MENTAL HEALTH LEGISLATION

Submission to the Health and Ambulance Services Committee of the Queensland Parliament

October 2015

Queensland
Government

Feedback

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ACKNOWLEDGEMENT

We wish to 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.

COMMISSIONER'S MESSAGE

Development of legislation that balances the rights of people with mental illness while providing for their involuntary treatment is necessarily complex.

Consultation and drafting of this Bill has taken over two years, but the time spent in achieving an appropriate balance that seeks to ensure that people with mental illness are at all times treated in the least restrictive manner with the interests of families and the community has resulted in a better outcome.

My thanks to Government over the last two years and to the drafting team for taking on so many of our recommendations and the timely way in which they have responded to our many questions.

This submission summarises our key recommendations and comments on the way in which they have been considered, noting that in some instances it has been decided that a policy rather than a legislative instrument is more appropriate in achieving the desired outcome.

I commend the Government on its commitment to one-off implementation costs of $4.8Million and recurrent costs of $12.5Million.

The Commission looks forward to being part of the Inter-departmental Executive Committee for the implementation of this legislation.

Dr Lesley van Schoubroeck
Queensland Mental Health Commissioner

SUBMISSION SUMMARY

The Queensland Mental Health Commission's role is to drive on-going reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system. Mental health legislation is a cornerstone of such a system.

Our submission focuses on the need for Queensland to have contemporary mental health legislation which adopts a recovery-oriented, least restrictive approach which respects and protects the human rights of patients and acknowledges the important role played by families, carers and support persons in recovery. Developing this type of legislation requires a continuous process of refinement.

It considers the provisions of both the Mental Health (Recovery Model) Bill 2015 and the Mental Health Bill 2015 (the Bill).

Our submission focuses on key areas of reform including:

- objectives and principles
- patient rights
- care and treatment
- review of decisions
- provisions relating to those coming in contact with the criminal justice system.

Our recommendations

1. The Bill make clear that Independent Patient Rights Advisers are to be employed and engaged consistent with the policy issued by the Chief Psychiatrist.

2. The 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.

3. 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.

4. The Bill includes provisions which:
    - provide 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 3 days and provide a mechanism for AMHSs (Rural and Remote) to seek an extension to this time period of up to 4 days.

5. If the legislation does not require a treatment and discharge plan which is developed in consultation with the patient and their nominated support person, and where appropriate, families and carers, then the implementation committee be asked to report on the current use of discharge planning, particularly for people who have self-harmed.

6. The Bill includes provisions which require more frequent review of treatment authorities for minors.

7. That access to legal and lay representation before the Tribunal be monitored in implementation.

8. The Bill includes provisions requiring Tribunal hearings to be recorded and a transcript made available on request.

9. The Bill includes provisions requiring the Tribunal to include expertise in forensic mental health when applications to apply tracking devices are being considered.

INTRODUCTION

The Queensland Mental Health Commission was established to drive on-going reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system under the *Queensland Mental Health Commission Act 2013*.

Mental health legislation plays a fundamental role in a recovery-oriented mental health system. The focus of our submission 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 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*.

Our submission has been developed taking into account the views of people with a lived experience of mental illness, their families and carers as well as the views of academics, service providers and members of the public.

Developing contemporary mental health legislation is complex and involves careful balancing of rights and practical considerations. The process requires continual refinement in its development and during its implementation.

Our submission considers the provisions of both the Mental Health (Recovery Model) Bill 2015 (the Recovery Model Bill) and the Mental Health Bill 2015 (the Bill). Both Bills contain very similar provisions.

As the Commission's most recent submission on mental health legislation related to the Bill's consultation draft and for ease of reading, our submission will refer to its clauses except where there are significant differences with the Recovery Model Bill. We will focus our submission on key areas of reform including:

- objectives and principles
- patient rights
- care and treatment
- review of decisions
- provisions relating to those coming in contact with the criminal justice system.

OUR PREVIOUS SUBMISSIONS

This submission builds on our previous submissions which were based on consultation with key stakeholders commenced in 2014 during the *Mental Health Act 2000's* Review (the Act's Review) and research into contemporary mental health legislation. 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 which have been taken into account when developing this submission.

We have also taken account of views of the Mental Health and Drug Advisory Council members and sought feedback on a range of issues using social media.

