Queensland Mental Health Commission

Submission to the Department of Health

Review of the *Mental Health Act 2000*

Queensland Government

THIS PAGE IS INTENTIONALLY LEFT BLANK.

Preface

This submission provides comment and specific recommendations in response to proposals made as part of the Queensland Government's review of the *Mental Health Act 2000* (the Act).

Legislation alone cannot improve the effectiveness and accessibility of services or change cultures within services. Effective mental health legislation can, however, establish a binding framework for a mental health system that protects and promotes rights and supports recovery of people with mental illness.

The Commission's submission does not seek to comment on every recommendation made by the review. Rather we address those proposals which have been subject to considerable discussion at forums and represent the most significant change in mental health legislation in Queensland. Our approach to the review is to apply human-rights recovery focused perspectives based on international instruments relevant to Australia, quality standards and nationally accepted policies for treatment in mental health services.

We support the proposal to replace the current Act with new legislation based on contemporary clinical standards and evidence. The Commission also supports efforts to reduce red tape by streamlining administrative processes in the legislation particularly where proposals ultimately benefit patients and maintain the system's transparency and accountability.

For these reasons, we recommend a staged approach to enacting the proposed amendments into legislation and a process of monitoring and evaluation to ensure that the amended provisions are working as intended.

The focus in our submission is on those matters which we believe require further consideration prior to drafting.

Finally, I urge the Department of Health if this has not already been done, to consider the costs of the proposals in detail, particularly as they relate to the protection of human rights. During our consultations over the last 12 months with community and professional groups, it is apparent that many people who work in publicly funded mental health services as well as people who rely on the mental health system for services and support perceive a diversion of resources from early intervention and outreach to crisis services in the broader health system.

Many of the proposals in this consultation paper are to be commended as they seek to protect the rights and promote the recovery of some of our most vulnerable people but it would be most unfortunate if they were not adequately funded or if they were funded at the expense of other mental health services.

Dr Lesley van Schoubroeck
Mental Health Commissioner
25 July 2014

Contents

Summary of recommendations

The Act's objects and principles	1. Expand the new Act's objectives to recognise the importance of, and facilitating, the involvement of the patient and their families, carers and other support persons in all decisions made under the Act. 2. Embed principles of supported decision making and least restrictive practices in the Act. 3. Ensure the proposed principles are appropriately embedded in the operational provisions of the Act.
Involuntary Examination Authorities	4. Implementation of the new provisions regarding Involuntary Examination Authorities are generally supported as a transition solution with a view to removing the involvement of specially trained Justices of the Peace from this process in the future and promoting access to services in other ways such as through general practitioners. 5. The following issues must be addressed appropriately prior to implementation: a. clarification to be provided about the type and frequency of training and support to be provided to Justices of the Peace and how this will be monitored on an on-going basis b. the practical effect of requiring applicants and some issuing authorities to receive clinical advice must be addressed including the proposed process for receiving and documenting this advice and the resourcing implications. 6. Undertake systemic monitoring of these provisions to identify opportunities to phase out the involvement of Justices of the Peace while addressing issues related to access.
Strengthening the provisions in the Act regarding families, carers and other support persons	7. Include provision, with appropriate safeguards, for family and significant others to have a right to certain information such as whether or not a person is detained or on Limited Community Release where it is necessary to ensure their personal safety or the safety of another person. 8. Ensure the right to receive information includes the requirement that information is communicated in a way that is easily understood by patients taking into account their unique circumstances. 9. Include safeguards so that the information provided to the patients does not have a detrimental effect on their mental health.
Treatment criteria and capacity	10. Include as part of the treatment criteria the requirement that there must be no less restrictive way to provide the treatment or care available. 11. Clearly articulate that all people are presumed to have the capacity to

	make decisions about their treatment and care in the Act. 12. Strengthen legislative provisions, opportunities and mechanisms for supported decision making in the Act that require appropriate support to be provided when determining capacity. 13. Require clinicians to have regard to advance mental health directives, enduring powers of attorney and other legally binding decision making authorities especially when emergency treatment decisions are being made. 14. Require clinicians to clearly document their reasons for continuing an Involuntary Treatment Order in the presence of capacity. Any decision on longitudinal and/or fluctuating capacity needs to be justified in the context of rights based, recovery orientated, supported decision making.
Allied person scheme	15. Maintain the Allied Person role as a right but not a requirement providing patients with the option of nominating a person of their choice to help them present their views and wishes. 16. Clarify the Allied Person role in working with and complementing other support functions (including the proposed Independent Patient Companion) with the rights and responsibilities of this role clearly articulated throughout the operational provisions. 17. Address key systemic issues currently associated with the Allied Person role including lack of information, awareness, training and support.
Independent Patient Companion	18. Staff, both clinical and peer support workers, in authorised mental health services should be resourced and supported to continue to meet their obligations in respect of providing information and support to patients. 19. A model of independent oversight of patient rights in mental health facilities that complements existing structures should be developed, legislated and resourced.
Legal representation at Mental Health Review Tribunal hearings	20. Review the circumstances in which it is proposed to provide legal representation at no cost for patients before the Mental Health Review Tribunal to operate as a further safeguard in special circumstances, including but not limited to: a. where an existing Involuntary Treatment Order has been upheld by a psychiatrist notwithstanding the individual appears to have regained the capacity to consent and make decisions about their treatment and care b. the use of electronic devices for patients on Involuntary Treatment Orders and Forensic Orders c. reviews of long-term Forensic or Involuntary Treatment Orders.

Frequency of reviews by the Mental Health Review Tribunal	21. Consider introducing early and more frequent automatic reviews in line with contemporary standards and other jurisdictions. 22. Consider shorter review timeframes for children and young people, with no more than 3 weeks before their first review.
Children and young people	23. Ensure separate accommodation is provided and clarify appropriate safeguards to be implemented when it is not available. 24. Continue Mental Health Review Tribunal oversight of children and young people in high secure units.
Cultural recognition, capability and practices	25. Undertake further consultation with Aboriginal and Torres Strait Islander leaders to review the adequacy of current proposals to take account of culture and custom in the legislation. 26. Undertake further consultation with ethnic community leaders to review the adequacy of current proposals to take account of culture, religion and custom in the legislation.
People with mental illness in the justice system	27. A specially constituted Mental Health Review Tribunal should be established in legislation to review those cases requiring forensic mental health expertise. 28. Ensure that the removal of the Special Notification Forensic Patient category does not remove or reduce safeguards currently in place in relation to people with a mental illness who have committed a serious offence.
General recommendations and comments	29. Replace the *Mental Health Act 2000* with a new Act consistent with a person-centred recovery oriented approach, with amendments to the existing Act to be enacted while further consideration is given to more complex provisions proposals. 30. Continue ongoing consultation with patients, families, carers and other support persons to refine the proposals under the Act and in developing policies and guidelines that govern the new Act's implementation. Other significantly impacted people, including victims and their families, should be consulted on relevant provisions. 31. Facilitate on-going monitoring and review of the new Act and its implementation.

1. Introduction

1.1. Contemporary mental health legislation

Contemporary mental health legislation is intended to provide an overarching framework for a modern system that incorporates both human rights and recovery perspectives. This approach acknowledges that mental health difficulties occur in a broader personal and social context and individual wellbeing is linked to family, carer, community and social support. It also recognises the importance of minimising the effects of discrimination, stigma and the impact of routine intrusions on the rights of persons with mental illness through embedding contemporary evidence and standards of treatment and care.

