Queensland
Mental Health
Commission

Human rights protection frameworks for people being treated involuntarily for a mental illness: Overview

October 2019

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Acknowledgements

We pay respect to Aboriginal and Torres Strait Islander Elders, past, present and future. We acknowledge the important role played by Aboriginal and Torres Strait Islanders as the First Peoples, their traditions, cultures and customs across Queensland.

We also acknowledge people living with mental illness, problematic alcohol and other drugs use, those impacted by suicide, and their families, carers and support people. We can all contribute to a society that is inclusive and respectful, where everyone is treated with dignity and able to focus on wellness and recovery and have fulfilling lives.

The Commission acknowledges and thanks the members of the Project Advisory Group established to oversee delivery of the project, including those with a lived experience, and representatives from Queensland Health, Department of the Premier and Cabinet, the Anti-Discrimination Commission (now Queensland Human Rights Commission), the Office of the Public Guardian, the Office of the Public Advocate, the Queensland Alliance for Mental Health, and the Mental Health Review Tribunal for their contributions.

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The Commission also thanks and acknowledges the contributions of people with a lived experience and stakeholders who took part in the study.

Feedback

We value the views of our readers and invite your feedback on this report. Please contact the Queensland Mental Health Commission on telephone 1300 855 945, fax (07) 3405 9780 or via email at info@qmhc.qld.gov.au.

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Contents

1. Executive Summary

Purpose

The purpose of this paper is to provide an overview of the findings of the research project *Human rights protection frameworks for people being treated involuntarily for a mental illness*, undertaken by a consortium co-led by the Social Policy Research Centre at the University of Sydney and the Menzies Health Institute at Griffith University, and involving Sydney Law School and the Centre for Values, Ethics and the Law in Medicine at the University of Sydney.

The full research report (Human rights protection frameworks for people being treated involuntarily for a mental illness: study findings, May 2019), literature review (Human rights protection frameworks for people being treated involuntarily for a mental illness: literature review, March 2019) and research summary (Queensland *Mental Health Act 2016* and Human Rights Project: research summary, September 2019) are published with this paper on the Queensland Mental Health Commission's (the Commission) website at www.qmhc.qld.gov.au.

Rationale

Following the commencement of the *Mental Health Act 2016* in Queensland, the Commission engaged a consortium in May 2017, to research the processes provided in the new Act to protect human rights for people being treated involuntarily for a mental illness[1].

Users of mental health services, persons with mental health conditions and persons with psychosocial disabilities are particularly vulnerable to breaches of their human rights through seclusion and restraint. A comprehensive approach to addressing their human rights situation requires the protection of autonomy and dignity as well as the other human rights guaranteed by the United Nations Convention on the Rights of Persons with Disabilities. The Australian Government ratified the Convention in 2008, inclusive of an interpretive declaration that retains involuntary treatment were necessary; however, only as a last resort and subject to safeguards.

The commencement of the *Mental Health Act 2016* has introduced some important changes, prompting a need to investigate the experiences of protection of human rights of people with lived experience under the Act. The intent of the research was therefore, to investigate and analyse whether the *Mental Health Act 2016* and its implementation went beyond a statement of patients' rights and principles and required consideration of rights when decisions about involuntary treatment were made.

Particularly, the study was aimed at exploring the processes provided in the *Mental Health Act 2016* to protect the human rights of people who receive involuntary treatment for a mental illness in hospital and community settings from the perspective of relevant stakeholders, people with lived experience of mental illness, and carers.

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[1] The meaning of involuntary patient is defined in section 11 of the *Mental Health Act 2016*

Methodology

The study focused on identifying common factors that helped or hindered the protection of people's human rights in five key areas:

1. rights and information for inpatients within mental health wards
2. the role of Independent Patient Rights Advisers
3. Advance Health Directives
4. the operation of the Mental Health Review Tribunal
5. rights and information regarding involuntary treatment in the community.

A total of 38 participants took part in the two phased qualitative study over 18 months from June 2017 to March 2019. The study consisted of a scoping literature review; telephone interviews with six selected stakeholders from non-government organisations; and interviews with 32 people that explored the experiences of human rights and their protection across the five study focus areas. Interviewees included:

- 10 people with lived experience of mental health challenges who received involuntary treatment under the *Mental Health Act 2016* (here referred to as people/participants with lived experience) (six men and four women)
- five family members and carers of people with lived experience (all women)
- 17 service provider stakeholders (referred to as service provider participants), including practitioners, experts, and advocates.