These processes including feedback provided by those living with mental illness, their families and carers has informed the Commission's submissions at various stages of the Bill's development including our:

- Response to the Review's Discussion Paper in July 2014
- Submission to the Department of Health on the Bill's consultation draft.

Throughout our submission we refer to this feedback and research where it relates to particular reforms outlined in the Recovery Model Bill and the 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 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 throughout Queensland. Over 150 stakeholders attended seven forums held in Brisbane, Cairns and Toowoomba.

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.

Submission on the Bill's consultation draft

Many of the Commission's recommendations made during the review were addressed in whole or partly in the Mental Health Bill 2014 (the 2014 Bill) introduced in the Queensland Parliament by the former Minister for Health on 27 November 2014. They were also addressed in the Bill's consultation draft released for consultation on 2 May 2015.

After an initial review of the 2014 Bill and Commissioner indicated publicly that the Commission (text from media release dated 27 November 2014 is available on the Commission's website at www.qmhc.gov.qld.au):

- Supported the nominated support person role to replace the allied person's role to enable people to choose who supports them when they are not well;
- Supported provisions that enable families, carers and nominated support persons to receive relevant information, which will help address the frustration experienced when they have been excluded from the care and support of their loved ones because of privacy issues;

- Acknowledged that 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 overseen by the Mental Health 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 Mental Health Tribunal;
- Supported strengthened provisions around advance health directives.

The Commissioner indicated in her public comments that the on-going 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.

Our submission on the Bill's consultation draft to the Department of Health indicated that the Commission supported its provisions in-principle but identified a number of areas requiring further attention outlining 19 recommendations.

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 themselves acknowledging that family, carers, friends, treating teams and the wider community play an important role. It recognises that 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 have been accepted internationally and nationally as best practice. 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 in acute mental health wards). This 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 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.

- 'health professionals to provide care of the same quality 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[1].

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. [2]

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 interventions 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 Quality Rights 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.

The project provides training for mental health workers as well as providing information on best practice.

Contemporary legislation goes beyond a statement of these rights in principles. It requires consideration of rights when decisions about treatment and care are made, including providing patients with information about their rights and enables 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 significantly support this change process and support better outcomes for people living with mental illness.

OBJECTS AND PRINCIPLES

The 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 Bill (clause 3) proposes that the new Act's 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 these objects are implemented. Legislation in other States refers specifically to concepts of rights and least restrictive practices in their objects.

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

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 (s5(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's role, which is discontinued in the Recovery Model Bill and the 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 workshops, participants indicated strong support for retaining the allied person's role as an essential way patients are supported to express their views and to represent the patient at Mental Health Review Tribunal (the 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 workshops included:

- A lack of training, information and 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's 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 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's role 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. The Commission is also pleased to see that there is recognition that nominated persons need to be advised of their rights and responsibilities.

Advance health directives

A new addition to the 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, the ability 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 (clause 53). Our reading of this is that the advance health directive is not binding and treating teams are able to over-ride a patient's direction.

The Commission welcomes the addition of new clauses in the Bill which requires an authorised doctor who makes a decision about treatment and care contrary to an advance health directive to explain the reason for making the decision and recording it in the person's health records (clause 54). However, the Bill does not outline the circumstances in which this can occur.

Attention is drawn to the Victorian Act (s73) which 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.

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

Independent Patient Rights Advisers

The Bill's proposal to establish Independent Patient Rights Advisers (Rights Advisers) to support patients, families and carers is supported in-principle by the Commission.

The functions outlined in the Bill including: to ensure patients, their families, carers and nominated supported person; 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 (clause 292).

To provide this support effectively, the Commission believes that the Rights Advisers must have the ability to act independently of the mental health service and be perceived by patients and their supporters as independent.

The provision in the Bill, however, is that Rights Advisers may be an employee of another organisation engaged by the Hospital and Health Service (HHS) or an employee of the HHSs who is not employed in its mental health service (clause 291). Clause 293 provides some level of independence requiring that when performing their functions, the Rights Advisers must act independently and impartially and is not subject to direction or control.

While this is an improvement on the provisions outlined in the consultation draft Bill, there is a need to ensure that the role is able to operate in a way that is perceived as independent.

By way of contrast, Victoria has established a new independent mental health advocacy service[3] delivered through Victoria Legal Aid which will include a function to ensure people know about their rights and options. In Western Australia mental health advocates will have a much stronger independent role and also encompasses the role currently undertaken by Community Visitors in Queensland.