Australia is a signatory to a number of binding international instruments relating to voluntary or involuntary treatment and care of vulnerable people. The obligations set out in these instruments have been incorporated into the Australian Mental Health Statement of Rights and Responsibilities 2012 which states that mental health legislation should comply with international human rights principles, be capacity based and recognise advance statements[1].

The statement declares that:

> *Mental health patients have the right to access assessment, support, care, treatment, rehabilitation and services that facilitate or support recovery and wellbeing on an equal basis with others. They are entitled to participate in all decisions that affect them, to receive high-quality services, to receive appropriate treatment, including appropriate treatment for physical or general health needs, and to benefit from special safeguards if involuntary assessment, treatment or rehabilitation is imposed*[2].

The United Nations Convention on the Rights of Persons with Disabilities encourages the inclusion of mechanisms that increase accountability and transparency, improve connections between institutional arrangements and the community, and enhance opportunities for supported decision making in the mental health context. The convention also provides guidance in relation to involuntary treatment stating that it should be allowed only as a last resort and subject to safeguards.

There is a close connection between these human rights principles and recovery oriented practice in mental health service systems.

The Australian Health Ministers' Advisory Council published *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers* (the Guide)[3]. The Guide requires that proposed treatment and care should be discussed with the person who is receiving care whenever possible and that the person should be involved in treatment decisions and planning to the greatest extent possible.

---

[1] Safety and Quality Partnership Subcommittee, Mental Health Standing Committee, Standing Council on Health, Commonwealth of Australia, *Mental Health Statement of Rights and Responsibilities* (2012) http://www.health.gov.au
[2] Ibid.
[3] Australian Health Ministers' Advisory Council, Commonwealth of Australia, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers* (2013). See also 'A national framework for recovery-oriented mental health services; policy and theory (AHMAC 2013)

1.2. People impacted by mental health legislation

In Queensland an estimated one in five people will experience mental illness in any given year. The Act impacts specifically on a small proportion of these people who are often amongst the most vulnerable and disadvantaged people in our community and also influences the wider culture of mental health services in Queensland.

In 2012-2013, 7,893 people were subject to involuntary assessments under the Act, 62 per cent of whom were then placed on an Involuntary Treatment Order. As at 30 June 2013 there were 4,400 people receiving treatment involuntarily under the Act as follows[4]:

- 3,638 on Involuntary Treatment Orders
- 28 as Classified Patients
- 596 people on Forensic Orders
- 138 people on Forensic Orders as Special Notification Forensic Patients.

In addition, 10,648 people were subject to an Emergency Examination Orders and 1,039 people were subject to a Justice Examination Order, some of whom were subsequently assessed as requiring involuntary treatment.

In formulating this response, the Commission deliberately sought to speak to people with direct experience of the current legislation, including patients, families and carers, as well as service providers and other key stakeholders including mental health clinicians and lawyers working directly with people being treated under the Act.

We engaged Dr Penelope Weller, a Senior Lecturer from the Royal Melbourne Institute of Technology who specialises in human rights law, to provide advice on mental health legislation and to facilitate a number of stakeholder forums throughout the State.

The forums sought to improve understanding of some of the complexities of Queensland's Act and provided an opportunity for stakeholders to ask questions to support personal submissions and to inform our submission.

Over 150 stakeholders attended seven forums held in Brisbane, Cairns and Toowoomba. Dr Weller's presentation and some initial responses to the recommendations were also published on the Commission's website as a resource for interested people[5].

There was a diversity of views and opinions regarding proposals to amend the Act. Not all matters raised can be appropriately addressed in mental health legislation and not all views raised are included in our submission.

[4] Annual Report of the Director of Mental Health 2012-2013.
[5] Available on the Commission's website at http://www.qmhc.qld.gov.au/work/research/legislative-reviews/.

The Commission also sought the views of the Queensland Mental Health and Drug Advisory Council to inform this submission. At their most recent meeting on 21 July 2014, members requested that the Commission focus on the following issues as part of our response:

- embedding a patient centred and recovery oriented approach and the importance of families, carers and other support persons in the object, principles and throughout the legislation
- maintenance of the Allied Person role as a right not a requirement and ensuring independence of the Independent Patient Companion
- that review time frames for the Mental Health Review Tribunal be commensurate with best practice in other jurisdictions, with specific consideration given to shorter review times for children and young people
- ensuring implementation is appropriately resourced and an early process for external review is established
- the importance of maintaining an approach to the legislation that is about treating people with mental illness, whether or not they subject to an Involuntary Treatment Order or a Forensic Order.

They also noted that while mental health legislation may not be the appropriate tool to ensure the physical health of patients, supporting practices, policies and guidelines should address this issue. While the Act and the review's recommendations address patient safety, other actions are needed to protect those most vulnerable when they are receiving treatment in in-patient facilities.

The recommendations in this submission are grounded in these consultations and expert advice.

2. Objects and principles

2.1. The Act's objects

The review recommends that the new Act's objects are:

- to maintain the health and wellbeing of people with mental illness who do not have capacity to consent to treatment
- to enable persons to be diverted from the criminal justice system
- to protect the community if those persons are at risk of harming others.

The review proposes that these objects will be achieved by safeguarding the rights of people, ensuring that rights and liberties are affected in an adverse way only where there is no less restrictive way to protect the health and safety of the person or other people, and by promoting recovery and the ability to live in the community without the need for involuntary treatment and care[6].

[6] Queensland Health, *Review of Mental Health Act 2000,* Recommendation 21.1.

The Commission supports the proposed objects as they improve the alignment of Queensland's legislation with national mental health policy.

However, the statutory objectives in mental health legislation elsewhere in Australia also include specific recognition of the need to facilitate the involvement of the person who has a mental illness and the involvement of families, carers, and other support persons in the consideration of options for treatment and care[7].

Given the critical role played by families, carers and other support persons in the treatment, care and recovery of people experiencing mental illness the Commission recommends that they are specifically included in the objects of the new Act.

2.2. The Act's General Principles

The review does not recommend changing the current Act's general principles which include that:

- to the greatest extent practicable, a person is to be encouraged to take part in making decisions affecting their lives, especially decisions about treatment
- to the greatest extent practicable, in making a decision about a person, the person's views and the effect on his or her family or carers are to be taken into account
- a person is presumed to have capacity to make decisions about their assessment, treatment and choosing an Allied Person[8].

The review makes a number of recommendations regarding principles related to the important role played by families, carers and other support persons in a patient's recovery and the unique needs of Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds. These are discussed further in our submission.

The Commission believes that the Act's General Principles require strengthening to acknowledge the need to adopt a supported decision making model wherever possible and to implement a least restrictive practices model of treatment in line with the 2012 National Report Card on Mental Health and Suicide Prevention recommendation to reduce the use of involuntary practices and work to eliminate seclusion and restraint.

Further, to give the Act's General Principles and other principles greater effect, the principles must be embedded in the new Act's operational provisions.

[7] *Mental Health Bill 2013* (WA), s3; *Mental Health Act 2014* (Vic), s11(1).
[8] *Mental Health Act 2000*, section 8

The Act's objects and principles

1. Expand the new Act's objectives to recognise the importance of, and facilitating, the involvement of the patient and their families, carers and other support persons in all decisions made under the Act.
2. Embed principles of supported decision making and least restrictive practices in the Act.
3. Ensure the proposed principles are appropriately embedded in the operational provisions of the Act.

