

Office of the Public Advocate Systems Advocacy

Submission to Queensland Health

For the Review of the
Mental Health Act 2000
Discussion Paper May 2014

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Introduction

Interest of the Public Advocate

The Public Advocate was established by the *Guardianship and Administration Act 2000* to undertake systems advocacy on behalf of adults with impaired decision-making capacity in Queensland. The primary role of the Public Advocate is to promote and protect the rights, autonomy and participation of Queensland adults with impaired decision-making capacity (the adults) in all aspects of community life.

More specifically, the functions of the Public Advocate are:

- promoting and protecting the rights of the adults with impaired capacity;
- promoting the protection of the adults from neglect, exploitation or abuse;
- encouraging the development of programs to help the adults reach their greatest practicable degree of autonomy;
- promoting the provision of services and facilities for the adults; and
- monitoring and reviewing the delivery of services and facilities to the adults.¹

In 2014, there are approximately 113,000 Queensland adults with impaired decision-making capacity.² Of these vulnerable people, most have a mental illness (54 per cent) or intellectual disability (26 per cent).

Engagement of the Public Advocate in this review

The Public Advocate has been closely engaged with the review of Queensland's Mental Health Act. This is for a number of reasons.

First, the issue of the regulation of mental health treatment comes within the Public Advocate's purview, which includes promoting and protecting the rights of adults with impaired decision-making capacity and monitoring and reviewing services to adults with impaired decision-making capacity.

Second, the *Mental Health Act 2000* is important legislation. Apart from the obvious fact that it affects the rights of people with mental illness, it also sets the tone and aspirations for the care and treatment of people with mental illness in Queensland.

This was a point made by Dr Ian Freckleton QC in the public lecture he gave at the Queensland University of Technology (QUT) in May 2014. The Public Advocate joined with the Australian Centre for Health Law Research and the Queensland Mental Health Commission to invite Dr Freckleton to give a public lecture on a human rights approach to mental health regulation. We sought out Dr Freckleton to present the lecture due to his extensive qualifications, experience and knowledge base in relation to mental health law³ and as part of a general strategy undertaken by the Public Advocate to become informed, and inform others to engage with the review of the *Mental Health Act 2000*.

¹ *Guardianship and Administration Act 2000* (Qld) s 209.

² Office of the Public Advocate, 'The Potential Population for Systems Advocacy' (2014) Office of the Public Advocate <http://www.justice.qld.gov.au/__data/assets/pdf_file/0012/100821/potential-population-for-systems-advocacy.pdf>.

³ Dr Freckleton is a Queen's Counsel and member of both the Victorian and Tasmanian Bars. He is also a Professorial Fellow of Law and Psychiatry at the University of Melbourne, an Adjunct Professor of Law at Monash University and a member of both the Mental Health Review Board of Victoria and the Psychosurgery Review Board of Victoria. He is an elected Fellow of the Australian Academy of Law, the Australian Academy of Social Sciences and the Australasian College of Legal Medicine, the editor of the *Journal of Law and Medicine* and the Editor-in-Chief of *Psychiatry, Psychology and Law*.

The Public Advocate also hosted a Roundtable with legal professionals and relevant statutory officers who work with the current *Mental Health Act 2000* to consider the proposed changes in the Review of the *Mental Health Act 2000* Discussion Paper ('the Discussion Paper'). The Public Advocate was interested to hear from those practitioners who have day-to-day practical experience of working with that Act to inform this submission. This Roundtable included representation from the Office of the Adult Guardian; the Director of Mental Health; the Office of the Director Forensic Disability; the Office of the Director of Public Prosecutions; Legal Aid Queensland; Crown Law; the Anti-Discrimination Commission Queensland; the Department of Health; Queensland Advocacy Incorporated and Queensland Public Interest Law Clearing House Incorporated (QPILCH).

Finally, the Public Advocate attended the forum facilitated by Dr Penny Weller, hosted by the Queensland Mental Health Commission with a variety of both government and community stakeholders in attendance.

In addition to the Office's own research and experience, this engagement strategy has informed this submission in response to the Discussion Paper.

Summary of recommendations

Overall, the Discussion Paper proposes many positive initiatives that will serve to clarify the current *Mental Health Act 2000*, make the legislation more workable and practicable for those who work within the system, and enhance safeguards for people with mental illness.