The Commission notes that the Minister for Health, at the sector briefing prior to introducing the Bill, acknowledged this concern and undertook to monitor it as part of the implementation and review of the legislation.

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.

The Commission 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[4].

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. It limits their ability for systemic oversight.

In our submission on the draft consultation Bill we noted that Community Visitors have legislated authority to access all areas of a site and to meet with and resolve complaints by or for a consumer. They produce reports after each visit to a facility. A cross reference in Chapter 9 that requires an Authorised Mental Health Service or other visitable site within the definition of the *Public Guardian Act 2014* to respond to any recommendations of the Adult Guardian arising from a visit by a Community Visitor would strengthen the oversight of that function. Alternatively this might be best achieved through an amendment to the *Public Guardian Act 2014.*

We note and support the expectation that Rights Advisers will work cooperatively with Community Visitors performing functions under the *Public Guardian Act 2014* (clause 292(c)). To ensure the Rights Adviser model is appropriate, the Commission recommends the model is developed in consultation with consumers, families and carers.

The Commission notes that the Chief Psychiatrist may develop a policy regarding the appointment and functions of the Rights Advisers (clause 303(2)(i)) and must report the details of their appointment (clause 305(2)(d)).

To avoid any confusion, it is recommended that clause 291 be amended to provide for the appointment of Rights Advisers consistent with the policy issued by the Chief Psychiatrist.

Recommendation

1. The Bill make clear that Rights Advisers are to be employed and engaged consistent with the policy issued by the Chief Psychiatrist.

Additional oversights

The function of oversighting mental health wards rests with the Chief Psychiatrist under the Bill and is complemented with the Inspectors role.

Statement of Rights

The Commission welcomes new provisions which will require a Statement of Rights to be developed by the Chief Psychiatrist (clause 270 of the Recovery Model Bill and clause 275 of the Bill) 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. It is important that the Statement of Rights is co-developed with consumers, families and carers.

Recommendation

2. The 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' (clause 279) while enabling patients to decide whether to accept the visitor .

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 Review Tribunal (clause 406).

The Bill confirms the right of patients to communicate in other ways with family, carers and supporters. As a step forward from the current Act, the Bill provides a specific right to community in a reasonable way using a mobile phone or electronic device (clause 282). The Commission supports this proposed provision as it is more likely to promote connections with family and friends.

It includes a provision enabling an AMHS to ban or restrict the use of an electronic device in the service (clause 279(3)) having considered the health and wellbeing and privacy of patients and others in the service (clause 279(4)). The right is limited to post or fixed line telephone.

The Commission was concerned that provisions in the draft consultation Bill would result in blanket bans across a service on use of mobile phones and not enable the use of communication through Skype.

We noted 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."[5]

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 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 explained 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.

The Commission accepts that these risks should be managed and supports the Bill's provisions which enable the AMHS to prohibit or restrict a person's ability to communicate via a fixed land line, a mobile phone or electronic communication if it is likely to be detrimental to the health or wellbeing of the person or others (clause 288).

Attention is drawn to the Victorian Mental Health Act 2014 s15-16 which 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.

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 Bill's provisions which will require the AMHS to take reasonable efforts to contact the person and encourage them to return (clause 362) and balancing this against any risk that the person may harm themselves or others.

CARE AND TREATMENT

The Bill significantly changes the way people are involuntarily examined, assessed and treated and its new treatment and care criteria are supported by the Commission (clause 12). They are that:

- 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 himself, herself or someone else, 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 submissions, 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 Bill 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 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.

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 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 JEOs had been used for malicious reasons and 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 ITO. Over half of all JEOs the assessment criteria were not found to be met. 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. That is, simply because a JEO that did not result in an assessment being made, is not an indication that there was not a mental health issue in every case.

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 authorised mental health services.

The Commission supports retaining an involuntary examination mechanism with strengthened safeguards, which includes considering clinical advice and whether reasonable attempts have been made to encourage voluntary treatment as outlined in the Bill (clause 502). This will increase the likelihood 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 Bill includes provisions requiring the Tribunal to hear applications for examination authorities (Part 8) as soon as practicable after the application is made (clause 725). 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. The Commission has been advised that through Justices of the Peace, decisions are often made within 24 hours whereas the Bill requires written notice of the hearing and at least 3 days notice unless otherwise agreed by the applicant [6].

