MENTAL HEALTH BILL 2015

Submission to the Department of Health on the Consultation Draft Bill

June 2015

Queensland
Government

Feedback

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

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ACKNOWLEDGEMENT

We pay respect to Aboriginal and Torres Strait Islander Elders, past and present, and acknowledge the important role of Aboriginal and Torres Strait Islander people, their culture and customs across Queensland.

We also acknowledge the people living with mental health and drug and alcohol problems, their families and carers. We can all contribute to a society that is inclusive and respectful, where everyone is treated with dignity and able to focus on wellness and recovery and have fulfilling lives.

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COMMISSIONER'S MESSAGE

In making this submission in relation to the Draft Mental Health Bill, I acknowledge the extent to which the issues we raised in response to the Discussion Paper in July 2014 have been considered.

Once again, in preparing this response, we have sought feedback from members of the Mental Health and Drug Advisory Council and the community. My thanks to all those individuals who have shared their experiences and sought to identify systemic changes that will result in more positive experiences for people who come after them.

To those of you who followed the discussion on Facebook and shared it with your friends, thank you. Our posts regarding the Mental Health Bill have actively engaged a total of 227 Facebook users and have received 93 likes, comments and shares. Our highest ranking post regarding the Mental Health Bill reached a total of 1,384 people.

The page on our website dedicated to the Mental Health Act 2000 Review has had 301 page views.

I am mindful that legislation is not the only instrument that sets the standards for the way in which people affected by mental illness are treated. However, it provides the minimum standards people can expect. When people may be deprived of their liberty by the State, even though it is with the best intent, those standards must be high and subject to external scrutiny. I urge the Government to consider the additional issues we have raised.

This draft Bill includes some excellent proposals. It is important that adequate resources to implement those proposals are allocated and that the development and implementation of these proposals take into account the need to consult with consumers, families and carers as well as professional bodies and service providers.

Dr Lesley van Schoubroeck
Queensland Mental Health Commissioner

THIS SUBMISSION

The Queensland Mental Health Commission supports new contemporary mental health legislation for Queensland that promotes recovery and respects the human rights of mental health consumers.

Mental health legislation plays a fundamental role in a recovery-oriented mental health system. The focus of this submission on the draft Bill is to ensure Queenslanders are able to access contemporary mental health legislation that supports recovery and respects the human rights of patients. It also seeks to align Queensland's mental health legislation to support government priorities to improve the mental health and wellbeing of Queenslanders including priorities set by the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019*.

The Commission supports the draft Bill in-principle and makes recommendations to inform the development of the 2015 Bill and its implementation.

Although we have reviewed all clauses and parts of the draft Bill, our comments and recommendations focus on a number of key areas:

- The draft Bill's objectives and principles
- Patient rights
- Care and treatment
- Review of decisions
- Provisions relating to those coming in contact with the criminal justice system
- Implementation and resource implications.

LIST OF RECOMMENDATIONS

1. The 2015 Bill's main objects specifically reference the need to protect the human rights of patients, promote least restrictive practices and focus beyond diversion from the criminal justice system.

2. The definition of 'less restrictive way' outlined in the draft Bill is reconsidered to have a broader application including the nature and extent of treatment and care.

3. The 2015 Bill makes it clear that Patient Rights Advisers are employed and engaged independently of the Authorised Mental Health Service (AMHS).

4. The Department of Health consult patients, families and carers and relevant professional and non-government bodies regarding an appropriate model of oversight and delivery of the Patient Rights Adviser role.

5. Consider strengthening the ability of the Public Guardian to require responses from Hospital and Health Services about concerns raised by Community Visitors to enable better monitoring of issues at the systemic level.

6. The 2015 Bill make clear that when developing information to support the implementation of the legislation, the Chief Psychiatrist is required to consult with consumers, families and carers.

7. The 2015 Bill include provisions which focus restrictions on the use of communication devices and communication generally where the restriction is 'reasonably necessary to protect the health, safety and wellbeing of the patient or another person'.

8. Consideration be given to providing guidance to the timeframe in which the Tribunal should make a decision regarding Examination Authorities either in legislation or in a published implementation plan.

9. The Bill include provisions which:
    - Specifically require consideration of least restrictive practices when deciding the nature and extent of treatment;
    - Include strict oversight of decisions to continue involuntary treatment and care where a patient has capacity to consent;
    - Require all AMHSs to review treatment authorities not made by psychiatrists within three days and provide an mechanism for AMHSs (Regional) to seek an extension to this time period of up to four days;
    - Consider appropriate oversight of assessments for people in an AMHS (Regional) if provisions in s40(3) of the Bill are necessary to ensure access to services.

10. Prior to finalising the 2015 Bill, consideration be given to the appropriate balance between legislation, policies and guidelines to ensure the safety of inpatients and that past trauma related to domestic violence and sexual assault is not exacerbated during their hospitalisation.

11. The 2015 Bill includes provisions requiring a treatment and discharge plan which is developed in consultation with the patient and their nominated support person, and where appropriate, families and carers.

12. The 2015 Bill includes provisions requiring the Tribunal to appoint legal representatives in complex cases.

13. The 2015 Bill include provisions which require more frequent review of treatment authorities for minors.

14. The 2015 Bill includes provisions requiring Tribunal hearings to be recorded and a transcript kept.

15. The 2015 Bill should have clear, transparent and objective criteria for determining whether a forensic or court treatment order should be made.

16. A specially convened Tribunal, with its constitution prescribed in legislation, be established to consider forensic mental health cases.

17. The 2015 Bill includes provisions in relation to the role of the Chief Psychiatrist that specify
    - The term of office similar to that of the Tribunal President
    - Removal from office, similar to that of the Tribunal President or the Queensland Mental Health Commissioner
    - Any direction given by the Minister under s303 be reported in the office's annual report.

18. The 2015 Bill includes provision for an independent review of the legislation within five years.

19. A costed implementation plan be developed that identifies resources for:
    - Transition from the current Act
    - Additional on-going recurrent costs
    - An early review of implementation of key changes within two years.

DEVELOPING THIS SUBMISSION

Our submission to the consultation draft Mental Health Bill 2015 (the draft Bill) is based on research, consultation with stakeholders undertaken in 2014 at the commencement of the review of the *Mental Health Act 2000* (the Review) and in mid-2014 in response to the Review's Discussion Paper.

The Commission has also been approached by a number of stakeholders and members of the public, both informally and formally, regarding aspects of the current Act and mental health services and has sought the views of community members on specific aspects of the draft Bill through social media.

These views and the views of the Mental Health and Drug Advisory Council have been taken into account when developing this submission and its recommendations to inform the Mental Health Bill 2015 (the 2015 Bill).

Response to the Review Discussion Paper

The Commission published its response to the Review's Discussion Paper in July 2014. Our response included 31 recommendations founded on the experiences of those who have received treatment under the Act or whose treatment was affected by the Act, their families and carers as well as service providers including mental health clinicians, lawyers and the non-government sector.

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 stakeholder forums.

The forums sought to provide an opportunity for stakeholders to share their experiences and inform our response. The forums were also designed to provide information and support others to prepare their own responses.

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

We also took into account the many issues raised in correspondence particularly from families that point to the need for systemic reforms.

There was a diversity of views and opinions regarding the Review's proposals illustrating the complexity of providing mental health treatment particularly on an involuntary basis.

Comments on the Mental Health Bill 2014

Many of the Commission's recommendations made during the Review were addressed in whole or part in the *Mental Health Bill 2014* (the 2014 Bill) introduced in the Queensland Parliament by the former Minister for Health on 27 November 2014.