3. Involuntary examination authorities

Under the current Act, an individual can apply to a Magistrate or Justice of the Peace for a Justice Examination Order requesting that another person be subject to an involuntary assessment of their mental health status in non-urgent situations[9].

In most jurisdictions in Australia, assessment and entry to the mental health system relies on clinical expertise. Queensland is the only jurisdiction with this arrangement in place, which we understand was intended to provide an important point of access for people to make such a request particularly in regional, rural and remote communities. This mechanism has, however, been criticised for permitting unwarranted intrusions in the lives of individuals in the community. Some people advised the Commission that a Justice Examination Order had been used for malicious reasons and caused significant distress.

Data from 2012-13 supports the view that these provisions are not working as intended or may be likely to have an unintended negative impact on individuals who are subject to an unwarranted Justice Examination Order. In 2012-13, Justices of the Peace issued 95 per cent of the 1,039 total number of Justice Examination Orders issued. Only 25 per cent of individuals were subsequently admitted involuntarily for mental health treatment[10].

It is noted however that for the same period approximately 40 per cent of those people who did not meet the assessment criteria voluntarily accepted mental health services (either in-patient or outpatient) within the following 14 days[11]. This suggests that while some people may not meet the criteria for involuntary assessment and treatment, in many instances there is still a need for some form of treatment and the Justice Examination Order provisions may provide a means to access services.

On the other hand, a number of stakeholders advised the Commission that currently the only way they could get treatment for their family member, friend or colleague was through an order issued by a Magistrate or Justice of the Peace. This was due in part to practices adopted by individual authorised mental health services.

---

[9] Information about Justice Examination Orders, Queensland Government/Queensland Health www.health.qld.gov.au (accessed to 24/5/2014)
[10] Annual Report of the Director of Mental Health 2012-2013.
[11] Information about Justice Examination Orders, Queensland Government/Queensland Health www.health.qld.gov.au (accessed to 24/5/2014)
[11] Department of Health Data

To address some of these issues the review proposes that the Justice Examination Order be replaced with an Involuntary Examination Authority[12]. Significant changes to the process for involuntary examination include:

- the new order may only be issued by Magistrates or specially trained Justices of the Peace
- the grounds for seeking an order are defined including consideration of whether attempts to encourage the person to seek voluntary treatment have failed and there is a risk of harm to the person or another person, or serious mental or physical deterioration
- the criteria for issuing the authority are to be more limited
- applicants and those who grant an Involuntary Examination Authority will be required to seek clinical advice before making or granting an application.

Further, the review proposes a number of additional safeguards in relation to Involuntary Examination Authorities including provisions which will enable the Director of Mental Health to recommend that action, such as referring a matter to the Crime and Corruption Commission[13], be taken against a person for making a misleading application.

Some forum participants expressed concern that the new proposals are unnecessarily complicated and will further limit access to mental health services in the community. Concerns were raised that people may not have access to timely, clinical advice before they make an application for an involuntary examination authority. Further, some indicated that the new criteria removed their ability to seek assessment of their family member, friend or colleague in a timely manner before they become acutely unwell.

Others welcomed the review's proposals as a way to reduce the number of unnecessary involuntary examinations but expressed concerns about the capacity of the system to ensure Justices of the Peace are trained appropriately and on an ongoing basis.

The Commission accepts that at this stage, to maintain access to assessment and treatment in some parts of the State, it is necessary to continue a mechanism that authorises Magistrates and specially trained Justices of the Peace to make orders for involuntary examinations. However, the use of these provisions should be monitored and action taken to reduce the reliance on the use of Justices of the Peace as a way of entering the mental health system.

[12] Queensland Health, *Review of Mental Health Act 2000*, Recommendation 1.1
[13] Queensland Health, *Review of Mental Health Act 2000* Background Papers 1, 11

Involuntary Examination Authorities

4. Implementation of the new provisions regarding Involuntary Examination Authorities are generally supported as a transition solution with a view to removing the involvement of specially trained Justices of the Peace from this process in the future and promoting access to services in other ways such as through general practitioners.

5. The following issues must be addressed appropriately prior to implementation:

    a. clarification to be provided about the type and frequency of training and support to be provided to Justices of the Peace and how this will be monitored on an on-going basis
    b. the practical effect of requiring applicants and some issuing authorities to receive clinical advice must be addressed including the proposed process for receiving and documenting this advice and the resourcing implications.

6. Undertake systemic monitoring of these provisions to identify opportunities to phase out the involvement of Justices of the Peace while addressing issues related to access.

4. Emergency transport provisions

Under the current Act, police and ambulance officers are authorised to apprehend and transport individuals if they reasonably believe that the person:

- has a mental illness
- is at imminent risk of significant physical harm to themselves or another person
- proceeding under other options would cause dangerous delay and significantly increase the risk of harm to the person or another person
- should be taken to an authorised mental health service for examination to decide whether a request for assessment should be made for the person[14].

The review proposes a change to these criteria to allow a police or ambulance officer to detain and transport a person to a place where they may receive treatment and care including a public sector hospital, their home or another place[15]. Detention at a service or facility would be for up to six hours in the first instance with an authorised doctor able to authorise an additional six hours of detention[16].

The revisions also propose to expand the current criteria to include individuals who appear to have a serious mental impairment as a result of the effects of drugs or alcohol, if there is an imminent risk of the person causing harm to him or herself, and they require urgent treatment or care.

[14] *Mental Health Act 2000* s33
[15] Queensland Health, *Review of Mental Health Act 2000*, Recommendation 1.12
[16] Ibid, Recommendation 1.13

The purpose of the emergency transport provisions should be to ensure that people are safe and receive appropriate treatment and care. The inclusion of mental impairment due to the effects of drug and alcohol is a welcome addition and may result in more people with dual diagnoses accessing treatment and care when needed. The Commission notes that some people under the influence of drugs or alcohol and who may appear to have a mental impairment will not necessarily have a mental illness and this will require an appropriate response.

To ensure that patient safety is maintained at all times and that appropriate places for treatment and care are available, the Commission suggests that implementation of the new provisions are closely monitored.

5. Strengthening the provisions regarding families, carers and other support persons

5.1. Principles

Currently the Act refers to family and carers in section 8(1)(b) stating that 'to the greatest extent practicable in making a decision about a person the person's views and the effects on his or her family, or carers are to be taken into account.'

The review proposes to strengthen the principles recognising the important role of family, carers and other support persons in the patient's treatment and recovery in line with the Australian Mental Health Statement of Rights and Responsibilities (2012).

The Commission heard from some individuals that it is not always appropriate to involve family members or others in treatment or other decisions depending on their relationship with the patient. Conversely, some family members indicated there were some instances where they required information, particularly for safety reasons, against the wishes of the patient.

The Commission understands that this is a complex issue requiring consideration of competing views and priorities, and recognises that there are some provisions that seek to regulate these issues. The Commission acknowledges the importance of protecting the right of patients to privacy and to determine who receives information about their treatment. We also understand that there are some occasions that will arise where family members and others should receive limited information in a timely manner.

To identify and address opportunities to improve any current processes regulating the provision of information, patients, families, carers and other support persons need to be included in development of guidelines for applying the proposed provisions.