While the Bill provides the alternative option for a more immediate response is an emergency examination authority, this process is not ideal as it often involves police and can lead to a situation escalating and reinforcing stigma associated with mental illness.

Recommendation

3. 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 examination authority 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 the treatment criteria may apply (clause 39 of the Bill). 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 be amended.

Treatment authorities

The Commission supports the Bill's provisions relating to the making of treatment authorities based on the treatment criteria which includes the capacity to consent and where there is 'no less restrictive way' for the person to receive treatment and care for their mental illness (clause 48).

The Commission strongly supports consideration of the patient's wishes and views when deciding the nature and extent of treatment and care to be provided under a treatment authority and specifically requiring that the authorised doctor talk to the patient (clause 53). 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 (clause 23).

The Bill's provisions makes inpatient treatment authorities as an exception rather than a rule and requires that it is ordered 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 (clause 51).

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. From a rights-based perspective, treatment decisions by individuals with capacity must be respected at all times. 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.

The Commission understands that these issues are complex and require a careful balancing of patient's human-rights and safety.

Access in rural and remote Queensland

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 Bill makes provisions which enable patients living in rural and remote Queensland to receive treatment and care in a mental health service closer to home through the declaration of a AMHS (rural and remote) (clause 329). Similar provisions are included in the Recovery Model Bill relating to AMHSs (regional) (clause 320). It is important to note that different conditions apply in these AMHSs including whether treatment authorities are reviewed if they are not made by an authorised psychiatrist.

For this reason, the Commission believes it is necessary to ensure that the provisions clarify that these AMHS provisions do not apply to existing services or those in regional centres by changing their title to AMHS (rural and remote).

The Commission continues to be concerned that patients receiving treatment and care in AMHSs (rural and remote) are subject to different review periods when a treatment authority is not made by an authorised psychiatrist (clause 56). The review period for all AMHSs must occur within 3 days. However, in relation to AMHSs (rural and remote) if this is not practicable the review must occur within 7 days.

While the Commission accepts that access to psychiatrists in rural and remote Queensland is limited, we are concerned that every effort is made to ensure those living in these communities are not disadvantaged. We recommended in relation to the consultation draft Bill the review periods for treatment authorities is the same in all AMHSs but that there is an option for AMHSs (rural and remote) to seek an extension of up to 4 days. This will ensure that every effort is made to review treatment authorities in a timely way.

Recommendation

4. The Bill includes provisions which:
    - provide 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 3 days and provide an mechanism for AMHSs (Regional) to seek an extension to this time period of up to 4 days.

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 (clause 263 in both Bills).

These provisions support Queensland's commitment to reduce and eventually eliminate restraint and seclusion from mental health treatment.

The Commission welcomes the Bill's provisions making it an offence to give medication to an involuntary patient unless the medication is clinically necessary (clause 271). The Commission particularly support's the Bill's provisions which requires the Chief Psychiatrist to develop a restraint, seclusion and other practices policy regarding the use of mechanical restraint, seclusion and physical restraint and the appropriate use of medication (clauses 294 of the Recovery Model Bill and 272 of the Bill).

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 (clauses 294 of the Recovery Model Bill and 303 of the Bill).

Nonetheless, a number of families have contacted the Commission with concerns about the apparent lack of consideration for patient safety following discharge, including taking account of the views of and notifying families and carers at the time. In particular the Commission has heard from family members of patients who were admitted to involuntary treatment following a suicide attempt. 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 (Rec 7.2).

The Commission has been advised by Queensland Health that this is a matter best implemented in a policy rather than a legislative context and notes also that this requirement may be limited to those who were admitted involuntarily unless specifically stated otherwise.

Recommendation

5. That if the legislation does not require a treatment and discharge plan which is developed in consultation with the patient and their nominated support person, and where appropriate, families and carers, then the implementation committee be asked to report on the current use of discharge planning, particularly for people who have self-harmed.

TRIBUNAL REVIEWS AND PROCEDURE

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 Mental Health Review 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 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. 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
- Victoria over 10 per cent are represented
- New South Wales, the Mental Health Review Tribunal reported that legal representation in mental health inquiries was provided in 98 per cent of cases[7].
- Tasmania, 10 per cent are presented by Legal Aid and a further 50 per cent have volunteer, non-legal representation
- Western Australia over 20 per cent are represented by a lawyer or a lay advocate.