After an initial review of the 2014 Bill the Commissioner indicated publicly that the Commission:

- Supported the nominated support person role to replace the allied person role enabling consumers to choose who supports them when they are not well

- Supported provisions that enable families, carers and nominated support persons to receive relevant information, to help address the frustration experienced when they have been excluded from the care and support of their loved ones because of privacy issues
- Acknowledged the proposed Patient Rights Advisers will further support consumers, but that 'implementation will need to be carefully considered to ensure advisers can act independently of the health services to which they are attached'
- Welcomed the replacement of the Justice Examination Orders with Examination Authorities issued by the Mental Health Review Tribunal (the Tribunal) and the requirement to consider the advice from a doctor or mental health practitioner
- Supported increased legal representation for certain patients when Involuntary Treatment Orders are reviewed by the Tribunal
- Supported strengthened provisions around advance health directives.

The Commissioner indicated in her public comments that the ongoing challenge would be to ensure the 2014 Bill's reforms were 'adequately funded and well implemented'. The Commissioner also indicated that the Commission would be reviewing the 2014 Bill in more detail before making further recommendations.

(Text from media release dated 27 November 2014 is available on the Commission's website at www.qmhc.gov.qld.au)

CONTEMPORARY MENTAL HEALTH LEGISLATION

Contemporary mental health legislation embeds recovery-oriented practice including least restrictive practices and respect and protections for the human rights of those experiencing a mental illness particularly those receiving treatment and care involuntarily.

Recovery-oriented practice

Modern mental health services and legislation place recovery at the centre. While there is no single definition of recovery, all descriptions focus on consumer empowerment, self-determination, hope and inclusion.

As outlined in the *National Framework for recovery-oriented mental health services: Guide for practitioners and providers*, personal recovery is linked to patients 'being able to create and live a meaningful and contributing life in a community of their choice with or without the presence of mental health issues'.

Recovery-oriented mental health service delivery is defined by the National Framework as the 'application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations'.

At the centre of recovery is the wellbeing of the person, acknowledging that family, carers, friends, treating teams and the wider community play an important role. It recognises the importance of minimising the effects of discrimination, stigma and the impact on intrusions on the rights of people living with mental illness by embedding contemporary evidence and standards of treatment and care as well as a robust and transparent system of effective safeguards.

Least restrictive practices

Least restrictive practices form an essential foundation to a recovery-oriented approach to mental health service delivery and has been accepted internationally and nationally as best practice. For example, the World Health Organisation's *Mental Health Care Law: Ten Basic Principles* indicate that institution-based treatments should be provided in the least restrictive environment.

In December 2014, the Commission published its *Options for Reform: Moving towards a more recovery-oriented, least restrictive approach in acute mental health wards including locked wards* paper (Options for reform report). The paper set out 15 options for reform to support recovery-oriented practice and the implementation of least restrictive practices adopting a whole-of-ward approach.

Human Rights approach

People receiving, or being considered for, involuntary treatment in mental health wards and through community mental health services are particularly vulnerable to their human rights being infringed. This has been recognised by the United Nations in a number of instruments including the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD).

Australia became a signatory to the UN CRPD in 2008 and consequently agreed to be bound by its provisions. Of particular relevance is Article 25 of the UN CRPD which outlines the rights of people living with disability including mental illness to the 'enjoyment of the highest attainable standard of health

without discrimination on the basis of disability'. The Article specifically requires State Parties including Australia to provide:

- The same range, quality and standard of free or affordable health care and programs as provided to other people
- The same quality of health care to persons with disabilities as to others, including on the basis of free and informed consent by, awareness of human rights, dignity, autonomy
- Health services as close as possible to people's communities including in rural areas.

The UN CRPD encourages increased accountability and transparency, improved connections between institutional arrangements and the community, and enhanced 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.

These obligations and others 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 health statements.

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.

These rights also form the foundation principles for the World Health Organisation's *Comprehensive Mental Health Action Plan 2013-2020* which includes a requirement that mental health strategies, actions and intervention for treatment must be compliant with the UN CRPD. It also recognises the need for people living with mental illness to have access to health services to enable them to recover and achieve the highest standard of health.

Internationally work is being undertaken by the World Health Organisation to support implementation of these rights through the WHO QualityRights Project which aims to:

- Improve the quality of services and human rights conditions in inpatient and outpatient mental health facilities
- Build capacity among service users, families and health workers to understand and promote human rights, recovery and independent living in the community
- Develop a civil society movement of people with mental disabilities to provide mutual support, conduct advocacy and influence policy-making in line with international human rights standards
- Reform national policies and legislation in line with best practice and international human rights standards.

Importantly, contemporary legislation goes beyond a statement of these rights and principles. It requires consideration of rights when decisions about treatment and care are made, including providing patients with information about their rights and enabling them to exercise their rights and review decisions.

Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019

The *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019* aims to improve the mental health and wellbeing of Queenslanders. The whole-of-government Strategic Plan outcomes include:

- Reduced stigma and discrimination
- People living with mental health difficulties or issues related to substance use have lives with purpose
- People living with mental illness or substance use disorders have better physical and oral health and live longer
- People living with mental illness and substance use disorders have positive experiences of their support, care and treatment.

Progress towards achieving these long-term outcomes will occur through actions that bring about change. New mental health legislation in Queensland can support this change process significantly and support better outcomes for people living with mental illness.

OBJECTS AND PRINCIPLES

The draft Bill's objects and principles play a significant role in guiding its implementation. This is particularly important when implementing complex legislation which includes the exercise of powers to involuntarily detain and treat others.

Importantly, the objects can be used to interpret legislative provisions and resolve uncertainty and ambiguity.

The draft Bill (s3) proposes that its main objects are:

- to improve and maintain the health and wellbeing of persons who have a mental illness who do not have the capacity to consent to be treated; and
- to enable persons to be diverted from the criminal justice system if found to have been of unsound mind at the time of committing an unlawful act or to be unfit for trial; and
- to protect the community if persons diverted from the criminal justice system may be at risk of harming others.

Matters of least restrictive practice, rights and dignity of patients are included to inform how the objects are to achieved. Legislation in other States refer specifically to concepts of rights and least restrictive practices in their objects.

For example, the objects of the *Mental Health Act 2014 (Vic)* (the Victorian Act) (s10) include:

- to provide for the assessment of persons who appear to have mental illness and the treatment of persons who have mental illness;
- to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity;
- to protect the rights of persons receiving assessment and treatment.

In the *Mental Health Act 2014 (WA)* (the WA Act), the objects (s10) include:

- to ensure people who have a mental illness are provided the best possible treatment and care
  - with the least possible restriction of their freedom; and
  - with the least possible interference with their rights; and
  - with respect for their dignity;
- to recognise the role of carers and families in the treatment, care and support of people who have a mental illness.

The objects in the WA Act also include ensuring 'the protection of the community'.

The *Mental Health and Related Services Act 2014 (NT)* (the NT Act) has an extensive list of objects (s3) and includes:

- to provide for the care, treatment and protection of people with mental illness while at the same time protecting their civil rights;
- to establish provisions for the care, treatment and protection of people with mental illness that are consistent with the United Nations' Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, the Australian Health Ministers' Mental Health Statement of Rights and Responsibilities and the National Mental Health Plan.

While the Commission appreciates that drafting conventions may differ between jurisdictions and that other jurisdictions may have different legislation to cover forensic patients the objects do set the scene for the way in which the legislation will be interpreted.

During the Act's review the Commission recommended that the principles include a commitment to implementing least restrictive practices in line with the *2012 National Report Card on Mental Health and Suicide Prevention*. As outlined in our Options for Reform paper on least restrictive practices in acute mental health wards, least restrictive practices refer to the way a patient receives treatment and care for example whether seclusion or restraint is used and whether community leave is granted.

While the draft Bill refers to least restrictive treatment and care in particular provisions, the Commission believes that the need to adopt the least restrictive approach should inform all decisions and actions taken and therefore should be included in the Bill's objectives.

