACT legislation such as the Crimes Act.

### Questions

22. Based on your knowledge or experience, do you have any feedback on including a sexual safety principle within the objects provision in the Mental Health Act?
23. Do you have any feedback on requiring the reporting of sexual safety incidents to the Chief Psychiatrist?

## Aboriginal and Torres Strait Islander people and Social and Emotional Wellbeing

The Health and Community Services Directorate is seeking feedback on how to strengthen the Mental Health Act to incorporate Social and Emotional Wellbeing and to include a requirement that cultural safety is part of the objects and principles.

The Mental Health Act currently includes a principle that a person with a mental disorder or mental illness has the right to access services that are sensitive and responsive to the

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[8] Government of Western Australia, Office of the Chief Psychiatrist, *Chief Psychiatrist's Guidelines for the Sexual Safety of Consumers of Mental Health Services in Western Australia*, 1 December 2020 <https://www.chiefpsychiatrist.wa.gov.au/publication/chief-psychiatrists-guidelines-for-the-sexual-safety-of-consumers-of-mental-health-services-in-western-australia>.

[9] NSW Government, *Sexual Safety of Mental Health Consumers Guidelines*, 12 November 2013 <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2013_012.pdf>.

[10] ACT Government, Canberra Health Services, *Sexual Safety Procedure*, 14 November 2025 <http://www.canberrahealthservices.act.gov.au/__data/assets/file/0008/2187899/Sexual-Safety.docx>.

person's individual needs, including in relation to age, gender, culture, language, religion, sexuality, trauma and other life experiences. However, the Mental Health Act does not specifically mention First Nations people nor adequately recognise First Nations people's Social and Emotional Wellbeing as distinct from mainstream clinical models.

Social and Emotional Wellbeing takes a holistic view of health as it recognises that connection to land, sea, culture and spirituality all influence wellbeing.[11] Social, historical and political factors can also affect wellbeing. It is a holistic concept encompassing connection to Country, culture, spirituality, family and Community.

This proposal is intended to support the expectation of shared decision making and system level reform, as well as improved wellbeing outcomes. As such, the following principles in national and ACT-based frameworks apply in the context of this proposal:

- that Aboriginal and Torres Strait Islander people are empowered to share decision-making authority with governments to accelerate policy and place-based progress on Closing the Gap through formal partnership arrangements (Priority Reform 1 of the National Agreement on Closing the Gap)
- that governments, their organisations and their institutions are accountable for Closing the Gap and are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people, including through the services they fund (Priority Reform 3 of the National Agreement on Closing the Gap)
- for a 'significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero' (Target 14 of the National Agreement on Closing the Gap)[12]
- the commitment of the ACT Government and the Aboriginal and Torres Strait Islander Elected Body to deliver real outcomes that improve the health and wellbeing of Aboriginal and Torres Strait Islander people in Canberra (the ACT Aboriginal and Torres Strait Islander Agreement 2019-2028).[13]

The proposal would also help to align with New South Wales, Queensland and Victoria which recognise Aboriginal people and Torres Strait Islander peoples in their Mental Health legislation.

The Health and Community Services Directorate will undertake further engagement with ACT Aboriginal and Torres Strait Islander community on this proposal.

If supported, further policy work will determine how these proposals could be implemented into practice including in the provision of mental health services in the ACT.

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[11] Social & emotional wellbeing - Australian Institute of Health and Welfare <Social & emotional wellbeing - Australian Institute of Health and Welfare>.

[12] Closing the Gap, *Closing the Gap Targets and Outcomes* <https://www.closingthegap.gov.au/national-agreement/targets>.

[13] ACT Government, *ACT Aboriginal and Torres Strait Islander Agreement* <https://www.act.gov.au/open/act-aboriginal-and-torres-strait-islander-agreement>.

## Questions

24. Do you have any feedback how best to incorporate Aboriginal and Torres Strait Islander Social and Emotional Wellbeing within the Mental Health Act?
25. Do you have views on how social and emotional wellbeing may be incorporated to deliver practical, positive outcomes for the community?
26. Do you have any feedback on how to best include a requirement that Aboriginal and Torres Strait Islander cultural safety is part of the objects and principles of the Mental Health Act?
27. Do you have any views on how it should be embedded within the objects and principles of the Mental Health Act to deliver positive outcomes for the community?

### Gender identity and gender safety of consumers

The Health and Community Services Directorate is seeking feedback on how to make it clearer in the Mental Health Act that a person's gender identity, or a lack of a gender identity, cannot be regarded as a mental illness or mental disorder.

A person with a mental disorder or mental illness has the right to access services that are sensitive and responsive to the person's individual needs, including, their age, gender, religion and culture.

The Mental Health Act says that a person's values, identity or behaviours including political or religious opinions, and sexual preferences cannot be used to determine whether the person has a mental illness or disorder. This section does not currently include gender identity or a lack of a gender identity.

The Health and Community Services Directorate is seeking feedback on how best to broaden this section to provide that a person's gender identity (or lack of) cannot be used to determine whether someone has a mental illness or disorder. This would help to align with New South Wales's Mental Health Act. The Health and Community Services Directorate is also seeking feedback on including a gender safety principle within the objects of the Mental Health Act.

## Questions

28. Do you have any feedback on how best to include a gender safety principle within the objects of the Mental Health Act at section 5?
29. Do you have any feedback on how best to include a reference to gender identity in section 11 to provide that a person's gender identity (or lack of gender identity) cannot be used to determine whether someone has a mental illness or mental disorder?
30. Are there any other considerations to improve gender safety in the Mental Health Act which should also be considered?