Research Findings

In summary, the research shows that significant positive changes towards strengthening human rights protections have been introduced by the *Mental Health Act 2016*, including treating people in a less restrictive way, introducing the role of Independent Patient Rights Advisers, and promoting the use of Advance Health Directives. These changes make the *Mental Health Act 2016* more closely align to the requirements of the United Nations Convention of the Rights of Persons with Disabilities compared with the previous *Mental Health Act 2000*. The changes put Queensland in a strong position compared with other Australian states and territories.

Even though the study findings represent a specific point in time soon after the commencement of the Mental Health Act 2016, the results identified aspects where the protection of human rights could be improved. These aspects include: cultural change with a stronger focus on patients' rights and opportunities to make treatment choices; training for Hospital and Health Services staff, clinicians and non-government mental health service providers to support the work of Independent Patient Rights Advisers and less restrictive ways; improved communication with consumers to support recovery; changes to current risk assessment practices; and promoting the uptake of Advance Health Directives and improving processes to register and update them. Some of these areas for improvement have also been identified in the evaluation of the implementation of the *Mental Health Act 2016* by Queensland Health.

Study Limitations

The non-random sampling methods employed generate a risk the study sample is not representative of the population being studied. Differences may exist between those who volunteered and those who declined to participate, that are difficult to quantify. Although this study's findings may not be generalisable to the wider population of people receiving involuntary treatment under the *Mental Health Act 2016*, the experiences and views of each single person about the protection of their human rights are valuable and important, regardless of whether they are typical of a large or small number of people.

The study findings present a specific point in time soon after the commencement of the *Mental Health Act 2016*. As participants did not have a long time to experience the implementation of the changes, it is acknowledged that improvements have been made since the study was conducted.

2. Introduction

The Queensland Mental Health Commission's role is to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health, drug and alcohol service system in Queensland.

Within this role, the Commission supports the protection of human rights of people living with a mental illness, especially the most vulnerable people who may be treated involuntarily, as outlined in the *Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018–2023.*

This support has included making three submissions to Queensland Health and the Queensland Parliament arguing the case for improved human rights protection as part of the 2014–15 review of Queensland mental health legislation that preceded the *Mental Health Act 2016*. These three submissions are available on the Commission's website at qmhc.qld.gov.au. The Commission also provided a submission in support of the Queensland *Human Rights Act 2019,* which can be found at www.parliament.qld.gov.au/documents/committees/LACSC/2018/HumanRights2018/submissions/094.pdf.

3. Project outline

Summary of methodology and other relevant information

The study focused on five key areas:

1. rights and information for inpatients within mental health wards
2. the role of Independent Patient Rights Advisers
3. Advance Health Directives
4. the operation of the Mental Health Review Tribunal
5. rights and information regarding involuntary treatment in the community.

The project did not aim to evaluate the five focus areas but investigated them to identify common factors that helped or hindered the protection of the human rights of people treated involuntarily for a mental illness under the *Mental Health Act 2016*.

The research project consisted of a qualitative study with Phase 1 and Phase 2 run over 18 months, from June 2017 to March 2019. A total of 38 participants took part in the study. Phase 1 (June 2017 to February 2018) consisted of a scoping literature review and telephone interviews with six selected stakeholders from non-government organisations. Phase 2 (March 2018 to March 2019) explored the experiences of human rights and their protection, across the five study focus areas, with a total of 32 interviewees:

- 10 people with lived experience of mental health challenges who received involuntary treatment under the *Mental Health Act 2016* (here referred to as people/participants with lived experience) (six men and four women)
- five family members and carers of people with lived experience (all women)
- 17 service provider stakeholders (referred to as service provider participants), including practitioners, experts, and advocates.

All the interviews were conducted in Brisbane and Townsville to allow the research team to include participants from a range of backgrounds and settings.

A third party facilitated participant recruitment for the study, seeking nominations from non-government organisations (NGOs), consumer and carer networks, peer support and other professional networks. Flyers and information sheets about the research were distributed and people contacted the research team to express interest in taking part.

Study limitations

The study was conducted using a purposive, maximum variation sampling method, which allowed the research team to include a wide range of experiences about the protection of human rights of adults who receive involuntary treatment under the *Mental Health Act 2016*. However, non-random sampling methods generate a risk that the study sample is not representative of the population being studied.

Differences may exist between those who volunteered and those who declined participation in the interviews, which are difficult to predict and quantify. Although this study's findings may not be generalisable to the wider population of people receiving involuntary treatment under the *Mental Health Act 2016*, the experiences and views of each single person about the protection of their human rights are valuable and important, regardless of whether they are typical of a large or small number of people.