5.2. Patient rights including the right to be visited and communicate

The review proposes that patient rights, including the right be visited and to receive and send communication, should be better protected under the Act. This recommendation accords generally with human rights and recovery oriented principles and practice.

Currently, the legislation requires that patients are given an information statement about their rights, including the right to make a complaint[17]. This statement of patient rights is prepared by the Director of Mental Health. The Act requires that oral explanation of the information is provided,[18] including in a language that the person is able to understand[19].

The Act also authorises the mental health service to refuse a visit from a person if satisfied that the proposed visit will 'adversely affect the patient's treatment and care'. If a visitor is refused the administrator must give written notice to the person, including the reasons for the refusal, and detail the person's right to appeal to the Mental Health Review Tribunal and how this can be done[20]. Otherwise the current Act is silent on the right to communicate.

The review has proposed to include a specific statement that involuntary patients in authorised mental health services the right to:

- be visited by family, carers and other support persons at any reasonable time, unless the person is expressly excluded by the Act, and
- send or receive correspondence, phone calls and electronic messages from individuals, unless contact with the person is expressly excluded under the Act[21].

In some jurisdictions, a statement of rights is enshrined within the legislation and some stakeholders were of the view that this provided an important safeguard.

The Commission supports all efforts to strengthen protection of the rights and interests of this vulnerable group of people. This will require a commitment to ongoing consultation with patients, families, carers and other support persons to identify opportunities to support implementation of the proposed changes.

Strengthening the provisions in the Act regarding families, carers and other support persons

7. Include provision, with appropriate safeguards, for family and significant others to have a right to certain information such as whether or not a person is detained or on Limited Community Release where it is necessary to ensure their personal safety or the safety of another person.
8. Ensure the right to receive information includes the requirement that information is communicated in a way that is easily understood by patients taking into account their unique circumstances.
9. Include safeguards so that the information provided to the patients does not have a detrimental effect on their mental health.

[17] *Mental Health Act 2000* s344.
[18] Ibid s345
[19] Ibid s541A.
[20] Ibid s374.
[21] Queensland Health, *Review of Mental Health Act 2000*, Recommendation 7.4.

6. Regional, rural and remote issues

There are a number of significant barriers to accessing mental health services in regional, rural and remote Queensland. Evidence strongly suggests that a person's recovery is improved if they are accessing services as close to home as is safe and remaining close to family and friends.

Many who attended the forum in Toowoomba indicated that accessing acute mental health services was a significant challenge for those not living in urban or regional centres.

The review proposes a number of measures that will improve access to mental health services for those living in rural and remote areas including:

- enabling the Director of Mental Health to approve authorised mental health services with conditions or limitations to enable small rural or remote health facilities to provide a limited range of in-patient treatment for involuntary patients[22]
- removing the blanket restriction on the use of audio-visual facilities for assessments[23]
- clarifying that community treatment can be provided at any clinically-appropriate place determined by the relevant clinician such as an authorised mental health service, a community mental health service, a primary healthcare centre or another place such as the person's home[24]

The Commission commends the review's recommendations to support the use of Telehealth and enable people with mental illness to receive treatment as close to home as is safe.

7. Treatment criteria and capacity

The review proposes new treatment criteria which must be met before a person can be placed on an Involuntary Treatment Order. The new proposed criteria are that:

- the person has a mental illness
- the person lacks the capacity to consent to be treated for the illness
- because of the person's illness, the absence of involuntary treatment (or continued voluntary treatment) is likely to result in:
    - imminent serious harm to himself, herself or someone else, or
    - the person suffering serious mental or physical deterioration[25].

The proposed treatment criteria differ from those in the current Act by not including the requirement that there is 'no less restrictive way of ensuring the person receives appropriate treatment for the illness[26].'

[22] Ibid, Recommendation 16.1.
[23] Ibid, Recommendation 16.2
[24] Queensland Health, *Review of Mental Health Act 2000*, Recommendation 16.4.
[25] Ibid, Recommendation 1.17

The principle of least restrictive practices is proposed to be highlighted in the principles of the Act, however the Commission affirms its position that it is essential that principles are embedded in operational provisions. The other significant issue in the Act relates to a person's lack of capacity to consent to treatment and how this is assessed. Those consulted indicated that the capacity to consent is a subjective test and the assessment of capacity may be influenced by when and how information is communicated to a patient and whether they are supported.

In accordance with a range of human rights-based obligations to which Australia is a signatory, substituted decision-making regimes should be replaced with supported decision-making mechanisms as far as possible. In the context of mental health legislation this could be given effect by including consideration of whether a person who is deemed not to have the capacity would have the capacity to consent if and when appropriately supported.

The Commission also notes a significant change regarding the capacity of individuals who are already subject to an Involuntary Treatment Order. The review proposes that an authorised psychiatrist may maintain a person on the order, notwithstanding that the person appears to have capacity to consent to their treatment, if the psychiatrist reasonably believes that revoking the order is likely to result in the person:

- causing harm to himself, herself or someone else, or
- suffering serious mental or physical deterioration.[27]

These recommendations seek to address a situation where a person has become well and wishes to discontinue treatment against the recommendations of the treating team. From a rights-based perspective, treatment decisions by individuals with capacity must be respected at all times. Further, empowering individuals to make decisions about their treatment and care promotes recovery. However, the issue of longitudinal and/or fluctuating capacity needs to be seen in the context of rights-based, recovery orientated and supported decision making. Therefore the proposal to allow treating psychiatrists to override the patient's treatment decisions when they have capacity requires further consideration and strict oversight if implemented.

There is also scope to further define what regard treating teams should have to advance health directives. The Commission notes that the review's proposals regarding the role of the new Independent Patient Companion include advising patients of the advantages of having an advance health directive however there is no explicit obligation or guidelines about their use.

[26] *Mental Health Act 2000*, section 14(1)(e)
[27] Queensland Health, *Review of Mental Health Act 2000,* Recommendation 1.19

Treatment criteria and capacity

10. Include as part of the treatment criteria the requirement that there must be no less restrictive way to provide the treatment or care available.

11. Clearly articulate that all people are presumed to have the capacity to make decisions about their treatment and care in the Act.

12. Strengthen legislative provisions, opportunities and mechanisms for supported decision making in the Act that require appropriate support to be provided when determining capacity.

13. Require clinicians to have regard to advance mental health directives, enduring powers of attorney and other legally binding decision making authorities especially when emergency treatment decisions are being made.

14. Require clinicians to clearly document their reasons for continuing an Involuntary Treatment Order in the presence of capacity. Any decision on longitudinal and/or fluctuating capacity needs to be justified in the context of rights based, recovery orientated, supported decision making.

8. Rights protection and support

8.1. Allied Persons

Currently, the function of the Allied Person is 'to help the patient to represent the patient's views and wishes and interests relating to the patients assessment, detention and treatment and care under the Act'[28]. The Allied Person is also able to receive notices about a person's treatment and reviews of their orders and can represent the patient at Mental Health Review Tribunal hearings.

The current Act makes it a requirement for a patient to appoint an Allied Person, however in the event that they are unable to, one is appointed for them. In most cases, a person's Allied Person is a family member or carer. The proportion of patients with Allied Persons appointed in Queensland is considered low.

