Queensland Mental Health Commission

REVIEW OF MENTAL HEALTH ACT 2000

Response of the Queensland Mental Health Commission to the request to identify areas of potential improvement in the *Mental Health Act 2000* (Qld)

Introduction

The Queensland Mental Health Commission (the Commission) was established on 1 July 2013 to provide independent leadership and advocacy in mental health, promote the best interests of people with mental illness, and drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.[1]

The Queensland government has announced a review of the *Mental Health Act 2000*. The purpose of the review is to identify and enact improvements in the Act, having regard to the experiences of stakeholders and those responsible for administering the Act since its inception. The Queensland Mental Health Commission offers this response to the first phase of the review.

Approach

The current review provides an opportunity to consider the *Mental Health Act 2000* in light of the national and international debate about the appropriate form and content of mental health legislation and the obligations that arise from Australia's ratification of the Convention on the Rights of Persons with Disabilities (CRPD).[2] CRPD perspectives encourage the inclusion of mechanisms that improve accountability and transparency; increase connections between institutional arrangements and the community; and enhance opportunities for supported decision making in the mental health context.

[1] *Queensland Mental Health Commission Act 2013*, s4 & s5.
[2] Adopted 13 December 2006, GA Res 61/106, UN Doc A/Res/61/106, entered into force 3 May 2008. Australia ratified the CRPD on 17 July 2008.

Queensland Government

The Commission identifies the following aspects of the *Mental Health Act 2000* that may benefit from review. In considering these issues, I am mindful that some may be addressed administratively rather than through legislative amendment. However, the protection of the rights of people with a mental illness who are being treated involuntarily is an important pillar in ensuring a fair and just society.

1. Improve the connection with the Convention on the Rights of Person with Disabilities

Alignment with the CRPD may be partially achieved by aligning the statutory principles in the *Mental Health Act 2000* with human rights standards.[3] The principles that currently guide the *Mental Health Act 2000* (s9) have some gaps and differ for instance from the principles in the *Forensic Disability Act 2011* (Qld).[4]

2. Strengthen recognition of Aboriginal and Torres Strait Islanders peoples

Other than a reference to cultural values in s8 (g), the Act is silent with respect to the Aboriginal and Torres Strait Islander cultural context in Queensland. The *Mental Health Statement of Rights and Responsibilities* states that Aboriginal and Torres Strait Island communities should have their distinctive rights respected in relation to status, culture and the land.[5] Opportunities to strengthen this aspect of the legislation should be considered.

3. Improve the articulation of patient rights and entitlements

In several jurisdictions in Australia the obligation to provide a statement of rights (s344 of the *Mental Health Act 2000*) is strengthened by the inclusion of a statement or charter of rights in the legislation.[6]

4. Improve the operation of the allied person scheme

Despite the active statutory function expressed in section 340, the Act ascribes a passive role to the allied person, with the exception of the entitlement to attend at Mental Health Review

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[3] See *Mental Health Statement of Rights and Responsibilities,* Safety and Quality Partnership Subcommittee of the Mental Health Standing Committee of the Standing Council on Health and endorsed by Australian Health Ministers, Commonwealth of Australia (2012). http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/8F44E16A905D0537CA257B330073084D/$File/rights.pdf

[4] *Forensic Disability Act* (2011) s7

[5] Above note 3 at [2f]. Consultations are currently underway for a renewed *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social emotional wellbeing (2004-2009)*. http://www.healthinfonet.ecu.edu.au/key-resources/conferences?cid=1406. See also the preamble to the *Constitution of Queensland 2001*. http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ConstofQA01.pdf

[6] See for example *Mental Health Act 2007* (NSW) s68 Principles for Care and Treatment; Schedule 3 – Statement of Rights; *Mental Health Bill 2012* (WA) s10 & s11; Schedule 1—Charter of Mental Health Care Principles; *Youth Justice Act 1992* (Queensland) Schedule 1- Charter of Youth Justice Principles.