The study findings present a specific point in time soon after the commencement of the *Mental Health Act 2016*. As participants did not have a long time to experience the implementation of the changes, it is acknowledged that improvements have been made since the study was conducted.

4. Results

According to the study findings, most participants welcomed the changes brought about by the *Mental Health Act 2016,* which they believed improved the protection of human rights of people with lived experience who receive involuntary treatment. However, many commented on the very limited changes they had observed in mental health practice.

Focus area 1: Rights and information for inpatients within mental health wards

Participants with lived experience described the experience of being hospitalised as scary and confusing. The following experiences were discussed as affecting the protection of human rights in mental health wards under the *Mental Health Act 2016***.**

- People experienced difficulty maintaining communication with family and friends, reporting the practice in some wards of locking away mobile phones regardless of a specific assessment of whether they were going to be detrimental to the health or wellbeing of the person or others.

- There was an identified need for more training aimed at educating clinicians about the role of Independent Patient Rights Advisers.

- People with lived experience, family and carers had limited access to appropriate, linguistically and culturally relevant information about their rights, treatment and available services, including social benefits. The importance of this information being offered at different times during hospitalisation was stressed.

- People reported negative experiences when requesting information about medication or providing feedback to treating professionals about what had worked for them in the past. Some reported difficulties having their concerns or wishes heard and were concerned that if they did complain the treatment would get worse rather than better. Participants also identified that general health care was not always managed appropriately in mental health setting.

- The right to access a second opinion about a person's treatment and care (part of the clinical governance in an Authorised Mental Health Service to ensure accountability and oversight for the clinical judgement of authorised doctors — Section 301(1)(d)), was identified as a positive addition to the *Mental Health Act 2016*, which supported the rights of those being treated involuntarily. However, service provider participants raised concerns about the independence of the reviews when a second opinion was arranged by Hospital and Health Services.

- The requirement for Authorised Mental Health Services to provide data on the use of restraint on children and young people to the Office of the Public Guardian (section 274) was considered an important improvement. Nevertheless, the lack of written informed consent from parents, guardians and carers for using restraint or seclusion on children, as well as a lack of mechanisms to monitor that information about these practices had been provided by doctors to the children's parents, guardians and carers, was seen as limiting their rights and choices.

- The absence of a similar requirement for Authorised Mental Health Services to notify the Office of the Public Guardian about the use of restraint or seclusion on adults was seen as a limitation to safeguarding people's right to bodily integrity and autonomy. Concerns were also raised about the lack of safeguard mechanisms for advocates to question the use of medication, particularly in the case of forensic orders.[2]

- More than half the participants with lived experience, family and carers reported experiencing trauma when security guards were involved in restraining practices, with resulting physical pain and injury, fear and distress. Participants requested that mental health staff put more effort into de-escalation techniques before calling security.

- People with a dual diagnosis (e.g. an intellectual disability and a mental health challenge) were reportedly at risk of prolonged hospitalisation or detention because of the shortage of disability services in place to transition back into the community. There are only 10 beds at the Forensic Disability Service provided under the *Forensic Disability Act 2011*.

- There was high concern about sexual assault among consumers, not staff, in wards and concerns were expressed about mixed-gender wards.

- For those who smoked, being prevented from smoking on the inpatient ward was reported by participants with lived experience, family and carers to have a negative impact on their wellbeing and recovery.

Focus area 2: The role of Independent Patient Rights Advisers

The introduction of Independent Patient Rights Advisers was considered important in protecting the rights of those being treated involuntarily under the *Mental Health Act 2016*. However, most participants with lived experience, and family and carer participants had no knowledge of the role of Independent Patient Rights Advisers. Only two of the 10 participants with lived experienced and one of the five family members and carer participants had experienced accessing an Independent Patient Rights Advisers. They described the experience as positive and reported that they would access the Independent Patient Rights Adviser again if needed.

The following experiences were discussed as affecting Independent Patient Rights Advisers' roles and therefore their capacity to inform patients, family and carers about their rights under the *Mental Health Act 2016*:

- There is a lack of guidelines and direction to assist the development of the role of Independent Patient Rights Advisers. As a result, each Hospital and Health Service implemented the role and governance structure differently.

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[2] Forensic orders are made primarily by the Mental Health Court for persons charged with a serious offence who are found of unsound mind at the time of an alleged offence or unfit for trial. Persons on a forensic order may be treated or cared for without consent and, if necessary, detained in an authorised mental health service or the Forensic Disability Service.