The Bill includes several types of matters where legal representation would clearly benefit the patient, requiring that the Tribunal appoint a legal representative if the person is not already represented in matters regarding: minors, fitness for trial reviews and approval to perform electroconvulsive therapy and reviews where the State is legally represented by the Attorney-General (clauses 632 of the Recovery Model Bill and 738 of the Bill).

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 may not be required or beneficial in all cases, further consideration should be given as to whether the recommendations will sufficiently meet the needs of patients. The Commission notes that Victoria's *Human Services (Complex Needs) Act 2009* provides for a definition of people with multiple and complex needs who may need additional coordinated support.

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 Forensic or Involuntary Treatment Orders. It is noted that the *Mental Health Act 2007 (NSW)* (s 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.

Recommendation

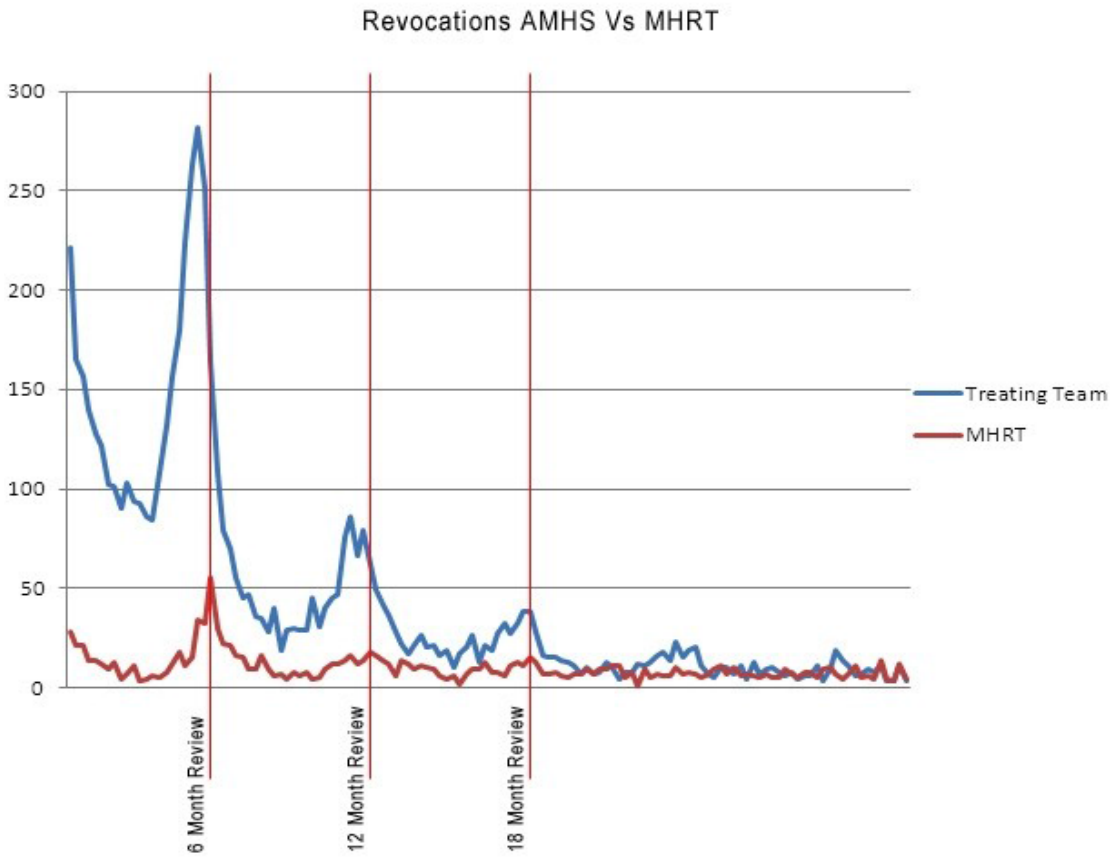
6. That access to legal and lay representation before the Tribunal be monitored in implementation.

Frequency of reviews by the Tribunal

The Commission welcomes provisions in the Bill which increase the frequency of periodic reviews of involuntary treatment authorities (clause 398 of the Recovery Model Bill and clause (411 of the Bill), while retaining the ability for patients to seek a review by the Tribunal at any time.