The Commission notes that the draft Bill includes a definition of 'less restrictive way' (s13) which is based solely on whether a patient or their guardian has consented to treatment. However least restrictive care is not simply a question of whether or not a person should be subject to involuntary or to inpatient treatment. Rather it needs to be embedded in the treatment of people at all stages of their illness, whether or not they are in the community or an inpatient and whether they are being treated voluntarily or involuntarily.

The Department of Health has advised that least restrictive practices in the draft Bill is intended to be read as including the extent and nature of treatment and care. The Commission is concerned that this intention may not be stated as clearly as is needed in the 2015 Bill to ensure that patients receive appropriate treatment.

Our concerns about the draft Bill's main objects are that they:

- do not prioritise patient rights with assessment and treatment in a least restrictive way and we recommend they be revised accordingly
- have undue focus on the criminal justice aspects, acknowledging however that in most other jurisdictions these provisions are not included in the mental health legislation
- do not include a focus on patient and community safety but rather adopt a more narrow focus of diverting people from the criminal justice system.

The Commission supports the draft Bill's principles which focus on recovery and respect for human rights. Specifically the Commission supports principles which acknowledge that people living with mental illness have the same human rights as others in the community (s 5(a)) and the presumption that a person has capacity to make decisions about their treatment and care as a starting point in providing treatment and care involuntarily (s5(b)).

The Commission particularly supports the inclusion of principles acknowledging:

- the importance of recovery-oriented services and stigma reduction (s5(k))
- the role of family, carers and supporters in a patient's recovery (s5(c))
- the need to tailor services to meet the unique circumstances of Aboriginal and Torres Strait Islander people (s5(g))
- people from culturally and linguistically diverse backgrounds (clause 5(h)) and children and young people (s5(i)).

Recommendations

1. **The 2015 Bill's main objects specifically reference the need to protect the human rights of patients, promote least restrictive practices and focus beyond diversion from the criminal justice system.**

2. **The definition of 'less restrictive way' outlined in the draft Bill is reconsidered to have a broader application including the nature and extent of treatment and care.**

PATIENT RIGHTS

Involuntary patients are extremely vulnerable and often face considerable barriers in communicating with treating teams, having input into their treatment and exercising their rights. As outlined in the draft Bill's principles (s 5(d)), patients are to be provided, to the greatest extent possible, with the necessary support and information to enable them to exercise their rights.

The scheme for patient rights proposed in the draft Bill involves a number of elements to support patients to exercise their rights and make decisions regarding their future care including:

- Nominated support person
- Advance health directives
- Patient Rights Advisers
- Maintaining contact with family, carers and supporters

Nominated support persons

The current Act provides support to patients primarily through the allied person role, which is discontinued in the draft Bill. The aim of the allied person role is to address the vulnerability and isolation experienced by many involuntary patients. Patients are able to appoint an allied person or will have one appointed for them.

During our Review consultations, participants indicated strong support for retaining the allied person role as an essential way patients are supported to express their views and to represent the patient at Tribunal hearings. Participants also indicated that in most instances the allied person is a family member or carer.

However, some indicated that the current Act's scheme was not working as well as it could. Issues raised during the Review consultations included:

- A lack of training and information support for allied persons to undertake their roles effectively
- Difficulty in the role particularly where they did not agree with the patient's wishes. This was particularly an issue where the allied person was a family member or carer.

The need for a role similar to the allied person role is accepted in a number of other jurisdictions including Western Australia and Victoria and internationally in Scotland.

The Commission recommended as part of the Review that the allied person role be maintained as a right rather than a requirement providing patients with the option of nominating a person of their choice to help them present their views and wishes.

The draft Bill's new nominated support person role meets the need for patients to have the option to appoint someone of their choice to represent their views and wishes to their treating team and at the Tribunal hearings.

The Commission supports the new nominated support person role as outlined in ss231 and 232 of the draft Bill as a role which complements the role played by family, carers and next of kin. Consistent with the Commission's Review recommendation, the nominated support person is appointed by the patient and is a person of their choice and has wide ranging powers including representing the patient in the Tribunal

(s232). The Commission is also pleased to see that there is recognition (s288) that nominated persons need to be advised of their rights and responsibilities.

Advance health directives

A new addition to the draft Bill is the better use of advance health directives as a way for patients to direct their care should they become unable to give consent to treatment. This reform is consistent with the recovery-oriented practice and human rights approach to treatment and care enabling patients, when they are able to give consent, to direct their future treatment and care.

However the Commission notes that when deciding the nature and extent of treatment and care the authorised doctor must have regard to the views, wishes and preferences of the patient including in an advance health directive (s50). Our reading of this is that the advance health directive is not binding and treating teams are able to override a patient's direction. The draft Bill does not outline the circumstances in which this can occur.

Other jurisdictions have adopted a different, more transparent approach. For example the Victorian Act (s73) outlines the circumstances in which a patient's preferences in an advance health directive may be overridden. This includes:

- is not clinically appropriate; or
- is not a treatment ordinarily provided by the designated mental health service.

If the psychiatrist does override the patient's preferred treatment, they must

- inform the patient of the decision and include the reasons for the decision
- advise the patient that they a right to request written reasons for the decision
- must provide written reasons for the decision within 10 business days after receiving a request.

These provisions in the Victorian Bill ensure that decisions to override a patient's wishes are based on clear criteria and are recorded.

While the ability for a patient to make an advance health directive in relation to mental health treatment and care is welcome, not providing for oversight or accountability measures could limit the potential positive impact these provisions have on patient recovery.

Patient Rights Advisers

The draft Bill's proposal to establish Patient Rights Advisers to support patients, families and carers is supported in-principle by the Commission. This initiative, if implemented appropriately, could make a positive contribution to recovery and the experiences of patients, nominated support persons, families and carers.

The functions outlined in the draft Bill are likely to make a positive contribution to patient, family and carer experiences of mental health services and support recovery. The Patient Rights Advisers functions include: ensuring patients, their families, carers and nominated support person are advised of their rights and responsibilities; helping patients, their families, carers and nominated support person to communicate with health practitioners; improving access to the Tribunal; and educating patients about advance health care directives and enduring powers of attorney (s288).

To provide this support effectively, the Commission believes that the Patient Rights Advisers must have the ability to act independently of the Authorised Mental Health Service (AMHS) and be perceived by patients and their supporters as independent.

The current proposal, however, is that Patient Rights Advisers must be employed or otherwise engaged by the Hospital and Health Service (HHS) and must report directly to the administrator of the service who is appointed to oversee the Act's implementation within their service (ss287 and 321).

The Commission notes that the draft Bill includes provisions to protect the independence of Patient Rights Advisers including that they must not be a member of a treating team (s287) and must act independently and impartially and not subject to direction or control in relation to their advice (s289).

The Commission is concerned that they will still be accountable to the AMHS as its employee or as an organisation receiving funding from the AMHS. This relationship with the AMHS may lead to perceptions that it is not independent, resulting in a lack of confidence in this role, reducing its effectiveness. The Commission believes that to reduce this risk and enhance the role's effectiveness, Patient Rights Advisers should be employed and engaged by an external body from the AMHS with a seamless service across the State.

By way of contrast, Victoria has established a new independent mental health advocacy service delivered through Victoria Legal Aid which will include a function to ensure people know about their rights and options. Western Australia has an independent mental health advocacy service attached to the Mental Health Commission.

The Commission also notes that there may be a need to consider support outside of usual business hours, particularly when patients are first admitted. An example of a similar service is PalAssist which provide a 24 hour, 7 day a week support line for palliative care through a telephone service and e-support. The Commission understands that unlike other services this provides information about what you can expect and where a person can seek assistance. As well as supporting patients, this particular model would better support families, carers and supporters.