Tribunal hearings (s 332). There is an opportunity to define the role of the allied person as a 'supported decision making' role in accordance with Article 12(3) of the CRPD.

5. Improve the recognition of the rights and interest of parents, families and carers

In the event that the 'allied person' is not the person's parent, family or carer, the Act currently makes no provision for the communication of information that may by relevant to those people or other people who may be connected with the person. For instance, consideration could be given to the grounds on which parents, families and carers and other interested persons may be entitled to receive notice when a patient is discharged, changes hospital or is re-admitted as an involuntary patient. This discussion may refer to the content of a statement of rights and complement victim specific legislation if appropriate.

6. Improve the operation of treatment decision and treatment plans

With respect to the medical treatment of involuntary patients, the *Mental Health Act 2000* places the treating psychiatrists in the role of a substituted decision maker. International standards are moving toward the requirement that substitute decision making regimes should be modified to 'respect the rights, will and preferences of the person' wherever possible.[7]

7. Recognise an obligation to attend to the person's general health care

There is currently no reference in the Act to the individual's personal, general and dental health care needs. Given the current understanding of the relatively poor general and dental health of many people with mental illness, consideration could be given to including these matters in treatment plans or as part of the obligation to undertake regular assessments of the person's health.

8. Recognise the special situation of children and young people

The *Mental Health Act 2000* applies uniformly to children under the age of 18 (minors) as well as adults.[8] This means it does not recognise the special vulnerabilities of children and young people, nor recognise the overarching obligations that apply to their treatment and care.[9] For example, new standards are emerging with respect to children, young people and ECT.[10]

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[7] Convention on the Rights of Persons with Disabilities, Article 12(4)
[8] *Mental Health Act 2000*, s1.
[9] *Mental Health Statement of Rights and Responsibilities (*2012), [25]-[33] above note 3.
[10] For example National Institute of Clinical Excellence (UK) does not recommend the use of ECT for children or young people between the ages of 5 and 11. http://www.nice.org.uk/nicemedia/live/10970/29860/29860.pdf *The Exposure Draft Mental Health Bill 2010* (Victoria) prohibits the use of ECT for children under 13. In their respective reviews WA has proposed a prohibition for children under 14, and the ACT has proposed a prohibition for children

9. Improve the regulation of restraint and seclusion

In their current form, the provisions in the Act that regulate the use of restraint and seclusion may be interpreted in such a way as to suggest that such measures may be used as a matter of routine.[11] The use of restraint and seclusion is widely regarded as antithetical to recovery based approaches in mental health. Comprehensive safeguards and oversight measures are required for the use of these measures.

10. The right to legal representation

Part 4 of the *Mental Health Act 2000* provides that a person may be represented at the hearing by a lawyer, but requires leave of the Tribunal to be represented by another person or an agent, other than the allied person who is entitled to attend (s 332). The principles of support and participation enshrined in the CRPD indicate that, within reasonable limits, additional or alternative support should be provided to enable individuals to participate fully in Mental Health Tribunal proceedings.[12]

Finally, the Commission understands that the Act is unique in Australia in its inclusion of both of civil and criminal pathways to mental health treatment and care in one piece of legislation. In the Commission's view a comprehensive evaluation of the health and justice outcomes for individuals who are subject to the *Mental Health Act 2000*, particularly with respect to the diversion of individuals with minor criminal offences, is warranted. A number of individuals have raised the issue that too many people who accept they have committed minor offences are appearing before the Mental Health Court when the individuals themselves would prefer that the matter was dealt with in the normal course of events.

I look forward to providing further comment when the consultation paper is completed.

Dr Lesley van Schoubroeck

Mental Health Commissioner
Queensland Mental Health Commission
31 July 2013

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under 12 years. See Review *of the NSW Mental Health Act 2007,* Report for NSW Parliament Summary of Consultation Feedback and Advice, NSW Ministry of Health, May 2013, 78.

[11] See also sections 169N with respect to transport

[12] Terry Carney, David Tait, Julia Perry, Alikki Vernon and Fleur Beaupert, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?* Federation Press, 2011.