As the 2014 Annual Report of the Mental Health Review Tribunal illustrates, there is significant increase in the number of revocations of Involuntary Treatment Orders (ITO) by AMHSs directly preceding the scheduled Tribunal review[8]. Notification of an independent review appears to trigger an assessment process relating to the involuntary provisions of the Act resulting in revocations.

It would be expected therefore that increasing the time between scheduled reviews would lead to an increase in the average time that people remained subject to treatment authorities.



The table below includes a comparison of other states:

State	First review	Second review	Third review	Periodic review
Queensland (current)	6 weeks	12 months		Then 12 monthly
Both Bills	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 (in patient) and 12 months (community)		

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

Of particular note is that some jurisdictions such as Western Australia include an earlier initial review for children at 10 days. The Commission notes and supports that the Bill and the Recovery Model Bill include a new requirement for the Tribunal to review any decision of the Chief Psychiatrist to detain a minor in a high security unit (clause 463 of the Recovery Model Bill and clause 497 the Bill) within 7 days and at 3 month intervals thereafter.

Recommendation

7. The Bill includes provisions which require more frequent review of treatment authorities for minors.

Record of Tribunal proceedings

Our reading of the Bill does not require the Tribunal to record proceedings. The Tribunal may however publish a decision and its reasons, provided that no person is identified (clause 756).

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 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. The NT Act (s136) requires electronic recordings of all proceedings to be kept for 12 months.

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 and a transcript provided if requested.

Recommendation

8. The Bill includes provisions requiring Tribunal hearings to be recorded and a transcript made available on request.

Tribunal Constitution

The Commission welcomes the 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 (clause 717).

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 Bill's provisions which require, in a proceeding involving a minor and where the Tribunal must be constituted by at least one psychiatrist with expertise in child and adolescent psychiatry (clause 717).

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 Bill and the Recovery Model Bill 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:

- 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
- new powers for the Magistrates Court
- new options for the Mental Health Court
- changes in arrangements for tracking devices.

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 punished for relatively minor offences.

The Recovery Bill and the Bill both 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. The significant difference between both bills is the type of orders the Magistrates Court can make when they make this finding.

The Recovery Model Bill enables the Magistrates Court to either:

- Discharge the person unconditionally without punishment or
- On conditions the court considers appropriate (clause 171).

To ensure a person before the court accesses treatment and care the Magistrates Court also will have the ability to make an examination order (clause 176).

For more serious offences (an indictable offence) the Magistrates Court will also have the ability to refer a matter to the Mental Health Court (clause 173).

The Bill enables the Magistrates Court to make these findings in relation to a simple offence as defined in section 4 of the *Justices Act 1886* which is punishable on conviction in the Magistrates Court whether it is indictable or not.

The Magistrates Court can dismiss the charge (clauses 172 and 173). It also enables the Magistrates Court to refer a matter to the Mental Health Court if the nature and circumstances of the offence create an exceptional circumstance in relation to the protection of the community and the making of a forensic order or treatment support order may be justified (clause 175).

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.

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.

Currently the Mental Health Court's only powers are to make a Forensic Order, which is reviewable by the Tribunal. The Bill includes provisions which provide new options enabling the Mental Health Court to make:

- a forensic order (mental health)
- a forensic order (disability)
- a treatment support 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 or the community. The Commission also welcomes provisions which would enable the Mental Health Court to include a condition on a forensic order about intervention programs that should be provided for example drug and alcohol programs (clause 136).

Treatment support orders/court treatment orders

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 under the Recovery Model Bill (s 139) or under the Bill (clause 145) . The need for such an order which does not require people 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 treatment support 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 treatment support order is the way in which treatment in the community is authorised and the nature of clinical oversight of the person.

Court treatment orders and treatment support orders also differ from forensic orders in a number of ways:

- they can include monitoring conditions but not a condition to wear a tracking device (clause 140(1)(b) of the Recovery Model Bill and Schedule 3 definition of condition in the Bill);
- 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 (clause 144(2) of the Recovery Model Bill and clause 145 of the Bill).

A treatment support order category can be changed by an authorised doctor who can also change a condition or impose a condition but not a requirement to wear a tracking device (clause 216 of the Bill).