To ensure the Patient Rights Adviser model is appropriate, the Commission recommends the model is more fully developed in consultation with consumers, families and carers.

In our discussion about the draft Bill, there has been no consensus on which agency should provide oversight for determining the policies and implementing the Patient Rights Adviser function but there is a strong view that it must be independent of service providers.

The Commission notes that the Chief Psychiatrist has the policy function regarding the appointment and functions of the Patient Rights Advisers (s296(2)(i)) and must report the details of their appointment (s298(2)(d)).

Recommendations

3. **The 2015 Bill makes it clear that Patient Rights Advisers are employed and engaged independently of the AMHS.**

4. **The Department of Health consult patients, families and carers and relevant professional and non-government bodies regarding an appropriate model of oversight and delivery of the Patient Rights Adviser role.**

Additional oversights

The function of oversighting mental health wards rests with the Chief Psychiatrist under the draft Bill and is complemented with the Inspector role (ss292 and 299). The Commission supports this approach however believes there is a need to provide an opportunity for patients to raise concerns with an officer outside the system consistent with the United Nations Optional Protocols 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 and psychiatric hospitals.

Other systems where people are detained involuntarily in Queensland include these independent oversight mechanisms. For example, independent oversight of correctional centres is vested in the Chief Inspector of Corrections which is appointed by and reports directly to the Commissioner for Corrective Services.

The Commission notes that Community Visitors in the Office of the Public Guardian have a role in oversighting conditions in mental health facilities. Community Visitors regularly visit mental health wards and are able to visit at the request of patients. They are then able to raise these concerns with the HHS who must investigate. However there is no corresponding requirement for HHSs to respond to issues raised. This function needs to be strengthened if it is to fulfil its mandate and enhanced its ability to provide systemic oversight.

There may be potential to better align this function with the Patient Rights Advisers functions.

Recommendations

5. Consider strengthening the ability of the Public Guardian to require responses from HHSs about concerns raised by Community Visitors to enable better monitoring of issues at the systemic level.

Statement of Rights

The Commission welcomes new provisions which will require a Statement of Rights to be developed by the Chief Psychiatrist (s270) and explained to patients and given to them after they have been admitted and to the person's nominated support person, family, carers and other support persons if requested (s273). It is important that the Statement of Rights is developed in partnership with consumers, families and carers.

Recommendation

6. The 2015 Bill make clear that when developing information to support the implementation of the legislation, the Chief Psychiatrist is required to consult with consumers, families and carers.

Right to communicate and receive visitors

Maintaining contact with families, carers and supporters such as friends and work colleagues for many is essential to recovery. The Commission is pleased that the Bill includes provisions that support visits by a patient's nominated support person, family, carers and other support persons at 'any reasonable time of the day or night' (s276) while enabling patients to decide whether to accept the visitor (clause 2762)(b)).

The Commission notes that an AMHS can refuse to allow a person to visit a patient if it is satisfied the visit will adversely affect the patient's treatment and care. The focus of all treatment and care should be the needs of the patient and the Commission accepts that there will be times when visitors may impact on a person's mental health and recovery. The Commission however supports requirements that the AMHS

provide the person proposing to visit a patient with a written notice and the reasons for the decision as well as a right to appeal the decision to the Mental Health Tribunal (s399).

The draft Bill confirms the right of patients to communicate in other ways with family, carers and supporters, however the general right remains limited to post or fixed line telephone (s279(1)). The draft Bill includes a provision enabling an AMHS to prohibit or restrict the use of an electronic device in the service (s279(3)) having considered the health and wellbeing and privacy of patients and others in the service (s279(4)).

As noted by those consulted in developing the Commission's Options for Reform Report, the rules and regulations applying in acute mental health wards can limit communication with family, friends and carers to physical visits, phone conversations and letters. Some hospital staff consulted in developing the Options for Reform Report advised that these rules resulted in patients from rural and remote areas having little contact with family, carers and friends. This situation could be assisted by offering a broader range of contact options including use of the internet and Skype.

As noted by some hospital staff this may involve a degree of risk with one staff member noting 'People are sharing pictures because they have anorexia or bulimia, self-harming sites'. However, they expressed the view that many of these risks can be managed by using current technology to block access to certain sites and closely monitoring use.

Consequently, our Option for Reform Report recommended that the Department of Health investigate options to enable consumers to communicate with families and friends through greater access to phones and the internet, subject to treatment plans, and by encouraging the presence of families, friends and other supporters on the ward.

The Commission also notes that research undertaken by the Young and Well Cooperative Research Centre concluded that 'Children and young people…see digital citizenship as fundamental to their wellbeing...they overwhelmingly experience digital media as a powerful and positive influence on their everyday lives ...crucial to their rights to information, education and participation.'

The Commission is concerned that the current provisions in the draft Bill may result in blanket bans in some services on use of mobile phones and the use of communication through Skype. The Commission accepts that there is a need to protect the privacy and wellbeing of others in mental health wards however these issues can be resolved in a number of ways including providing a private area for use of these devices.

Other jurisdictions have adopted a more flexible patient-centred approach to communication rights. The Victorian Act (ss15-16) focuses restrictions to communication on an individual rather than on a service, where that restriction is 'reasonably necessary to protect the health, safety and wellbeing of the inpatient or of another person.' These provisions provide a default position that communication by letter, telephone or electronic means is the default position, only to be curtailed on a case by case basis.

Recommendations

7. The 2015 Bill include provisions which focus restrictions on the use of communication devices and communication generally where the restriction is 'reasonably necessary to protect the health, safety and wellbeing of the patient or another person'.

Absenteeism

The Commission's Options for Reform Report outlined options to reduce the number of people being absent without permission (AWoP) from acute mental health wards in Queensland. As noted in our report, patients leave wards or do not return to wards when required for a wide range of reasons including needing contact with family and supporters, not feeling safe and not being able to engage in meaningful activities while on the ward.

The current Act's provisions do not allow for addressing an individual's reason for being AWoP and do not work practically with AMHSs being required to give a notice to a patient that they return to the ward or for treatment.

The Commission supports the draft Bill's provisions which will require the AMHSs to take reasonable efforts to contact the person and encourage them to return (s355) and balancing this against any risk that the person may harm themselves or others.

CARE AND TREATMENT

The draft Bill significantly changes the way consumers are involuntarily examined, assessed and treated. The starting point for these changes are new treatment criteria (s12):

- the person has a mental illness
- the person does not have 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 the person or others, or
  - the person suffering serious mental or physical deterioration.

Central to the treatment criteria is a person's capacity to consent to treatment. As outlined earlier in our submission, being able to make decisions about treatment is essential to a person's recovery. In some cases this may involve support from others and may require information to provide in a manner capable of being understood. These concepts have been included in the draft Bill (s14) in the definition of 'capacity to consent to be treated' by recognising that a person still has capacity even though they may need support to understand and make decisions.

The Commission supports the draft Bill's definition of 'capacity to consent to be treated' as it incorporates concepts of supported decision making and specifically acknowledges that a person may still have capacity to consent even though they decide not to receive treatment.

Tribunal ordered examination authorities

The Commission supports strengthening safeguards surrounding authorities to involuntarily examine members of the community through Tribunal ordered Involuntary Examination Authorities (IEAs).

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

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 using Justices of the Peace, 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 JEOs had been used for malicious reasons and have caused significant distress.

This view is supported by the data that the majority of JEOs did not result in involuntary treatment. As reported in the Director of Mental Health's Annual Report 1,061 JEOs were made in 2013-14. Of these 260 (25 per cent) resulted in an Involuntary Treatment Order (ITO). Assessment criteria were not found to have been met in relation to over half of all JEOs. As noted in the annual report this may occur if the doctor or authorised mental health practitioner finds that the person did not appear to have a mental illness, or the person agrees to voluntarily engage with the mental health service.