The proposal to provide the Magistrates Court with procedural provisions to deal with unsoundness of mind and unfitness for trial represents a long-overdue response to the issue of people with mental illness or intellectual disability charged with simple offences and appearing in the lower courts. Giving the Mental Health Court flexibility to make a number of different orders will also assist in providing a more responsive forensic mental health system.

There are, however, a number of areas where the Public Advocate has concerns. A number of recommendations have been made that highlight and provide suggestions for addressing these concerns.

First, there is a need to provide a greater focus on a rights-based and recovery-oriented approach. This includes the need to review and amend the current purpose and principles of the *Mental Health Act 2000*.

Second, the proposed division between the Magistrates Court and the Mental Health Court with (subject to some limited exceptions) only those matters that must be heard on indictment being able to be referred to the Mental Health Court, creates a number of potential problems. In particular, an overly rigid enforcement of this division could lead to offenders with mental illness and intellectual disability 'slipping through the cracks', not receiving the treatment and care that they need and exposing the community to greater risks. Further, without appropriate supporting systems, the Magistrates Court will be ill-equipped to deal with these complex issues.

There has been a disappointing response to the issues for people with intellectual disability who come into contact with the criminal justice system. There must be a greater investment in support systems and infrastructure for this cohort, as well as a more comprehensive and holistic review of the current fragmented legislative response.

Finally, there are a number of areas that represent a potentially dangerous infringement of people's rights. These include the ability to impose non-revokable periods on forensic orders and involuntary treatment orders; the change in review periods; the expansion of Director of Mental Health's ability to impose monitoring conditions to people subject to involuntary treatment orders; and a reduction in the safeguards for the use of restraint and seclusion.

A summary of the Public Advocate's recommendations is set out below.

1. The current principles in the *Mental Health Act 2000* should be reviewed with a view to better reflect a rights-based and recovery-oriented approach.
2. The current purpose of the *Mental Health Act 2000* should be amended to better reflect a positive right to treatment and a rights-based and recovery-oriented approach to the assessment and treatment of all people with mental illness, not just those subject to involuntary treatment and forensic orders.
3. The proposed *Mental Health Act 2014* should emphasise the right to treatment for people with a mental illness and include positive rights that extend to people who are being voluntarily treated for mental illness.
4. There should be a full review of both the legislative and service system responses to people with intellectual disability who engage in offending behaviours and are in contact with the criminal justice system, in order to address the current inequitable response.
5. Consideration should be given to providing for a doctor or authorised mental health practitioner to make an involuntary examination authority in place of a Magistrate or Justice of the Peace.
6. The definition of capacity should be amended to exclude 'understand the benefits and risks of the treatment and alternatives to the treatment'. Rather an ability to assess the alternatives to the treatment should be added to point d) of the definition.
7. The current exception to the capacity-based approach to involuntary treatment should be amended. Rather, consideration should be given to requiring that a person arrive at a decision 'that is sufficiently stable for it to be followed'. If this criterion is adopted, it must be accompanied by a suite of legislative and non-legislative measures aimed at engaging the person in their treatment and treatment decisions.
8. The proposed *Mental Health Act 2014* should incorporate a positive obligation to provide a person with support and assistance to make a decision about treatment before the person's decision or refusal can be overridden. The definition of capacity should explicitly state that a person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
9. The assessment of capacity should also be informed by consultation with members of the adult's support network, particularly family, carers or close friends.
10. The proposed *Mental Health Act 2014* should adopt a review process characterised by gradually tapering reviews. Following the initial six-week review, the Tribunal should conduct reviews at three, six and 12 months and thereafter 12-monthly. This should be accompanied by a strong obligation on authorised doctors to review the person's treatment at regular intervals.
11. A Magistrate should have the power to refer both summary and indictable offences to the Mental Health Court. The discretion to make such a referral should not be subject to the approval of the Director Mental Health or the Director Forensic Disability.
12. The proposed restriction of the provision of mandatory psychiatric reports (where a person is already subject to a forensic order or involuntary treatment order) to situations where a person is charged with an offence that must be heard on indictment and where they, or their representative requests a report, should be broadened to include:
 - those matters referred to the Mental Health Court by a Magistrate; and
 - those matters where a person intends to pursue a defence of unsoundness or unfitness in the Magistrates Court.
13. The proposed *Mental Health Act 2014* should include a requirement that Magistrates receive a report about a person with mental illness or intellectual disability to inform their decision about whether a person is likely to be, or appears, unfit for trial or of unsound mind.