- A lack of clarity regarding the role of Independent Patient Rights Advisers, including whether they provide advice rather than advocacy, in some instances generated tension with some treatment teams, resulting in the Independent Patient Rights Adviser's role being viewed with suspicion. This created difficulties in establishing positive working relationships. A collegial relationship with treatment teams was seen as being important to allow Independent Patient Rights Advisers access to information and referrals. Most Independent Patient Rights Advisers described their roles as being an adviser or facilitator, but not an advocate.

- Some service provider stakeholders questioned the independence of Independent Patient Rights Advisers due to the current governance and management structures within Hospital and Health Services, with recommendations that the governance of the role be outside Hospital and Health Services, with direct reporting to the Office of the Chief Psychiatrist. Further resourcing to expand access to Independent Patient Rights Advisers across a number of sectors, including community-based services and prisons, was recommended by service provider participants.

- A current lack of Independent Patient Rights Advisers based in community services and prisons was identified as a limitation that needed to be addressed to help people with lived experience, their family and carers to access information about their rights in these settings (sections 285 and 286 of the *Mental Health Act 2016*).

Focus area 3: Advance Health Directives

Advance Health Directives were introduced for adults to consent to future treatment should they become unable to make their own decisions. Advance Health Directives can include the person's views, wishes and preferences about their future treatment.

Most service provider participants saw Advance Health Directives as a welcome addition in the *Mental Health Act 2016*. Advance Health Directives were seen as an option that would promote less restrictive treatment practices and support the rights to autonomy and bodily integrity of people with lived experience. Nevertheless, very few of the consumer, family member and carer participants had heard of Advance Health Directives.

The only participant with lived experience who had completed an Advance Health Directive described the process as complicated, requiring several steps and visits to different people, including a solicitor and a general practitioner. This participant was assisted by an Independent Patient Rights Adviser, who offered help with information and writing the participant's wishes in a way that was clear and suitable to the Advance Health Directive form.

In considering the type of help that people with lived experience might require to complete their Advance Health Directive and to keep it up-to-date, the question was raised about whether Independent Patient Rights Advisers are the best people to offer that support.

The following experiences and factors were discussed as affecting the availability, accessibility and use of Advance Health Directives in times of need, for people with lived experience, family, carers and treatment teams.

- Keeping Advance Health Directives up-to-date. The way Advance Health Directives are currently used is not conducive to regular updating and so there is a risk that Advance Health Directives may quickly become outdated.

- More consumer-accessible and consumer-appropriate documents and processes for completing Advance Health Directives are needed to increase their accessibility to different groups of consumers.

- Support is needed for people with lived experience in the community or in prison who do not have access to an Independent Patient Rights Adviser and therefore might not know or have the help they need to complete an Advance Health Directive.

- Further training and information about Advance Health Directives for clinical staff is need so they can better understand the concept and how to work with people with lived experience to use Advance Health Directives effectively. It was suggested that this training needed to target medical practitioners as well as mental health workers to ensure integration of Advance Health Directives across acute and community settings, as well as provide practical resources to support current training options.

- There is a limited and slow uptake of Advance Health Directives statewide. Among the three people with lived experience and two carers who were aware of Advance Health Directives, their main reason for not completing an Advance Health Directive was a belief that it would not make any difference to how they would be treated on admission to hospital. Service provider participants also reported they had received feedback from people with lived experience who believed they were unsure if the Advance Health Directive would be followed by the treating team and had concerns that, even after completing an Advance Health Directive, their wishes would not be respected.

- The current ways and procedures to upload and store Advance Health Directives in the health service information systems raised concerns that, in a fast-paced health system, information about a consumer’s Advance Health Directive would not be accessed. Advance Health Directives are automatically highlighted on the public mental health consumer record, but not for emergency, other health areas, or in private hospitals. Uploading Advance Health Directives into the electronic health record was described as requiring a more effective process to ensure accessibility of relevant current information.

Focus area 4: Mental Health Review Tribunal

The Mental Health Review Tribunal is an independent decision-making body under the *Mental Health Act 2016*. The Tribunal is not part of any health service or treating team and its primary purpose is to review the involuntary status of people with a mental illness or intellectual disability. The Tribunal also approves the use of electroconvulsive therapy and non-ablative neurosurgical procedures. In making its decisions, the Tribunal must balance the rights of the patient with the rights of others, including victims of unlawful acts, and the need to protect the community.