This suggests that while some people may not meet the criteria for involuntary assessment and treatment, in some instances there is still a need for some form of treatment and a mechanism providing for

involuntary examinations may provide a means to accessing services. For example, a number of stakeholders advised the Commission that the only way they can ensure their family member, friend or colleague received treatment was through a JEO, due in part to the practices adopted by individual health services.

The Commission supports retaining an involuntary examination mechanism (to be called an Examination Authority) with strengthened safeguards, which includes clinical advice and taking steps to encourage voluntary treatment as outlined in the draft Bill (s469). This will ensure that those who do not require treatment for a mental illness do not have their rights unnecessarily curtailed.

Some stakeholders expressed concern that including a requirement for clinical advice would limit access to mental health services particularly where the person concerned refuses to go to a doctor. 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.

The Commission accepts that at this stage, to maintain access to assessment and treatment in some parts of the State, it is necessary to include these safeguards and monitor their impact on accessing services across Queensland.

The draft Bill includes provisions requiring the Tribunal to hear applications for Examination Authorities as soon as practicable after the application is made (s685). The Commission notes the views of family members and carers who indicated that the purpose of involuntary examination is to prevent the person from deteriorating. It is essential that the Tribunal has mechanisms in place to ensure it is able to hear applications in a timely fashion to reduce the risk of further deterioration. Through Justices of the Peace, the Commission has been advised that decisions were often made within 24 hours.

Recommendation

8. Consideration be given to providing guidance to the timeframe in which the Tribunal should make a decision regarding Examination Authorities either in legislation or in a published implementation plan.

Assessments

Once an IEA is ordered, a doctor or an authorised mental health practitioner may, after examining a person, make a recommendation for assessment for the person if satisfied that an authorised doctor 'may form the view' that the treatment criteria apply and there is no less restrictive way for the person to receive treatment and care (s36). This close alignment with the treatment criteria is important and acts to protect patients from being inappropriately assessed.

However, the Commission is aware of situations where people have been assessed and then not found to be experiencing a mental illness. Their medical records however suggest that the person did experience a mental illness which can have a detrimental impact on their employment and raise other issues.

It is critical that medical records in this regard are accurate and if a person is assessed and found not to be experiencing mental illness the records must reflect this clearly.

The Commission has also been approached by a stakeholder who advises that their reading of the draft Bill is that a recommendation for assessment involves a doctor or authorised mental health practitioner

deciding that the treatment criteria apply, that is, that a person is experiencing a mental illness. This level of confusion may need to be resolved through clear guidelines to support the process of making a recommendation for assessment.

Treatment authorities

The Commission supports the draft Bill's provisions replacing ITOs with treatment authorities made on the basis of the treatment criteria and where there is 'no less restrictive way' for the person to receive treatment and care for their mental illness (s45).

However the Commission has concerns regarding the narrow definition given to the phase 'less restrictive way' as outlined in the draft Bill (s13) and discussed earlier in this submission.

The Commission strongly supports consideration of the patient's wishes and views when deciding the extent of treatment and care to be provided under a treatment authority and specifically requiring that the authorised doctor talk to the patient and their nominated support person (s50). The Commission also welcomes that authorised doctors are required, to the extent practicable, to talk to the person's family, carers and other support persons. However the Commission notes that in deciding the nature and extent of treatment and care no reference is made in the draft Bill to considering least restrictive practices (s50).

The draft Bill's provisions make inpatient treatment authorities an exception rather than a rule. It requires that an inpatient category of a treatment authority is made only if the person's treatment and care needs and the safety and welfare of the person and others cannot reasonably be met with treatment in the community (s48). This assessment will be made having regard to the person's mental state and psychiatric history, social circumstances including family and social support, response to treatment and care and previous response to treatment in the community (s48).

In practice this may mean that a person who has capacity to consent to treatment continues to be detained and treated involuntarily.

These provisions seek to address a situation where a person has become well and wishes to discontinue treatment against the recommendations of the treating team. They are also designed to address situations involving fluctuating capacity to consent.

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 which require a patients capacity to consent to be respected at all times. 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.

Rural and regional access to services

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 draft Bill makes provisions which enable patients living in rural and regional Queensland to receive treatment and care in a mental health service closer to home through the declaration of an AMHS (Regional) (ss320 and 322). The Chief

Psychiatrist is responsible for declaring, by gazette, an AMHS to be an AMHS (Regional). The legislation provides no guidance on what might constitute a regional service but discussion with the Department of Health indicate that the provisions are intended to cater for small rural and remote centres.

However the Commission is concerned that patients receiving treatment and care in AMHSs (Regional) are subject to different review periods when a treatment authority is not made by an authorised psychiatrist (s52). Specifically, the review period for AMHS (Regional) is within seven days and the review period in other AMHSs is within three days.

We note also that the authorised doctor who makes an assessment must not generally be the authorised doctor who made the recommendation for assessment (s40(2)). This is an important oversight that does not apply however in an AMHS (Regional) (s40(3)).

While the Commission understands that access to psychiatrists in regional and rural Queensland is limited, we are concerned that every effort is made to ensure those living in these communities are not disadvantaged. We note that with increased use to telehealth access to a psychiatrist will improve. We therefore propose that the review periods for treatment authorities is the same in all AMHSs but that there is an option for AMHSs (Regional) to seek an extension of up to four days. This will ensure that every effort is made to review treatment authorities in a timely way.

Recommendations

9. The Bill include provisions which:

- **Specifically require consideration of least restrictive practices when deciding the nature and extent of treatment;**
- **Include strict oversight of decisions to continue involuntary treatment and care where a patient has capacity to consent;**
- **Require all AMHSs to review treatment authorities not made by psychiatrists within three days and provide an mechanism for AMHSs (Regional) to seek an extension to this time period of up to four days;**
- **Consider appropriate oversight of assessments for people in an AMHS (Regional) if provisions in s40(3) of the Bill are necessary to ensure access to services.**

Domestic violence and sexual assault

Unresolved trauma often leads to mental health problems. The draft Bill has already made a significant change to support and protect victims of domestic violence or sexual assault. The barrier to having someone required to be assessed for a mental illness has been raised with Justices of the Peace no longer able to approve the Examination Order. In addition, the current Act's requirement that any strip search of a patient on an involuntary order to be done by some one of the same sex is retained (s357).

We note that the principles (s5(f)) state that age-related and gender-related needs must be taken into account and s5 (i) includes a further principle that requires minors to receive treatment and care separate from adults where practicable. There is no similar principle related to gender.

We are also aware that there are operational policies and guidelines in Queensland about sexual assault and sexual safety on mental health wards and question whether or not any additional provisions in this Bill would further protect and support patients in hospitals.

We further note provisions in the WA Act 2014 (s254) which requires staff to report unlawful sexual contact or unreasonable use of force with a mental health patient to the Chief Psychiatrist. Non-compliance attracts a penalty. This is an attempt by that government to address a perception that more could be done to protect patients, especially women, from further harm when they are inpatients.

Recommendation

10. Prior to finalising the 2015 Bill, consideration be given to the appropriate balance between legislation, policies and guidelines to ensure the safety of inpatients and that past trauma related to domestic violence and sexual assault is not exacerbated during their hospitalisation.

Seclusion and Restraint

The Commission strongly supports new provisions which strengthen safeguards surrounding the use of seclusion and restraint and in particular provisions regarding the development of reduction and elimination plans (s259).

These provisions support Queensland's commitment to reduce and eventually eliminate restraint and seclusion from mental health treatment. Of particular note is the requirement that the Chief Psychiatrist develop a policy regarding the use of seclusion and restraint including ways of minimising any adverse impacts on patients (s268).