The aim of the Allied Person role is to address the vulnerability and isolation experienced by many involuntary patients. Similar roles are recognised in Western Australia, Victoria and Scotland[29]. Defining this role in legislation is thought to be a more effective strategy than informal or in principle measures to promote the participation of family, carers and other support persons. When the role works well, the Allied Person provides a point of contact and liaison between the treating team and the family, carer or support person. The Allied Person may also complement the role of family who may provide perspectives that are at odds with the views of the patient.

[28] *Mental Health Act 2000* s340
[29] The Mental Health (Care and Treatment Act) 2003 (Scotland) establishes 'named persons' to protect the rights and interests of individuals with mental illness. The Mental Health Act 2014 (Victoria) and Mental Health Bill 2013 (Western Australia) establishes 'nominated persons'.

Evaluation of a similar role in Scotland found that when the role operates effectively, it provides a distinct and separate voice for the patient, upholds the patient's best interests and provides ongoing support. The Scottish report noted that people fulfilling the role required confidence, time, information, advice and support[30].

Research in Australia has demonstrated that 'continuing advocacy' can improve outcomes for involuntary patients, including reductions in the duration of admissions, reductions in re-admissions and improved health and wellbeing[31].

Participants in the forums were strongly in favour of retaining the Allied Person role perhaps in a modified form particularly to support patients to express their wishes regarding treatment. Of particular importance was that the Allied Person was a person of the patient's choice.

However, there was general consensus that the Allied Person scheme is currently not working as intended and requires attention going forward. A range of issues were identified at forums, including:

- that the Allied Persons have not been trained or provided with information regarding their role and therefore could not properly fulfil it
- the difficulties for family members and carers who have been appointed as Allied Persons to undertake the role when they did not agree with the patient's views and could therefore not genuinely advocate their position
- instances of refusal of clinicians and hospitals to involve other family members or carers in a patient's treatment on the basis that they are not an Allied Person.

The Commission is of the view that the Allied Person role is an important mechanism giving patients the opportunity to nominate someone to advocate on their behalf and present their wishes to the treating team. It is especially important for patients with long term persistent mental illness. It plays an important and distinctive role in maintaining the dignity of individual choice and empowering patients to participate in decisions regarding their treatment and in turn supporting their individual recovery. It should be used to complement other proposed functions and roles.

[30] Scottish Government 2009
[31] Rosenman, S. et al.(2000) 'Efficacy of Continuing Advocacy in Involuntary Treatment' 51 *Psychiatric Services* 1029-33.

Allied person scheme

15. Maintain the Allied Person role as a right but not a requirement providing patients with the option of nominating a person of their choice to help them present their views and wishes.

16. Clarify the Allied Person role in working with and complementing other support functions (including the proposed Independent Patient Companion) with the rights and responsibilities of this role clearly articulated throughout the operational provisions.

17. Address key systemic issues currently associated with the Allied Person role including lack of information, awareness, training and support.

8.2. Independent Patient Companion

The Commission supports the intent to improve support and representation for patients of the mental health system. The model implemented must address systemic issues that have been identified and provide meaningful support to involuntary patients.

The review proposes that the Independent Patient Companion will:

- advise patients, families, carers and other support persons about the patient's rights and responsibilities
- assist patients, family, carers and other support persons to constructively engage in treatment
- advise patients, families, carers and other support persons about Mental Health Review Tribunal proceedings
- provide support in Mental Health Review Tribunal hearings
- identify whether or the person has a personal guardian or attorney
- advise patients about advance health directives or enduring powers of attorney.

The role does not explicitly include a role in assisting patients to express their wishes.

The review proposes that an Independent Patient Companion is appointed in each authorised mental health service and employed or funded by that service.

There are three important considerations in addressing this recommendation.

Firstly, the Commission is cognisant of international expectations of the United Nation Optional Protocol on the Convention on Torture which requires jurisdictions to provide external oversight of all places where people are deprived of their liberty such as prisons, immigration detention facilities and

psychiatric hospitals[32]. In Queensland, independent oversight of prisons is vested in the Chief Inspector of Corrections which is appointed by and reports directly to the Commissioner for Corrective Services although this has been criticised by the Anti-discrimination Commission as not being sufficiently independent.[33]

Secondly, Community Visitors in the Office of the Public Guardian have a role in oversighting conditions in mental health facilities. Links with this function need to be considered.

Thirdly, the proposed functions of the Independent Patient Companion are an integral role of staff in the mental health facilities who are in daily contact with patients. It would appear counterproductive if this role was created in another part of the health service. The Commission is supportive of additional support for both clinicians and peer support workers in mental health services to carry out most, if not all, of the functions proposed for the Independent Patient Companion. Support should include the provision of state-wide resources to assist services provide information to patients, their families and carers.

Whatever the final form of the role, improving the ability of mental health services to respond to patients, families and carers, improving access to the Mental Health Review Tribunal and educating patients about advance health care directives and enduring powers of attorney is likely to make a positive contribution to the delivery of mental health services in Queensland.

In addition, a form of external oversight to ensure rights are protected and that complements the existing Community Visitors program is essential.

Independent Patient Companion

18. Staff, both clinical and peer support workers, in authorised mental health services should be resourced and supported to continue to meet their obligations in respect of providing information and support to patients.

19. A model of independent oversight of patient rights in mental health facilities that complements existing structures should be developed, legislated and resourced.

8.3. Legal representation at Mental Health Review Tribunal hearings

The review has made a number of recommendations aimed at improving the operation of the Mental Health Review Tribunal.

Currently, patients have the right to be represented by a lawyer or, with leave of the Mental Health Review Tribunal, an agent. Queensland rates of legal representation before such tribunals or review panels are amongst the lowest in the country.

[32] Australian Human Rights Commission, 2012, Consideration of Australia's ratification of the Optional Protocol to the Convention against Torture. https://www.humanrights.gov.au/consideration-australia-s-ratification-optional-protocol-convention-against-torture

[33] http://www.adcq.qld.gov.au/human-rights/women-in-prison-report/women-in-prison-contents/accountability#Link3

In 2012-2013, 28 per cent of patients on Involuntary Treatment Orders and 40 per cent of Forensic Order patients attended Tribunal hearings. However, only two per cent were legally represented at Tribunal hearings[34]. This is lower than other jurisdictions. Despite differences in their mandates, broad comparisons can be made. For instance:

- In Northern Territory all patients have legal representation[35]
- In Victoria over 10 per cent are represented[36]
- In New South Wales, almost three quarters have free legal representation[37]
- In Tasmania, 10 per cent are presented by Legal Aid and a further 50 per cent have volunteer, non-legal representation[38]
- In Western Australia over 20 per cent are represented by a lawyer or a lay advocate[39].

The review identified several types of matters where legal representation would clearly benefit the patient, recommending that legal representation be provided at no cost in three specific situations: matters involving minors, fitness for trial reviews and any reviews where the State is legally represented by the Attorney-General.

The review has limited its recommendations for representation on the basis that it would not be feasible to require legal representation at all Mental Health Review Tribunal hearings and that not all patients would need or want representation.

Given the importance and complexity of these hearings and the vulnerability of the people who appear before the Tribunal, it is essential that people receive appropriate support, which may include legal or lay advocacy and support. While the Commission commends efforts to improve legal representation for patients and acknowledges that it is not required or beneficial in all cases, further consideration must be given as to whether the recommendations will sufficiently meet the needs of patients.