Court treatment orders and treatment support orders must be reviewed every six months by the Tribunal (s441 and clause 463 of the Bill) which has the ability to revoke the order and either make a treatment authority for the person or make no other order (s450 and clause 481 of the Bill). The Tribunal can also change the court treatment order category; order limited community treatment; remove or change a condition.

The Commission supports the Bill's provisions which will enable the Mental Health Review 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 when it considers that the new orders and not a forensic order is necessary to protect the safety of the individual as well as community including from risk of serious harm to other persons or property. This ability to step down the intensity of order is consistent with a recovery-oriented approach to mental health service delivery.

The Bill also 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 expressed concern that the Tribunal may not have the necessary expertise to make these determinations particularly in relation to determining risk to the community.

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's earlier submissions recommended 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 Bill requires a child psychiatrist for hearings involving children and young people and the current Act's requirements in relation to psychosurgery.

While we have been advised that this is consistent with current practice of the Tribunal, a legislative requirement however would enhance community confidence. This is a matter that should be monitored as the legislation is implemented.

Concerns were also raised about the 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.

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 Special Notification Forensic Patient (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 Bill with provisions enabling the Chief Psychiatrist to make information notices in relation to those on forensic orders and treatment support 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. The Commission also notes new provisions will enable victim impact statements to be considered by the Mental Health Court when making a decision in relation to an order (clause 133) and the Tribunal when reviewing a forensic order (clause 430) or a treatment support order (clause 462).

Tracking devices

The ability for the Director of Mental Health (to be the Chief Psychiatrist under both Bills) to require patients to wear a GPS tracking device under the current Act, has been criticised by stakeholders on the basis that it criminalises and stigmatises patients, and that the use of tracking devices are of limited value in reducing risks to patients and others.

The Commission supports limiting the use of tracking devices to forensic orders as outlined in both Bills however we are concerned about continuing power of the Chief Psychiatrist to impose a tracking device as proposed in the Recovery Model Bill (clause 217). While this decision is reviewable by the Tribunal (clause 459), the Commission is of the view that a more independent authority should make decisions regarding the imposition of a condition requiring a person to wear a tracking device.

The Commission considers the Bill's provisions which ensure that tracking devices can be included only as a condition of a forensic order and that they can be ordered only by the Mental Health Court and the Tribunal (Schedule 3, clauses 135 and 443 to 445). However, as noted in this submission, it is important that steps are taken to improve the transparency of the Tribunal through the recording of hearings and including a legislative requirement that its constitution when considering these types of matters includes expertise in forensic mental health, particularly when making a decision to impose a monitoring condition involving a tracking devise.

Recommendation

9. The Bill includes provisions requiring the Tribunal to include expertise in forensic mental health when applications to apply tracking devices are being considered.

IMPLEMENTATION AND ADMINISTRATION

Independence and accountability of statutory offices

Legislation governing the appointment of statutory officer 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 s 291)
- 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.

In our submission on the draft Bill, the Commission noted that these factors are generally well taken into account in provisions 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 were well embedded in the draft Bill, but it was proposed that the accountability mechanisms be strengthened. The following were proposed for consideration:

- 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 (s310), consider including 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 the approach to legislation in Queensland is that a person is eligible for re-appointment unless there are specific provisions to the contrary and support the implicit position that the Chief Psychiatrist should be eligible for re-appointment.

The Commission commends the inclusion of provisions for removal from office and reporting ministerial directions in the Bill. In relation to the term of appointment, we are advised by the Public Service Commission that "the person appointed as the Chief Psychiatrist has an underpinning appointment as a Senior Executive or District

Executive (SES/DES) appointment with conditions that set out a maximum period of appointment, which would then correspondingly apply to the Chief Psychiatrist. This is standard practice for a number of health statutory roles".

Implementation

The Commission notes that resources to one-off implementation costs of $4.8Million and recurrent costs of $12.5Million have been allocated to the implementation of the Bill.

Noting that the Bill does not require a review of the Act within a specified time, and substantial changes are being made, the Commission recommends on-going monitoring and early review of matters including:

- Effectiveness of the Patient Rights Advisers in the broader context of independent oversight
- Transfer of the provisions for emergency examination from the Act to the *Public Health Act 2005*, noting that the requirement to report on this is no longer the responsibility of the person administering the Act
- Adequacy of allocated resources for effective implementation.

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