Participants reported the *Mental Health Act 2016* included significant improvements for supporting the human rights of people with lived experience in Tribunal hearings.

Participants with lived experience, family and carers stressed the importance of receiving more accessible and ‘stepped’ information on the Tribunal processes before their first appearance. Similarly, service provider participants stressed the need for more information about the Tribunal’s decision-making processes, including recording proceedings as other tribunals and courts do. Transparency in the decision-making processes of the Tribunal was identified as necessary to improve the right to information and support for people with lived experience.

The inclusion of representation for people with lived experience within the Tribunal process was overwhelmingly seen as a positive addition to the *Mental Health Act 2016*. Although service provider participants agreed that representation supported the human rights of people with lived experience, it was noted that the introduction of advocates and representatives in the Tribunal process did not always proceed smoothly. All parties involved were required to learn about individuals’ roles, which takes time, and some participants described negative experiences with this process. Service provider participants reported two major limitations of the advocacy system: no training in place for advocates and lawyers, and support being offered only at the hearing, leaving people with lived experience with no help between hearings (when help would often be most needed).

Participants also believed that, despite the improvements brought by the *Mental Health Act 2016*, the Tribunal tended to focus on risk rather than recovery. This was particularly evident when the Tribunal considered changing a forensic order to a Treatment Support Order, which is less restrictive. One opinion was the Tribunal had a risk-averse attitude to accepting existing procedures to assess the risk of stepping people down to a Treatment Support Order. In some instances, this had led to delaying hearings, compromising people’s rights to autonomy and family and community participation.

The following factors were discussed as affecting the experiences of Mental Health Review Tribunal hearings for people with lived experience, family and carers:

- There is a lack of obligation to appoint Tribunal assistants with expertise in supporting people with an intellectual disability when reviewing forensic orders for disability and/or an assistant with appropriate cultural or social knowledge to support Aboriginal people and Torres Strait Islanders or people from other culturally and linguistically diverse backgrounds. Section 750 of the *Mental Health Act 2016* states that the Tribunal may appoint a person with appropriate knowledge or experience to assist it in these proceedings, but it is not obliged to do so.

- The difficulties associated with learning to manage new administration processes introduced by the *Mental Health Act 2016* may have resulted in an increased number of Tribunal hearing adjournments. The addition of a Tribunal Registrar was suggested to support the administration processes.

- Although provision of information before the hearings was considered important, participants with lived experience reported the detailed content of the clinical reports could generate stress and anxiety, highlighting the importance of support to go through the clinical reports with them. There was also concern that the volume of long-standing history detailed in medical reports could unfairly influence Tribunal decisions that may focus on past behaviour, often from many years ago, rather than on current risk.

Focus area 5: Rights and information regarding involuntary treatment in the community.

Given the new protections in the *Mental Health Act 2016*, service provider participants saw that people with lived experience living in the community should receive information aimed at strengthening the protection of their human rights. Participants with lived experience, family and carers reported having good relationships with their case managers and saw them as their primary source of information about the new Act.

Nevertheless, there seemed to be a limited structured approach from health services on providing rights-based information. There was general consensus that ensuring people were provided with information about the *Mental Health Act 2016* and human rights protections had not necessarily been a priority for community-based service providers. Providing people with information is not tracked and it is unknown how many of the people being treated involuntarily in the community had been informed of the changes to the *Mental Health Act 2016* and the additional protections it affords.

The introduction of more Independent Patient Rights Adviser services to the community was identified as an option for increasing access to information and support that would lead to an increased uptake of Nominated Support Persons and Advance Health Directive applications.

Conceptual framework — perceived factors promoting and limiting the protection of human rights

Through the reported views of the study participants, a conceptual framework was developed (Attachment 1) summarising the factors that promote and limit the protection of the five human rights stated in the World Health Organization’s *Quality Rights Toolkit* (2012) to assess and improve quality and human rights in mental health and social care.

The framework outlines systemic, implementational or cultural factors perceived as either hindering or promoting the protection of human rights of people being treated involuntarily in hospitals and in the community.