The Commission welcomes the inclusions of provisions making it an offence to give medication to an involuntary patient unless the medication is clinically necessary (s268).

Treatment and discharge plans

The Commission notes that there is no reference to treatment and discharge plans in the draft Bill but we further note that 'the person's social circumstances, including for example, family and social support' must be considered in a range of circumstances. The Commission appreciates that provision for treatment and discharge plans may be matters for policy or practice guidelines to be developed by the Chief Psychiatrist (s296).

Nonetheless, a number of families, including families of patients who were admitted following a suicide attempt, have contacted the Commission with concerns about the apparent lack of consideration for patient safety following discharge. For example, not taking account of the views of and notifying families and carers at the time.

It is important that provisions include a positive duty of hospitals to discharge patients to safety and appropriate safeguards are in place to address the risk of suicide. This may include advising family, carers or other supporters of the patient's discharge. This should be a positive duty enshrined in legislation rather than an issue that is taken into account when making a decision to discharge a patient to the community.

The Northern Territory Act (s89) requires a discharge plan before a person is discharged from a mental health facility as a patient right.

The Western Australian Act requires a treatment, support and discharge plan that must consider treatment and support to be provided under a community treatment order and the treatment and support to be offered when the patient is no longer under the order (s186). In most circumstances, a family member or carer must be involved in the preparation and review of the plan. This change was recommended in the Stokes Review in Western Australia which followed a number of suicides of people who had been

discharged from mental health services and recommended a comprehensive discharge plan that includes a carer (Rec 7.2).

The Commission recommends similar provisions be included in this legislation to strengthen the focus on family involvement across the life course of the patient's treatment and support.

Recommendation

11. The 2015 Bill includes provisions requiring a treatment and discharge plan which is developed in consultation with the patient and their nominated support person, and where appropriate, families and carers.

General Medical Treatment

The Commission notes that the draft Bill includes a responsibility for an administrator of an AMHS 'to the extent practicable, the treatment and care for any other illness or condition affecting the patient' (s204). However, the practical application of this provision may be limited, as involuntary patients have limited or no capacity to consent to treatment and the draft Bill could be read as only authorising mental health treatment and care.

The Commission notes that there is no reference to who has the authority to consent to such treatment for an involuntary patient. Attention is drawn to the provisions in the Victorian Act (ss74-76) which clearly articulates a decision hierarchy for consent to general medical treatment, defined as treatment normally carried out by a registered medical practitioner or a registered dental practitioner, if the patient does not have the capacity to give informed consent. The default position is the authorised psychiatrist. We have also been advised that New South Wales had similar provisions and these have been removed.

Given the importance of addressing the physical and oral health of people with mental illness the Commission has noted that s241 of the WA Act requires that a physical examination is undertaken with the patient's consent on admission to an AMHS.

The Commission has not formed a view as to whether or not strengthening mental health legislation is the appropriate mechanism for improving oversight of the general health of patients but draw attention to the need for policies and practices which ensure the physical health of people with mental illness is attended to.

TRIBUNAL REVIEW OF DECISIONS

Timely, accessible and transparent reviews of involuntary treatment by an independent body are an essential part of contemporary mental health legislation. The draft Bill proposes a number of changes to the Tribunal hearing process and the timeframes for reviews of treatment and care.

Legal representation at Mental Health Review Tribunal hearings

Currently, patients have the right to be represented by a lawyer or, with leave of the Tribunal, an agent. However, Queensland rates of legal representation before the Tribunal are amongst the lowest in the country.

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

- In the Northern Territory all patients have legal representation
- In Victoria over 10 per cent are represented
- In New South Wales, the Mental Health Review Tribunal reported that legal representation in mental health inquiries was provided in 98 per cent of cases
- In Tasmania, 10 per cent are presented by Legal Aid and a further 50 per cent have volunteer, non-legal representation
- In Western Australia over 20 per cent are represented by a lawyer or a lay advocate.

The draft Bill includes several types of matters where legal representation would clearly benefit the patient, requiring that legal representation be provided in three specific situations:

- matters involving minors
- fitness for trial reviews
- approval to perform electroconvulsive therapy
- any reviews where the State is legally represented by the Attorney-General (s698).

The Commission understands that the requirement for legal representation has been limited on the basis that it would not be feasible to require legal representation at all 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 provisions in the 2015 Bill will sufficiently meet the needs of patients.

The Commission recommends that consideration be 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 orders or authorities. It is noted that the *Mental Health Act 2007 (NSW)* (s154) for instance prescribes 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.

Rather than prescribing additional sub-groups of people who must receive legal representation, a more generic right for consumers with particularly complex issues as determined by the Tribunal may assist in a cost-effective but fair use of legal support. We note that the Human Services (Complex Needs) Act 2009 provides useful guidance to define a person with complex needs.

Recommendation

12. The 2015 Bill includes provisions requiring the Tribunal to appoint legal representatives in complex cases.

Frequency of reviews by the Tribunal

The Commission welcomes provisions in the draft Bill which increase the frequency of mandated reviews of involuntary treatment authorities (s403), while retaining the ability for patients to seek a review by the Tribunal at any time. We argued in our initial submission against the proposal to extend the second review period from 6 months to 12 months was inappropriate.

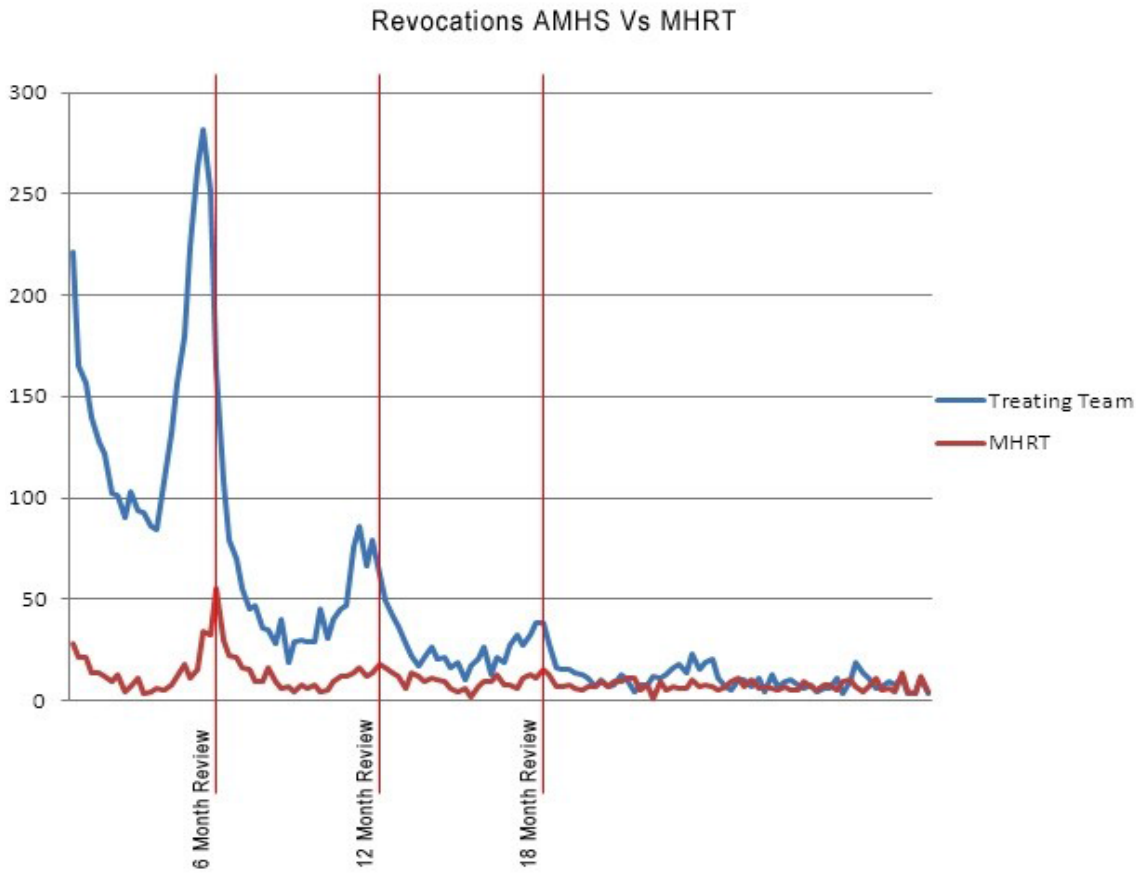
As outlined in the table below these review periods are in line with those adopted by other jurisdictions.