The Commission recommends that consideration is given to extending this right in other situations as an increased safeguard to protect the rights of people subject to orders under the Act. This might include situations involving the use of monitoring devices and reviews of long term Forensic or Involuntary Treatment Orders. It is noted that the New South Wales *Mental Health Act 2007*[40] (Section 154) for instance prescribes that legal representation in a wider set of circumstances. At the same time, consideration needs to be given to the appropriate administrative arrangements and resourcing to increase access to representation for many more patients.

---

[34] Mental Health Review Tribunal. Annual Report 2012-2013
[35] Northern Territory Mental Health Review Tribunal. Annual Report 2012-2013
[36] Victorian Mental Health Review Board. Annual Report 2012-2013
[37] NSW Mental Health Review Tribunal. Annual Report 2012-2013
[38] Advocacy Tasmania Inc. Annual Report 2012-2013
[39] Mental Health Review Board Annual Report 2012. http://www.mhrbwa.org.au/publications/pdfs/Annual_Report_2012.pdf
[40] http://www.austlii.edu.au/cgi-bin/download.cgi/au/legis/nsw/consol_act/mha2007128

Legal representation at Mental Health Review Tribunal hearings

20. Review the circumstances in which it is proposed to provide legal representation at no cost for patients before the Mental Health Review Tribunal to operate as a further safeguard in special circumstances, including but not limited to:

    a. where an existing Involuntary Treatment Order has been upheld by a psychiatrist notwithstanding the individual appears to have regained the capacity to consent and make decisions about their treatment and care
    b. the use of electronic devices for patients on Involuntary Treatment Orders and Forensic Orders
    c. reviews of long-term Forensic or Involuntary Treatment Orders.

8.4. Appointment of a Deputy President

The Commission further notes recommendation 9.1 to provide for a position of Deputy President of the Tribunal, to have the same minimum qualifications as the President and who would act as President in the President's absence.

It is suggested that consideration be given to providing for a Deputy President who may be a psychiatrist or community member. Such an appointment may facilitate a change in culture and perception better suited to more client focused hearings encouraging patients to attend.

8.5. Frequency of reviews by the Mental Health Review Tribunal

The review proposes to reduce the frequency of mandated reviews of Involuntary Treatment and Forensic Orders, while retaining the ability for patients to appeal to the Mental Health Review Tribunal at any time.

Currently, Involuntary Treatment Orders are reviewed within six weeks of the order being made and then at intervals of not more than six months[41].

The review proposes that the first review will remain at six weeks with subsequent reviews every 12 months[42]. At any stage, a patient, a person on behalf of the patient, the Director of Mental Health or the Tribunal itself can seek an earlier review. The rationale for this change is that the majority of Involuntary Treatment Orders are in place for a short time and 95 per cent of reviews do not result in changing the order[43].

Patients, families and carers attending forums indicated that in many instances they are reluctant to engage with Mental Health Review Tribunal processes for a range of reasons, including lack of support and understanding about the process, lack of trust in the process and a perception that the Mental Health Review Tribunal will generally uphold psychiatrists' orders.

---

[41] *Mental Health Act 2000* s187
[42] Queensland Health, *Review of Mental Health Act 2000*, Recommendation 9.6.
[43] Mental Health Review Tribunal Annual Report 2012-13.

The approach proposed in Queensland contrasts with a trend toward earlier and more frequent compulsory reviews in other jurisdictions. The table below includes a comparison of other states:

State	First review	Second review	Periodic review
New South Wales - *Mental Health Act 2007*	3 months, following an initial review as soon as practicable	12 months	Then 6 monthly
Tasmania – *Mental Health Act 2013*	30 days (Initial review on 3 days)	90 days	Then 6 monthly
Western Australia – *Mental Health Bill 2013*	10 days for children 35 days for adults	3 months	Then 6 monthly
Victoria – *Mental Health Act 2014*	10 days and 20 days after a change	Maximum order is 6 months (inpatient) or 12 months (community)	
Queensland – current provisions	6 weeks	6 months	Then 6 monthly
Queensland – proposed provisions	6 weeks	12 months	Then 12 monthly

Given the reluctance of patients to engage in Tribunal processes, it is unlikely that many will initiate earlier reviews of their orders. This may lead to an increased number of patients remaining on Involuntary Treatment Orders for longer periods of time, which is detrimental to both the individual and the taxpayer.

The Commission is particularly concerned about the need for more frequent and timely reviews of children and young people, given their specific developmental needs and vulnerabilities.

Frequency of reviews by the Mental Health Review Tribunal

21. Consider introducing early and more frequent automatic reviews in line with contemporary standards and other jurisdictions.

22. Consider shorter review timeframes for children and young people, with no more than 3 weeks before their first review.

9. Children and young people

The role of mental health legislation in the protection of children and young people has become a recent focus in mental health law reform debates, recognising that international human rights and national policy frameworks should guide law, policy and practice with respect to children.

Article 3 of the United Nations Convention on the Rights of the Child states that the best interests of the child shall be a primary consideration in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies.

There is a growing awareness of the special issues relating to children and young people in Australia, and this is increasingly apparent in the inclusion of special provisions for children and young people in mental health legislation in other states and territories.

The review proposes to improve protections for children and young people through a range of recommendations.

9.1. Separate facilities

Human rights instruments and the national Mental Health Statement of Rights and Responsibilities (2012) require the provision of separate accommodation for children and young people. The stipulation recognises that children and young people are entitled to benefit from special protections and safeguards appropriate to their age and development.

Separate accommodation enhances the ability of mental health services to provide a safe environment, while responding to the needs of young people flexibly and with the least restriction possible. Where the availability of suitable accommodation is an issue, the overarching principle of 'the best interests of the child shall be the primary consideration' should apply.

The proposal to accommodate this requirement 'where practicable' is supported[44] but must be balanced with appropriate safeguards and oversight.

9.2. Presumption of capacity

Making the presumption of capacity explicit with respect to people under the age of 18 is an important safeguard. It ensures that 'mature' minors who are able to demonstrate the requisite capacity will not be subject to involuntary treatment, while opening the way for mature minors to consent to treatment in circumstances where they demonstrate sufficient understanding, intelligence and maturity to appreciate the nature, consequences and risks of the proposed health care[45].

There is some concern that services may mistakenly regard a child or young person's mere compliance or agreement with proposed treatment as informed consent. If this were to occur, the child or young person, who in reality may lack capacity, may forego the benefits afforded by oversight mechanisms that apply with respect to involuntary patients.

Forum participants reported that their experience of involuntary treatment when they were aged 18 was frightening and distressing. The participants indicated that although they were treated as adults they would have liked special support that took into account their vulnerability as a young person.

9.3. A child psychiatrist at the Mental Health Review Tribunal

The review proposes that Mental Health Review Tribunal hearings involving a minor should include a member with specific child psychiatry expertise[46]. The recommendation is supported, however it is suggested that the views of experts in the field be consulted on the availability of child psychiatrists to

[44] Queensland Health, *Review of Mental Health Act 2000,* Recommendation 18.2
[45] Ibid, Recommendations 18.3 and 18.4
[46] Ibid, Recommendation 18.5

fulfil this role, and any implications detrimental to children and young people that may arise if there are not sufficient appropriately trained psychiatrists available.

9.4. Discontinuing Mental Health Review Tribunal oversight of young patients detained in high security units

The current Act enables the Mental Health Review Tribunal to review a young person's placement in a high security unit[47]. The review proposes that the Mental Health Review Tribunal's oversight be discontinued on the basis that the provision is rarely used and the Director of Mental Health approves their admission to the high security unit[48].