The main systemic factors that were identified as **promoting and protecting** the human rights of patients, family and carers in focus areas of the study were changes introduced by the *Mental Health Act 2016* that offer more opportunities to enact specific rights as well as more safeguard mechanisms to protect these rights:

- the right to health, access to health care services and information (for example through the introduction of Independent Patient Rights Advisers), provision of information about treatment, and access to a second opinion
- the right to autonomy, including freedom of movement, freedom from interference, and bodily integrity (for example through a more prominent role of Advance Health Directives) and the requirement that Authorised Mental Health Services provide data on the use of restraint on children and young people to the Office of Public Guardian
- the right to family and community participation, for example through acknowledging patients' rights to communicate with family and friends using different communication means, including mobile phones and other electronic devices
- the right to equal justice and presumption of capacity, for example through the addition of representation for people with lived experience in the Mental Health Review Tribunal process.

The main systemic factors that **hindered the promotion and protection** of human rights of patients, family and carers in the five study focus areas can be summarised into two groups: 1) what participants perceived as current shortcomings in the *Mental Health Act 2016* and 2) cultural barriers and implementation issues.

The main perceived shortcomings in the *Mental Health Act* regarding the five study focus areas were:

- a lack of safeguard mechanisms for the 72-hour assessment period
- limited mechanisms to challenge seclusion and restraint, particularly for people with intellectual disability and a mental health challenge
- for certain groups of people on forensic orders, a non-revocation period of up to 10 years may not allow a more dynamic consideration of the person's response to treatment and right to recovery
- the lack of requirement for Authorised Mental Health Services to communicate the use of restraint or seclusion on adults to the Office of the Public Guardian
- the lack of safeguard mechanisms for advocates to question the use of medication, particularly in the case of forensic orders.

The main cultural barriers and implementation issues were:

- a long-standing paternalistic and risk-averse rather than recovery-focused culture
- a lack of understanding of and training on the rights introduced by the *Mental Health Act 2016*, including the role of Independent Patient Rights Advisers, Advance Health Directives, and the right to communication, with some Authorised Mental Health Services still locking away patients' mobile phones regardless of any specific assessment of whether they are detrimental to the patient's or others' health and wellbeing
- limited access of people with lived experience, family and carers to accessible, appropriate, 'stepped', linguistically and culturally relevant information about their rights, treatment and available services, including social security benefits.

- people with a dual diagnosis (e.g. intellectual disability and a mental health challenge) experiencing prolonged hospitalisation or detention because of the shortage of disability services in place to transition them back to the community

- inadequate resourcing to expand the role of Independent Patient Rights Advisers from in-patient units to people with lived experience, family and carers in the community and people in prisons, who do not currently have access to these resources.

5. Stakeholder responses

Key stakeholders provided a number of clarifying comments, raised concerns, and responded to the research project.

Project Advisory Group

Members represented on the Project Advisory Group raised concerns about the representation of the study due to the small sample size and the number of people with a lived experience interviewed (10 people).

Queensland Health

Queensland Health clarified and confirmed the role of Independent Patient Rights Advisers was to be advisers, not advocates, as some participants of the study had indicated.

Mental Health Review Tribunal

The Mental Health Review Tribunal highlighted that it must balance the rights of the patient with the rights of others, including victims of unlawful acts, and the need to protect the community. While acknowledging that participants may feel the Tribunal is too focused on risk, it must also be acknowledged that the legislation requires the Tribunal to consider risk in its decision making.

The Tribunal suggested the Attorney-General and victims should have been included in the study.

The Tribunal informed the study team that it had recently rejuvenated its website (www.mhrt.qld.gov.au/information-about/about-the-tribunal) with the aim of providing more information that was easier to find and understand. The website includes information for Authorised Mental Health Service staff, including on how to prepare for hearings and how to draft clinical reports. Further work is under way to provide additional resources to Authorised Mental Health Service staff and consumers. A page for legal representatives was recently added to the website: www.mhrt.qld.gov.au/information-for/legal-representatives.

The Tribunal noted that it does not have a role to provide legal support outside hearings as suggested by participants, and referred to the services of a range of community legal centres.

The Tribunal has concluded phase one of its project in relation to electronic audio recording of hearings. Based on the findings of the project report, the Tribunal has agreed in principle to proceed with audio recording of hearings. The next phase of the project will investigate the most appropriate manner to implement electronic recording.

6. Evaluation of the *Mental Health Act 2016* implementation

Due to a number of significant reforms introduced with the commencement of the *Mental Health Act 2016* (replacing the *Mental Health Act 2000,* which had been in operation for more than 10 years), Queensland Health recently evaluated implementation of the *Mental Health Act 2016* to gain an understanding of:

- the extent to which key initiatives within the *Mental Health Act 2016* have been successfully implemented
- stakeholder views about the change-management processes associated with implementing the *Mental Health Act 2016*.

