

Queensland Mental Health Act and Human Rights Project: Research summary

Research Project

The Queensland Mental Health Commission (the Commission) wanted to understand how the new Queensland Mental Health Act 2016 (the Act) protected the human rights of adults being treated involuntarily for mental illness.

They asked researchers from Griffith University, the University of New South Wales, and University of Sydney to investigate. The research team looked at two areas:

- people's experiences of being treated under the act, along with the views of their carers and families, as well as the views of service providers, experts and advocates;
- how the human rights protections in the Act compared to similar acts in other Australian States and Territories.

Their study investigated five areas:

- rights and information for inpatients within mental health wards;
- the role of Independent Patient Rights Advisers (IPRAs);
- Advance Health Directives (AHDs);
- the operation of the Mental Health Review Tribunal (MHRT);
- rights and information about involuntary treatment in the community.

Research Process

The research project took place in two parts between June 2017 and March 2019.

In part one the research team reviewed national and international academic research about human rights and involuntary treatment. They used a scoping approach, a research technique that explores topics that are complex or not well researched. Their search included research on health, law, medicine, human rights, and experiences of receiving healthcare, and helped them better understand the five study areas they were investigating.

They also interviewed six people with expertise in framing the Act to better understand Queenslanders' experience of mental health care compared with people around Australia.

In part two the research team added to their understanding and explored human rights protections across the five study areas using a further 32 interviews in Brisbane and Townsville, including:

- Ten people with lived experience of involuntary treatment under the Act and ;
- Five family members and carers of people with lived experience of involuntary treatment under the Act ;
- Seventeen service provider participants, including practitioners, experts, and mental health advocates.

The words they used to describe their experiences were analysed and compared to patients' rights listed in the Act, including the right to:

- be visited by the nominated support persons, family, carers and other support persons (Section 281);
- be visited by a health practitioner (Section 282);
- be visited by legal or other advisers (Section 283);

- communicate with other persons (Section 284);
- be given information about treatment and care (Section 285) and make sure they understand the information (Section 286);
- get a second opinion about their treatment and care (Section 290).

These words were also compared against the five themes used by the World Health Organisation to measure good quality healthcare, based on the United Nations Convention of the Rights of Persons with Disabilities for mental health and social care facilities. These five themes include a person's right to:

- social protection;
- health, including access to health care services and information;
- equal justice and presumption of capacity;
- autonomy, including freedom of movement, freedom from interference, and bodily integrity;
- family and community participation.

Overall these comparisons allowed the research team to take people's experiences in the interviews and make important conclusions about the quality of care and human rights protection for anyone being treated under the Act, even though only a relatively small number of people were interviewed. Further, when this research is published, the words of these people will join the national and international research and will potentially be studied the whole world over.

Research Conclusions

The research team combined all the experiences of the people they interviewed and divided what they said into two categories:

- changes in the Act that promoted and protected human rights;
- existing problems that the Act hadn't made any better.

In the first category, the main things that promoted and protected the human rights of patients, family and carers were changes introduced by the Act that gave more opportunities to act on specific rights as well as more safeguards to protect them.

These included:

- the right to health and access to health care services and information. This was done through the introduction of Independent Patient Rights Advisors, better treatment information, and access to a second opinion;
- the right to make your own choices, including freedom of movement and freedom from having things done to your body without permission. This was done by promoting Advance Health Directives, and compulsory information on restraining children and young people that mental health services had to provide to the Office of the Public Guardian;
- the right to family and community participation. This was done by acknowledging patients' rights to communicate with family and friends using different ways to communicate means, including using mobile phones;
- the right to equal justice and the assumption that you could make decisions about yourself and your care. This was done by adding representatives to support people in the Mental Health Review Tribunal.

In the second category, the things that got in the way of promoting and protecting human rights of patients, family and carers were recorded in two groups: problems that the Act didn't solve, and problems with making the Act work as it was intended because health services and health care providers were part of the problem.

In this first group the things that got in the way included:

- a lack of ways to make sure the 72-hour assessment period was followed;
- limited ways to challenge being secluded and restrained, particularly for people with both intellectual disability and mental illness;
- restrictions for people on forensic orders, specifically that their order could not be removed for up to ten years, which did not recognise their ability to recover with treatment;
- no requirement in the Act for mental health services to communicate to the Office of the Public Guardian when they restrain or seclude adults, as this requirement was only for children and young people;
- the lack of ways that advocates could question mental health services' medication use, especially for people on forensic orders;

In the second group the things that stopped the Act being properly used included:

- a long-standing culture, or accepted way of treating people, that assumed medical opinion and diagnosis was always more important than a person's individual experiences
- this same culture also being criticised for being more concerned with what might go wrong, rather than the ways people could direct their own recovery
- a lack of understanding of and training on the rights introduced by the Act, including those rights most valued by patients, including access to Independent Patient Right Advisors and Advance Health Directives, and using their mobile phone on the ward when there was no need to restrict its use;
- limited access for people with lived experience, family and carers to information about their rights, treatment, accessible services and social benefits, that was written in a way they could understand and which recognised their different language and cultural backgrounds;
- extended hospitalisation and detention for people who had both an intellectual disability and a mental illness, because disability services' shortages of places to help them back into the community;
- not enough money to employ Independent Patient Rights Advisors in the community and prisons, not just inpatient units.

In summary, the research has shown that despite shortcomings of both the new Act and current health practices, positive change is being achieved. Most importantly, by focussing on the experiences of people most impacted by the Act--consumers, their carers and family members--alongside experiences of people working within the mental health system, we begin to understand the complexity of making structural changes via legislation to modern mental health care. Further research will continue to illuminate that complexity as long as it remains grounded in the voices of vulnerable people seeking care and gives them opportunities to better define and direct what good quality healthcare looks like for them.

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