Notwithstanding this, minors in high security units are extremely vulnerable and independent oversight of their treatment and care is critical. In such circumstances it is appropriate to maintain and strengthen the opportunities for independent oversight.

Children and young people

23. Ensure separate accommodation is provided and clarify appropriate safeguards to be implemented when it is not available.

24. Continue Mental Health Review Tribunal oversight of children and young people in high secure units.

10. Cultural recognition, capability and practices

With regard to Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds, the review proposes two additional principles be included in the Act:

- the cultural, communication and other unique contexts and needs of Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds must be recognised and taken into account

- to the extent that is practicable and appropriate to do so services provided to Aboriginal and Torres Strait Islander peoples are to have regard to the person's cultural and spiritual beliefs and practices and the views of families and significant members of the person's community[49].

The evidence about the need for cultural recognition, capability and practices and its effectiveness in facilitating the recovery of Aboriginal and Torres Strait Islander peoples and those from culturally and linguistically diverse backgrounds is overwhelming. Cultural constructs of mental illness have a significant effect on a person's experience and must be considered in determining appropriate and effective responses. Importantly, a different approach from mainstream responses is required.

[47] *Mental Health Act 2000* sections 194-199.

[48] Queensland Health, *Review of Mental Health Act 2000,* Recommendation 9.11.

[49] Ibid, Recommendation 17.1.

The Commission acknowledges that the proposed recommendations aim to strengthen the Act's response to these population groups however our preliminary discussions with community leaders indicate concern that in their proposed form they will have little practical impact in ensuring the provision of culturally capable services.

This is one area where it is our view that further targeted consultation is essential prior to drafting amendments to the legislation.

Cultural recognition, capability and practices

25. Undertake further consultation with Aboriginal and Torres Strait Islander leaders to review the adequacy of current proposals to take account of culture and custom in the legislation.

26. Undertake further consultation with ethnic community leaders to review the adequacy of current proposals to take account of culture, religion and custom in the legislation.

11. People with mental illness in the justice system

Any discussion on this issue must firstly acknowledge that the vast majority of people with a mental illness are not dangerous and do not pose a threat to others. However, where people commit an offence as a result of their mental illness it is important that the Act balances the rights of the individual to receive recovery oriented treatment, with community safety.

As at 30 June 2013, there were 743 patients on Forensic Orders which represents 16 per cent of all patients on orders under the Act at that time[50]. Of this, 596 were general Forensic Order patients and 138 were classified as Special Notification Forensic Patients (SNFP). This category includes people who have been charged with the most serious offences including unlawful homicide, attempted murder, dangerous operation of a motor vehicle causing the death of another person, or rape or assault with the intent to commit rape.

The review proposes a wide range of reforms to the Act's current provisions relating to people with mental illness charged with a criminal offence from the point where a person is taken into custody to expanding the range of options available to the courts and enhancing the rights of victims.

The review's proposals seek to address practical barriers to receiving treatment and support the recovery of those charged with a criminal offence. The Commission acknowledges that striking the right balance between competing priorities is a complex task and welcomes many of the reforms proposed by the review including:

- the proposed transfer provisions for people in custody to an authorised mental health service including the provision that the Director of Mental Health can be notified within 72 hours if a person in custody is not accepted by the authorised mental health service[51]

[50] Director of Mental Health report 2012-2013

[51] Queensland Health, *Review of Mental Health Act 2000*, Recommendations 2.1 to 2.11.

- removal of the mandatory assessment of people on Forensic Orders or Involuntary Treatment Orders who are charged with an offence enabling people who are fit for trial to decide whether they wish to rely on a mental health defence[52]

- the statement of the rights and protections of people subject to psychiatric examinations[53].

Other proposed amendments require careful consideration in their practical application and their impact on the person who is charged with an offence, their families and carers as well as victims and their families.

11.1. The role of the Magistrates Court

The review seeks to provide greater clarity about the role of the Magistrates Courts and expands the types of charges Magistrates can deal with.

Currently only the Mental Health Court can determine whether a person has a mental health defence for indictable offences.

The proposals will see Magistrates being able to make decisions under the new Act in relation to summary offences such as shop lifting and committing a public nuisance. They will also enable Magistrates to determine whether a mental health defence applies for someone who has been charged with an indictable offence that would ordinarily be considered by the Magistrates Court, for example low level assaults and stealing.

The review proposes that where a Magistrate is satisfied that a person is likely to be, or appears to be, unfit for trial or of unsound mind at the time of the alleged offence due to mental illness they can:

- discharge the person unconditionally, or

- discharge the person and order an Involuntary Treatment Order with a non-revokable period of up to six months for summary offences and up to 12 months for indictable offences[54].

When making a non-revokable Involuntary Treatment Order, the review proposes that a Magistrate must be satisfied that the community cannot be adequately protected by voluntary treatment or by a standard Involuntary Treatment Order[55]. It is important to note that these non-revokable orders cannot be reviewed by either the treating psychiatrist or Mental Health Review Tribunal.

The Commission welcomes these amendments in-principle as they are likely to reduce the time taken to resolve criminal charges and may result in improved access to services and support recovery.

However, the Commission has been advised by the Department of Health that it is not anticipated that Magistrates will receive full psychiatric assessments but rather would base their decisions on a shorter form of assessment.

---

[52] Queensland Health, *Review of Mental Health Act 2000*, Recommendations 3.1 and 3.2
[53] Ibid, Recommendation 3.7

[54] Ibid, Recommendation 4.24
[55] Ibid, Recommendation 4.26

Some stakeholders who attended the Commission's forums indicated that the proposed amendments could lead to Magistrates making non-revokable Involuntary Treatment Orders without all of the necessary information and that treating psychiatrists may form the view, after the order has been made, that this is not warranted based on the treatment criteria. Full psychiatric assessments would mitigate this situation.

The Commission would support amendments that would enable the Magistrates Court to make Involuntary Treatment Orders that can be revoked only by the Mental Health Review Tribunal. This would provide some level of clinical oversight of decisions made by Magistrates.

The Commission notes that the review proposes that the powers of the Magistrates Courts be evaluated. The Commission supports this proposal and believes that a review of Magistrates Courts powers should include an assessment of non-revokable Involuntary Treatment Orders, whether they are necessary and if additional information is needed for Magistrates.

11.2. New options for the Mental Health Court

The Mental Health Court is unique to Queensland and is considered by many as the best practice model for determining whether a person was of unsound mind at the time of the alleged offence or unfit for trial.

As indicated above, the Mental Health Court is the only court able to make these determinations for people charged with an indictable offence. The review proposes that the Mental Health Court will hear only those matters that must be heard on indictment, as well as a limited number of prescribed other non-indictable offences, such as stalking.

Currently the Mental Health Court's only powers are to issue a Forensic Order which is reviewable by the Mental Health Review Tribunal. The review proposes that the Mental Health Court's powers are expanded to enable it to make:

- a Forensic Order with a non-revokable period for up to three years or for up to seven years for murder or attempted murder[56]
- an Involuntary Treatment Order which is revokable only by the Mental Health Review Tribunal[57]
- a standard Involuntary Treatment Order.

The review proposes criteria that the Mental Health Court must apply when making its decisions which take into account a number of factors including the person's current mental state and psychiatric history, the nature of the offence and whether serious harm to individuals has occurred.