State	First review	Second review	Third review	Periodic review
Queensland (current)	6 weeks	12 months		Then 12 monthly
Queensland (draft Bill)	28 days	6 months	6 months	Then 12 monthly
New South Wales	3 months, following an initial review as soon as practicable	12 months		Then 6 monthly
Tasmania	30 days (initial review after 3 days)	90 days		Then 6 monthly
Western Australia	35 days	3 months		Then 6 monthly
Victoria	10 days and 20 days after a change	Maximum order is 6 months (inpatient) and 12 months (community)		

As the 2014 Annual Report of the Mental Health Review Tribunal illustrates, currently there is significant increase in the number of revocations of ITOs by AMHSs immediately preceding the scheduled Tribunal review. Notification of an independent review appears to trigger an assessment process relating to the involuntary provisions of the Act resulting in revocations.

Based on this information, it is reasonable to expect that the length of time patients are subject to treatment authorities will be reduced.

However the Commission remains concerned that treatment authorities for minors will be reviewed at the same frequency as adult authorities.



Of note is that some jurisdictions such as Western Australia include an earlier initial review for children at 10 days. Victoria requires all first reviews within 10 days. The Commission notes and supports that the Bill introduces a new requirement for the Tribunal to review any decision of the Chief Psychiatrist to detain a minor in a high security unit (s466) within seven days and at three month intervals thereafter.

Recommendation

13. The 2015 Bill include provisions which require more frequent review of treatment authorities for minors.

Record of Tribunal proceedings

Our reading of the draft Bill does not require the Tribunal to record proceedings. The Tribunal may however publish a decision and its reasons, provided it does not identify any person (s711) and we understand that the Tribunal is progressively adopting technology to record proceedings.

The Tribunal's role is fundamental to an accountable and transparent system. It has broad ranging powers which are appealable to the Mental Health Court.

Tribunals with similar powers in other jurisdictions are required to record proceedings as well as decisions and reasons for the decisions.

For example, the NT Act (s136) requires electronic recordings of all proceedings to be kept for 12 months. The WA Act (s467) requires hearings to be recorded and the recording to be kept in a form from which a transcript of the hearing can be made.

Similarly the *Queensland Civil Administration Tribunal Act 2009* (s123) provides for written transcripts and or audio recordings to be provided if the tribunal is required to give a decision in writing, thus implying proceedings will be recorded.

To bring the mental health system in Queensland in line with other jurisdictions through a transparent and accountable review process, the Commission recommends the Bill includes provisions requiring Tribunal hearings to be recorded so that a transcript can be provided on request.

Recommendation

14. The 2015 Bill includes provisions requiring Tribunal hearings to be recorded.

Tribunal Constitution

The Commission welcomes the draft Bill's provisions which require the Tribunal President have regard to the safety and welfare of the patient and others; and have regard to the patient's mental condition when constituting the Tribunal. They must also, to the extent practicable, include a member who is culturally appropriate to the patient (s677).

The Commission raised concerns during the Act's Review regarding the need to ensure that a psychiatrist with expertise in child psychiatry was a member on the Tribunal when considering reviews involving minors. The Commission is pleased to support the draft Bill's provisions which require, in a proceeding involving a minor that the Tribunal must be constituted by at least one psychiatrist with expertise in child psychiatry (s677).

CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

The vast majority of people experiencing mental illness do not commit criminal offences. According to the Director of Mental Health's Annual Report 2013-2014, as at 30 June 2014, 741 patients were on forensic orders, which represents 16 per cent of all patients on orders under the Act at that time.

Of this, 139 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, and dangerous operation of a motor vehicle causing the death of another person, or rape or assault with the intent to commit rape.

However, for this small group of people it is essential that options are available to support recovery and where necessary, provide protection from harm.

The draft Bill's provisions provide a wide range of reforms to the current Act relating to people experiencing 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 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:

- When psychiatrists reports are prepared
- New powers for the Magistrates Court
- New Court Treatment Orders
- New provisions regarding limited community treatment
- Changes in arrangements for monitoring conditions

Psychiatrists reports

Currently the Act requires that a psychiatrist prepares a report in relation to any consumer on an ITO or forensic order who is charged with a criminal offence. The purpose of the report is to assess whether a person has a mental health defence to the charge.

The draft Bill removes this requirement and enables consumers to request a report and decide whether they wish to rely on a mental health defence (s20).

The Commission supports these provisions as the current requirement has led to delays in finalising court proceedings and did not allow consumers to determine how they wanted their court hearing to progress.

The role of the Magistrates Court

Currently only the Mental Health Court can determine whether a person has a mental health defence for indictable offences. This has the potential for people living with a mental illness not being able to access a mental health defence and being sentenced for relatively minor offences, particularly for people who were not subject to an ITO or forensic order.

It is also important to note that the Act currently requires a psychiatrist's report for those on an ITO or forensic order. This process is often lengthy, requiring multiple appearances in court while the report is being prepared.

The draft Bill will see Magistrates determine whether, on the balance of probabilities, the person was or appears to have been of unsound mind at the time of the alleged offence or is unfit for trial and either:

- Discharge the person unconditionally without punishment or
- On conditions the court considers appropriate (s171).

To ensure a person before the court accesses treatment and care the Magistrates Court also will have the ability to make an examination order (s176).

For more serious offences (an indictable offence) the Magistrates Court will also have the ability to refer a matter to the Mental Health Court (s173).

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

Court Treatment Orders

Currently the Mental Health Court's only power is to make a forensic order, which is reviewable by the Tribunal. The draft Bill includes provisions which provide new options enabling the Mental Health Court to make:

- A forensic order (mental health)
- A forensic order (intellectual disability)
- A court treatment order.

The Commission welcomes a broader range of options available to the Mental Health Court which will enable it to better tailor its orders to support recovery and protect the safety of the person and the community.

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 through the use of court treatment orders (s139). The need for such an order which does not require consumers to be on forensic orders for lengthy periods of time, particularly for less serious offences, and which do not promote recovery was raised by stakeholders.

The establishment of a court treatment order addresses these concerns in a number of ways.

As noted by the Department of Health the two main differences between a forensic order and a court treatment order is the way in which treatment in the community is authorised and the nature of clinical oversight of the person.

Court treatment orders also differ from forensic orders in the following ways:

- A court treatment order can include monitoring conditions but not a condition to wear a tracking device (s140(1)(b));
- the default position for a court treatment order is treatment in the community, with inpatient treatment only ordered if the Mental Health Court considers that one of the following cannot reasonably be met through community treatment the:
    - person's treatment and care needs;

- safety and welfare of the person; and
- safety of others (s144(2)).

Court treatment orders must be reviewed every six months by the Tribunal (s441) which can revoke the order and either make a treatment authority for the person or make no other order (s450). The Tribunal can also change the court treatment order category, order limited community treatment, remove or change a condition (s449).