Relevant to this human rights research project, the evaluation considered how the changes made by the *Mental Health Act 2016* meet the objectives and principles of the Act with regard to the use of less restrictive ways[3] (including the use of Advance Health Directives and substitute decision-making processes), patient rights focused treatment, and recovery-oriented practices.

The evaluation found the *Mental Health Act 2016* was effectively implemented and was supporting less restrictive ways and patient rights-focused treatment and care.

The evaluation findings are available at www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/evaluation.

The evaluation acknowledged three areas that require further action: targeted training and education, refined performance outcome monitoring, and improved data quality and analysis. This includes training related to Independent Patient Rights Advisers and their role, Advance Health Directives to increase uptake, and achieving a less restrictive environment in inpatient settings.

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[3] The Act states the main objectives of the Act are to be achieved in a way that: safeguards the rights of persons, is the least restrictive of the rights and liberties of a person who has a mental illness, and promotes the recovery of a person who has a mental illness, and the person's ability to live in the community, without the need for involuntary treatment and care. Being least restrictive of the rights and liberties of a person means restricting the rights and liberties only to the extent that is required to protect the person's safety and welfare or the safety of others. This means that actions taken under the Act that restrict a person's rights and liberties, for example under a treatment authority or forensic order, should only be the minimum necessary in the circumstances.

7. Conclusion

In summary, this research shows that significant positive changes towards strengthening human rights protections have been introduced by the *Mental Health Act 2016*, including treating people in a less restrictive way, introducing the role of Independent Patient Rights Advisers, and promoting the use of Advance Health Directives. These changes make the *Mental Health Act 2016* more closely align to the requirements of the United Nations Convention of the Rights of Persons with Disabilities compared with the previous *Mental Health Act 2000*. The changes put Queensland in a strong position compared with other Australian states and territories.

Even though the study findings represent a specific point in time soon after the commencement of the *Mental Health Act 2016*, the results identified aspects where the protection of human rights could be improved. These aspects include: cultural change with a stronger focus on patients' rights and opportunities to make treatment choices; training for Hospital and Health Services staff, clinicians and non-government mental health service providers to support the work of Independent Patient Rights Advisers and less restrictive ways; improved communication with patients to support recovery; changes to current risk assessment practices; and promoting the uptake of Advance Health Directives and improving processes to register and update them. Some of these areas for improvement have also been identified in the evaluation of the implementation of the *Mental Health Act 2016* by Queensland Health.

Queensland Health and the Mental Health Review Tribunal have already taken steps to address some of the concerns raised by participants in this study and continue to build on established processes for further improvements.

Importantly, the research highlighted the imperative to involve people with a lived experience, their carers and family members in all aspects of service planning, delivery, governance and research. They are the people most impacted by mental health legislation and its implementation. Only through involving people with a lived experience can reforms be made to ensure the best possible human rights protections are in place. The research also showed that implementing new mental health legislation is complex and issues will continue to emerge that can only be identified and considered along the way. Further research is required to build on the findings of this project and support the ongoing discussion of human rights protections and less restrictive ways.

The Queensland Mental Health Commission remains committed to supporting human rights protections as outlined in the *Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018–2023.* The Commission will promote and monitor less restrictive ways in policy and legislation, and support responses to human rights complaints. While the practice of locked wards was not included in this study, it has the potential to greatly affect the human rights of involuntary as well as voluntary patients and remains on the reform agenda.

The Commission notes the commencement of the *Human Rights Act 2019* and is hopeful the complaints process to the Human Rights Commission available from January 2020 will significantly improve protections and safeguards for all Queenslanders, but especially for the most vulnerable people receiving involuntary treatment for a mental illness.

Attachment 1

Conceptual framework summarising the study findings on the factors promoting and limiting the protection of the five human rights stated in the World Health Organization's Quality Rights Toolkit (2012) to assess and improve quality and human rights in mental health and social care.