## Reporting of death

The Health and Community Services Directorate is exploring whether deaths of mental health consumers should be reported to the Chief Psychiatrist to improve the safety and quality of health services.

Reporting of the death of mental health consumers could potentially include:

- Voluntary and involuntary patients in public approved mental health facilities
- Voluntary and involuntary patients residing in community care facilities
- Voluntary patients in private mental health facilities
- Consumers on mental health orders in the community or in other types of facilities such as correctional facilities
- People who were assessed by or sought care from a clinical mental health service (public or private) and were not treated or care for by the service. This may include presentations to emergency departments, community mental health services or telephone triage services within a prescribed period of time before a death.

This proposal would align with Victorian legislation which allows for the Chief Psychiatrist to be notified of all reportable deaths within the meaning of the Victorian *Coroners Act 2008*.

In the ACT, the *Coroners Act 1997* (Coroners Act) sets out functions of the coroner including their role in holding inquests into particular kinds of deaths. The Coroners Act outlines that the coroner must hold an inquest into the manner and cause of death of a person who dies in care or custody. A death in care means the death of a person:

- while being taken into or detained in custody, or subject to an order, under the Mental Health Act or under section 309 of the Crimes Act; or
- because of a fatal injury sustained in circumstances mentioned in the above point.

In addition to coronial reporting of death in the ACT, deaths related to mental health consumers may be notified or reviewed internally within the Health and Community Services Directorate by the following mechanisms:

- Reporting of certain events (including the unexpected death of a patient) by health facilities to the ACT Chief Health Officer
- Procedural review of a death in care (a consumer on a mental health order) by the Office of the Chief Psychiatrist. This type of review is done as accepted practice however is not legislatively required.

Expanding the reporting of deaths of mental health consumers to include reporting to the Chief Psychiatrist may present an opportunity for recommendations to be made to improve the quality and safety of mental health services. It may also help to understand emerging issues or themes related to deaths which may lead to future policy or service improvements.

## Question

31. Do you think the deaths of certain mental health consumers should be reported to the Chief Psychiatrist in addition to sections that require deaths in care to be reported to the ACT coroner?
32. If this proposal is supported, who do you think should be obligated to report the deaths of certain mental health consumers to the Chief Psychiatrist?

### Revocation of orders

The Health and Community Services Directorate is seeking feedback on whether to allow the Chief Psychiatrist to revoke mental health orders.

Currently, the Chief Psychiatrist can notify ACAT of their view that the order is no longer required but cannot revoke the order. This reflects that it is the ACAT that makes mental health orders. Although usually most mental health orders will be applied for by a delegate of the Chief Psychiatrist, in some cases they may arise because of an application by someone else – such as the persons' family.

Under the Mental Health Act the Chief Psychiatrist or their delegate must notify the ACAT and the Public Advocate in writing if the Chief Psychiatrist believes that a psychiatric treatment order or a restriction order is no longer appropriate. This notification means ACAT must review of the order within 72 hours.

Before the Chief Psychiatrist forms the view that a psychiatric treatment order or a restriction order is no longer appropriate, they must consult with the person's carer and the nominated person. This consultation process must include the Chief Psychiatrist's reasons for believing the order is no longer required, and the Chief Psychiatrist must seek any further information that may be relevant to determine if the psychiatric treatment order or restriction order should continue and if it is suitable for the person's circumstances.

Currently, the Chief Psychiatrist can delegate this function to psychiatrists employed in public health services (these are mental health services delivered by Canberra Health Services). There is a similar section in relation to community care orders in section 72 of the Mental Health Act. The main difference is the Care Coordinator, not the Chief Psychiatrist, is required to notify ACAT and the Public Advocate that an order is no longer required.

The Health and Community Services Directorate understands that in other states and territories, psychiatrists and authorised office holders have the power to revoke a mental health order.

## Questions

33. Would it be beneficial to allow the Chief Psychiatrist to revoke mental health orders in the ACT?
34. If beneficial, what kind of mental health orders should a power to revoke apply to?
35. Do you identify any risks in this proposal, or additional safeguards which would need to be incorporated?
36. Do you think there is an alternative model which could be used instead?
37. Should the Chief Psychiatrist's power to revoke an order be a function which can be delegated to psychiatrists under the Mental Health Act, or should it remain only with the Chief Psychiatrist?

# Human rights and the Mental Health Act

### Human rights

Human rights are protected in the ACT by the *Human Rights Act 2004*.

The Human Rights Act:

- lists human rights specifically protected in the ACT
- requires ACT government agencies to consider human rights in making decisions
- guides how ACT courts and tribunals interpret other laws that may impact on human rights[14]
- requires that human rights must not be unreasonably limited.

The Mental Health Act engages a number of rights, including the right to privacy and reputation, the right to equality, the right not to be subject to medical treatment without consent, and the right to liberty and security of person.

Under the Mental Health Act, a person with a mental illness or mental disorder has the same rights and responsibilities as other members of the community. These people are to be supported to exercise their rights without discrimination.

Services provided under the Mental Health Act need to be provided a way that recognises and respects people's rights, inherent dignity and needs.

## Question

38. Are there any areas of the Mental Health Act that either support human rights, or require greater human rights safeguards? If so, which areas?
39. In your view, what is or is not working? Your response may address any area of the Mental Health Act.

[14] Human Rights Commission, *How are human rights protected in the ACT?* <https://www.hrc.act.gov.au/humanrights/how-are-human-rights-protected-in-the-act>


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