Importantly, authorised doctors are also able to amend a court treatment order to change a category of order from inpatient to community; authorise, revoke, or change the extent of, limited community treatment; or to change a condition of the order (s215).

However the Commission is concerned that the criteria upon which the Mental Health Court would make a decision about the type of order. For both forensic (s138) and court treatment orders (s139) the Mental Health Court must take into account:

- The circumstance of the person;
- Any victim impact statement provided by the prosecution; and
- Any policies or practice guidelines made by the Chief Psychiatrist.

The policies or practice guidelines made by the Chief Psychiatrist are subject to change by one officer and their inclusion as criteria for a court is not considered appropriate. This is particularly the case where forensic orders may be in place for a non-revocation period of up to 10 years for some serious offences (s147). Rather, the draft Bill should include clear and objective criteria for determining the type of order to be made.

The Commission also supports the draft Bill's provisions which will enable the Tribunal, to review forensic orders not subject to a non-revoke period and make orders to 'step-down' a Forensic Order to a court treatment order or a treatment authority (s421). This ability to step down the intensity of order is consistent with a recovery-oriented approach to mental health service delivery.

Recommendation

15. The 2015 Bill should have clear, transparent and objective criteria for determining whether a forensic or court treatment order should be made.

Limited community treatment

The draft Bill clarifies the circumstances in which the Mental Health Court, the Tribunal or an authorised doctor, can grant limited community treatment and includes an assessment of risks to the community from serious harm to other people, serious property damage or repeat offending.

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

In the small number of cases in which a person with a mental illness has been found to have committed a serious unlawful act, it is important to balance the rights of the individual with those of their victims and families 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 Tribunal, with its constitution prescribed in legislation, be established to consider those cases requiring forensic mental health expertise in a similar way that the draft Bill requires 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 Tribunal. A legislative requirement however would enhance community confidence.

Concerns were also raised about receiving information when limited community treatment is granted. Some victims and families indicated that the current processes result in information that a person has been granted limited community treatment is not provided in a timely manner.

During the Review process the Commission was approached by a number of people who had been victims of crime and who had concerns regarding the proposed removal of the SNFP category. This category enables information to be provided to victims of certain serious crimes including attempted murder, murder, dangerous operation of a motor vehicle and rape.

The Commission raised these concerns in its response to the discussion paper based on the need that information is provided to victims who are at risk at particular times, for example when a patient is granted leave or their order is changed and the need to protect the privacy of those receiving treatment.

Many of these concerns have been addressed in the draft Bill with provisions enabling the Chief Psychiatrist to make information notices in relation to those on forensic orders and court treatment orders (Chapter 10, Part 6) and will relate to any type of offence.

The Commission supports the careful balancing of the rights of patients to privacy by limiting the type of information provided (Schedule 1), for example by excluding the nature of treatment and care being provided and the safety of the patient and others.

Recommendations

16. A specially convened Tribunal, with its constitution prescribed in legislation, be established to consider forensic mental health cases.

Monitoring conditions

The ability for the Director of Mental Health to require patients to wear a GPS tracking device has been criticised by stakeholders on the basis that it criminalises and stigmatises patients and that the use of GPS devices are of limited value in reducing risks to patients and others. A number of appeals have also been made to the Tribunal and Mental Health Court in respect of applying monitoring conditions under the provisions in the Act.

A 'monitoring condition' is defined in the draft Bill as 'a condition that would allow an involuntary patient's treating health service to monitor a patient's location while receiving treatment in the community' (Schedule 3). It includes a condition requiring the patient to telephone a person at the treating health service, requiring the patient to be contactable by mobile phone, requiring a patient to provide a detailed

plan of where, and with whom, the patient will be while receiving limited community treatment and a condition to wear a tracking device.

According to the draft Bill a tracking device can be included only as a condition on a forensic order and only by the Mental Health Court (s140) and the Tribunal. An AMHS cannot place a condition requiring a tracking device on a forensic order (s213).

A tracking device cannot be included in conditions on a court treatment order or a treatment authority (s200).

The Commission supports the strengthening of provisions regarding the use of monitoring conditions for patients on forensic orders receiving treatment in the community, which can be made by the Mental Health Court or the Tribunal.

IMPLEMENTATION AND ADMINISTRATION

Independence and accountability of statutory offices

Legislation governing the appointment of statutory office holders generally includes provisions that balance their accountability to Parliament or the Minister with their independence from Parliament or the Minister. For a regulatory role such as the Chief Psychiatrist, accountability mechanisms that might be considered include:

- Appointment by the Governor in Council (as outlined in the draft Bill s291)
- A fixed term of office, including eligibility for reappointment
- Remuneration, or the process whereby remuneration is determined
- Provisions relating to removal from office
- Ministerial powers to direct, with directions tabled in Parliament within a certain period and/or reported in annual reports
- Tabling of annual reports in the Parliament (s298)

Independence is enabled through

- Specific provisions that the office is not subject to the direction or control of a minister with respect to certain functions
- Levels of discretion
- Access to information
- Powers to delegate

The Commission notes that these factors are generally well taken into account in provisions in the draft Bill relating to the creation and oversight of the Tribunal President and in other legislation such as the *Queensland Mental Health Commission Act 2013* or the *Auditor General Act 2009*.

In relation to the Chief Psychiatrist, the provisions for independence are well embedded in the draft Bill, but it is proposed that the accountability mechanisms be strengthened. The following should be considered:

- The term of office similar to that of the Tribunal President
- Removal from office, similar to that of the Tribunal President of the Mental Health Review Tribunal or to the Queensland Mental Health Commissioner
- Ministerial direction (s303) provisions, similar to s13 of the *Queensland Mental Health Commission Act 2013* which requires any direction given by the Minister be reported in the agency's annual report

We have received advice that approach to legislation in Queensland is that a person is eligible for reappointment unless there are specific provisions to the contrary and support the implicit position that the Chief Psychiatrist should be eligible for reappointment.

As currently drafted, the Bill (s666) specifies a term of office for the Tribunal President of 'not more than five years' and for the deputy President 'not more than three years' as stated in the instrument of appointment.

The Commission suggests that consideration should be given as to whether or not appointments to these statutory offices should be for a fixed term of five years rather than a variable term to affirm their

independence and, and if so, the maximum number of years they may serve. It is noted that the Public Guardian (*Public Guardian Act 2014*, s94-96) is eligible for reappointment and that the requirement to seek approval of the Governor in Council is not required for re-appointment. The Auditor General (s10) is appointed for a fixed non-renewable term of seven years reflecting the level of independence from government.

Review

This is a significant Bill that aims to improve the safeguards of the rights of people with a mental illness who may be subject to involuntary treatment.

Early review of key changes will be important and must include the view of consumers, families and carers as well as agencies implementing the Act. A comprehensive review should also be planned.

Implementation resources

The Commission reaffirms its position that new resources need to be provided to support the implementation of this Bill. The proposed changes will enhance oversight and accountability for the way in which people with mental illness are treated and improve their access to services. 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. There is also a clear message that mental health clinical services are struggling to meet demand.

Additional resources are required not only during the transition phase but also recurrently. Without dedicated resources the new approaches to rights protection cannot be effective. It would be counterproductive if these resources were to be drawn from existing mental health resources.

Recommendations

17. The 2015 Bill includes provisions in relation to the role of the Chief Psychiatrist that specify

- **The term of office similar to that of the Tribunal President**
- **Removal from office, similar to that of the Tribunal President or the Queensland Mental Health Commissioner**
- **Any direction given by the Minister under s303 be reported in the office's annual report**

18. The 2015 Bill includes provision for an independent review of the legislation within five years.

19. A costed implementation plan be developed that identifies resources for:

- **Transition from the current Act**
- **Additional on-going recurrent costs**
- **An early review of implementation of key changes within two years.**

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