Rights[1] and domains	**Study focus areas: rights promoting and limiting factors[2]**
Right to health, including access to health care services and information	
Promoting factors	• **Independent Patient Rights Advisers and Advance Health Directives:** – Training to educate clinicians, medical practitioners and mental health workers about the role and importance of Independent Patient Rights Advisers and Advance Health Directives. • **Rights in the ward and community:** – Access to a second opinion (Section 290 of the *Mental Health Act 2016*).
Limiting factors	• **Rights in the ward and community:** – Lack of communication on consumers' treatment preferences. – Lack of attention on general health in mental health settings. – Lack of transparency by Hospital and Health Services in arranging a second opinion.
Right to family and community participation	
Promoting factors	• **Rights in the ward and community:** – Providing access to information on the consumers' rights and treatment at different times during their hospitalisation and in ways, which are accessible and appropriate to consumers as well as linguistically and culturally relevant (Section 285). – Expanding disability services to support the transition of people with a dual diagnosis (e.g. an intellectual disability and a mental health challenge) back to community.
Limiting factors	• **Rights in the ward and community:** – Locking away patients' mobile phones regardless of any specific assessment of whether they were going to be detrimental to the health or wellbeing of the person or others.
Right to autonomy, including freedom of movement, freedom from interference, and bodily integrity	
Promoting factors	• **Advance Health Directives:** – Promoting the implementation and uptake of Advance Health Directives. – Upload of Advance Health Directives into the electronic health record was described as requiring a different process. Concerns were raised that, in a fast-paced health system, information about a consumer's Advance Health Directives would not be accessed. • **Rights in the ward and community:** – Provision of data on the use of restraint on children and young people to the Office of the Public Guardian[2] (Section 274 of the *Mental Health Act 2016*). – Use of de-escalation techniques before security guards are called. – Recovery approach, including to smoking in the wards.
Limiting factors	• **Rights in the ward and community:** – Lack of written informed consent to the use of restraint or seclusion on children by parents, guardians and carers. – Lack of mechanisms to monitor provision of information on use of restraint or seclusion by doctors to children's parents, guardians and carers.

Rights[1] and domains	**Study focus areas: rights promoting and limiting factors[2]**
	– No requirement for mental health services to communicate the use of restraint or seclusion on adults to the Office of the Public Guardian. – Shortage of disability services to support the transition of people with a dual diagnosis (e.g. an intellectual disability and a mental health challenge) back to community. – Lack of safeguard mechanisms to question the use of medication by advocates, particularly in the case of forensic orders. – Involvement of security guards in restraining practices. – Risk of sexual assault in wards.
Right to equal justice and presumption of capacity	
Promoting factors	• **Independent Patient Rights Advisers:** – The implementation of Independent Patient Rights Advisers. – Training to educate clinicians, medical practitioners and mental health workers about the role and importance of Independent Patient Rights Advisers. – Informing consumers about Independent Patient Rights Advisers and their limitations. – Having the Independent Patient Rights Advisers role governance from outside the Hospital and Health Services. – Having Independent Patient Rights Advisers reporting directly to the Chief Psychiatrist office. – Expanding access to Independent Patient Rights Advisers across community-based services and prisons. • **Advance Health Directives:** – The implementation of Advance Health Directives. – Training to educate clinicians, medical practitioners and mental health workers about the role and importance of Advance Health Directives. – Simplifying storage and access of Advance Health Directives in the health service information systems and electronic health record. – Informing consumers about Advance Health Directives and their limitations. • **MHRT:** – The implementation of advocates and representatives in the Mental Health Review Tribunal[2] process. – Appointing assistants with expertise in the support of persons with an intellectual disability and people from Aboriginal and Torres Strait Islander backgrounds or culturally and linguistic diverse backgrounds.
Limiting factors	• **Independent Patient Rights Advisers:** – Lack of guidelines and direction to assist the development of the Independent Patient Rights Adviser role. – Lack of clarity regarding whether Independent Patient Rights Advisers provide advice or advocacy. • **Advance Health Directives:** – Lack of consumer accessible and appropriate Advance Health Directives forms and guidelines. • **Mental Health Review Tribunal:** – Lack of training for advocates and lawyers. – Lack of support for consumers in accessing the reports before the hearings. – Lack of legal support for consumers between hearings. – A focus on risk and consumers' past behaviour rather than current risk and behaviour.
Right to social protection	
Promoting factors	• **Rights in the ward and community:** Promoting information on the social security services that hospitalised consumers can access.

Rights[1] and domains	**Study focus areas: rights promoting and limiting factors[2]**
Limiting factors	• **Rights in the ward and community:** Lack of information and communication on social security when hospitalised.

Notes:

[1] The rights consist of the five themes reported in the *Quality Rights Toolkit. Assessing and improving quality and human rights in mental health and social care facilities*, which the World Health Organization (WHO) drew from the United Nations (UN) Convention of the Rights of Persons with Disabilities (CRPD) (WHO, 2012).

[2] The promoting and limiting factors are the findings of the Human Rights framework study by Giuntoli, Stewart, Wheeler, Gendera, Ryan, McAuliffe, Fisher (2019).