The Commission supports efforts to ensure those people who have committed less serious offences are managed in a way that is appropriate and promotes recovery. Having people who have committed less serious offences remain on Forensic Orders for lengthy periods of time, without the option to step-down

[56] Queensland Health, *Review of Mental Health Act 2000*, Recommendation 4.13.
[57] Ibid, Recommendation 4.3.

to Involuntary Treatment Orders where appropriate, has been a consistent concern identified during at our forums.

The additional options for the Mental Health Court enables it to assess each case on its merits and provides a more step down approach to involuntary treatment and therefore supports recovery.

11.3. Duration and revocation of Forensic Orders

For victims and their families, who may have already participated in lengthy Mental Health Court proceedings, the frequency of these reviews, which automatically occur every six months, may cause significant distress.

The proposals will mean the Mental Health Court will be able to set a non-revokable period of up to three years at the time the Forensic Order is made and where the charges are murder or attempted murder, up to seven years.

For matters before the Mental Health Review Tribunal, it is proposed to give them an option to 'step-down' a Forensic Order to an Involuntary Treatment Order that can be revoked only by them, not the treating clinician. This must occur only when the Mental Health Review Tribunal is satisfied that the community can be adequately protected by the Involuntary Treatment Order.

The review recommends also that for consistency with the making of orders by the Mental Health Court, the Mental Health Review Tribunal be required to consider the same factors as the Mental Health Court in revoking a Forensic Order, including:

- the patient's current mental state and psychiatric history
- the nature of the unlawful act and the period of time since the act
- the patient's social circumstances
- the patient's response to treatment and willingness to continue treatment
- where relevant, the patient's compliance with previous obligations while on limited community treatment or another community category order.

The review also proposes clarifying that the circumstances in which the Mental Health Court, the Mental Health Review Tribunal or an authorised doctor, can grant limited community treatment should include an assessment of risks to the community from serious harm to other people, serious property damage or repeat offending[58].

While these safeguards and criteria are essential, some expressed concern that the Tribunal may not have the necessary expertise to make these determinations particularly in relation to determining risk to the community.

[58] Queensland Health, *Review of Mental Health Act 2000*, Recommendations 6.4 to 6.9.

There are a small number of cases in which a person with a mental illness has been found to have committed a serious or dangerous offence. In these instances, it is important to balance the rights of the individual with those of their victims and families, provide appropriate care and treatment, and ensure they are handled in a way that manages any risk and protects the safety and interests of the community. This will require more rigorous and stringent assessment, management and review of these patients.

The Commission recommends that a specially convened Mental Health Review Tribunal, with its constitution prescribed in legislation, be established to consider those cases requiring forensic mental health expertise in a similar way that the review proposes including a child psychiatrist for hearings involving children and young people and the current Act's requirements in relation to psychosurgery. The Commission is advised that this is consistent with current practice of the Mental Health Review Tribunal. A legislative requirement would enhance community confidence.

Concerns were also raised about the Mental Health Review Tribunal's ability to grant limited community treatment. Some victims and families indicated that greater safeguards are needed to inform them of a person being granted such an order in a timely manner and more expertise is needed when considering these applications.

Under the current Act, those who have committed the most serious offences are generally included in the category of Special Notification Forensic Patients (SNFP). This category is created for people who have been charged with unlawful homicide, attempted murder, dangerous operation of a motor vehicle causing the death, rape or assault with the intent to commit rape[59].

Under the review's proposals, the SNFP category will be removed with steps introduced that are intended to:

- reduce the number of people placed on Forensic Orders who have committed non-serious offences and for which a Forensic Order is not necessarily required in the circumstances (but not specifically discounted) by having them dealt with by the Magistrates Court
- ensure that people who have been accused of serious offences will still be dealt with by the Mental Health Court which, under the new proposals, will have authority to impose more conditions for Forensic Orders including non-revokable periods.

While the recommendations do seek to ensure appropriate management of people with a mental illness who have committed a serious offence, it has raised some concerns that victims and families will not be notified if limited community treatment is granted or if a community treatment order is made. Victims were also concerned that a second opinion will not be provided where the Tribunal considers an application to revoke a Forensic Order for those charged with serious and violent offences.

These concerns are addressed in the review by:

- requiring the Mental Health Review Tribunal to notify a victim of an application to revoke a Forensic Order[60]

[59] *Mental Health Act 2000*, section 305A.

[60] Queensland Health, *Review of Mental Health Act,* Recommendation 8.7.

- making the process for obtaining a Forensic Information Order simpler by enabling victims to apply to the Director of Mental Health rather than the Mental Health Review Tribunal[61].

The system must continue to meet its obligation to ensure that there are appropriate safeguards in place to ensure that people with a mental illness who have committed a serious offence receive appropriate treatment and care while ensuring that risks to the community are managed and the rights of victims and their families are upheld.

Further consideration of the proposal to remove the SNFP category is needed including the provisions around the rights of victims and families to receive information and participate in hearings and reviews.

11.4. Conditions on Forensic Orders

Under the current Act, the Mental Health Court cannot impose conditions on Forensic Orders. As indicated in the review the intention of Forensic Orders is not to punish but to support recovery and reduce reoffending.

The review's proposals also enable the Mental Health Court to impose conditions on a Forensic Order recommending the authorised mental health service to consider specific interventions such as drug and alcohol programs or anger management counselling[62]. These conditions will be applied as a part of a rigorous examination of the issues in the Mental Health Court and the proposals in the review are supported. However, it is essential that services are available.

People with mental illness in the justice system

27. A specially constituted Mental Health Review Tribunal be established in legislation to review those cases requiring forensic mental health expertise.

28. Ensure that the removal of the Special Notification Forensic Patient category does not remove or reduce safeguards currently in place in relation to people with a mental illness who have committed a serious offence.

12. Next steps

The Commission acknowledges the complexity of issues raised during this review process and the diversity of views expressed by patients, families and carers throughout Queensland.

Given the significance of many of the recommendations, it is important to ensure consideration is given to the intended or unintended consequences of the proposed changes, including any systemic issues that might arise through implementation. Nonetheless there are many recommendations that could be implemented immediately and would cut red tape and improve the experiences of patients and their families.

[61] Queensland Health, *Review of Mental Health Act 2000,* Recommendation 8.10
[62] Ibid, Recommendation 4.11.

The Commission has been advised by the Department of Health that binding policies and guidelines will be developed to support implementation of the redrafted legislation. A consistent theme identified throughout our consultation with stakeholders was about the need to ensure appropriate implementation of the Act. Many issues identified were not limited to the current or proposed legislative provisions, but were reflective of poor experiences of service and non-compliance with requirements under the current Act.

It is therefore recommended that all policies and guidelines supporting the new Act's implementation are developed in collaboration with patients, families and carers. On-going monitoring of implementation of the new Act should be commenced as soon as possible.

General recommendations and comments

29. Replace the *Mental Health Act 2000* with a new Act consistent with a person-centred recovery oriented approach, with amendments to the existing Act to be enacted while further consideration is given to more complex provisions proposals.

30. Continue ongoing consultation with patients, families, carers and other support persons to refine the proposals under the Act and in developing policies and guidelines that govern the new Act's implementation. Other significantly impacted people, including victims and their families, should be consulted on relevant provisions.

31. Facilitate on-going monitoring and review of the new Act and its implementation.