The proposed *Mental Health Act 2014* should also be accompanied by a state-wide court liaison service for people with intellectual and cognitive impairment. Alternatively, the current mental health court liaison service must be expanded to encompass people with intellectual and cognitive impairments.

14. Further options, other than forensic orders, should be considered for people with intellectual disability in the Mental Health Court, including orders that link people to the support they need.
15. The current proposal to impose non-revokable periods on forensic orders or involuntary treatment orders should be removed.
16. Any 'conditions' imposed by the Mental Health Court should be in the form of recommendations that can be subject to review.
17. The Review take into account the feedback provided by stakeholders and give further consideration to the proposal for special hearings.
18. If a 'standard' forensic order is to be made for a person with an intellectual disability, then (as for people with mental illness subject to involuntary treatment orders) the criteria for involuntary treatment for a mental illness must be satisfied.

In addition, the proposed *Mental Health Act 2014* should clarify that where the criteria for involuntary treatment for a mental illness are satisfied, that an involuntary treatment order can co-exist with a forensic order (disability).

An involuntary treatment order applied to a person with an intellectual disability should not authorise chemical restraint.

19. If non-revoke periods are able to be imposed in the Magistrates Court, the proposed criteria for a non-revokable involuntary treatment order imposed by a Magistrate should be identical to that imposed by the Mental Health Court – that is, that the Magistrate must consider whether the community requires protection from “serious harm to other individuals, serious property damage or repeat offending”.
20. The Review must consider the implementation of additional legislative and supportive responses for people with intellectual disability who are accused of a criminal offence and appear in the Magistrates Court.
21. Particularly for people with intellectual disability and cognitive impairment, the threshold for unconditional or conditional discharge by a Magistrate should be reconsidered.
22. An appeal should be available as of right to those people made subject to an involuntary treatment order.
23. The Review should consider clarifying the definition of treatment to ensure that it is not used too broadly. There should not be scope for a person subject to an order authorising involuntary treatment to be given medication that is not directly related to treatment of the mental illness that led them to be placed on, or maintained on, an involuntary treatment order. A definition similar to that used in the *Mental Health Act 2014* (Vic) should be considered.
24. There must be sufficient policy requirements put into place to ensure that a patient's proposed and provided treatment and care is adequately recorded and accessible by both the patient and others (such as family, carers or supporters).

The proposed *Mental Health Act 2014* should include principles that must be followed by treating staff to ensure that treatment plans are reflective and supportive of a recovery-based model.

25. The proposed *Mental Health Act 2014* should more explicitly recognise advanced health directives, and clearly set out the process of considering the implementation of an advanced health directive and notifying a patient when that directive is not followed. This should be achieved through the incorporation of provisions similar to those in the *Mental Health Act 2014* (Vic).

26. The proposed *Mental Health Act 2014* should incorporate provisions that enable patients to obtain a second opinion regarding the applicability of the involuntary treatment criteria and/or the treatment that is being provided to them. These should be similar to the provisions in the *Mental Health Act 2014* (Vic).

27. The criteria for limited community treatment must be expanded to incorporate factors relevant to people with intellectual disability or cognitive impairment.

Amendments to the provisions for limited community treatment must not negatively impact upon the ability of a person to return for in-patient treatment and then be released back to the community.

28. The imposition of monitoring conditions should not be expanded to include people subject to an involuntary treatment order.

The procedure for imposing a monitoring condition should be amended. The Director of Mental Health should not be able to impose a monitoring condition, but rather should be able to make a recommendation to the Tribunal that a monitoring condition be imposed.

If that recommendation is not accepted, then the criteria upon which the Director of Mental Health may decide to impose a monitoring condition and the criteria upon which the Tribunal reviews a monitoring condition must be aligned.

29. The definition of seclusion should not be amended to exclude instances where a person consents to seclusion.

30. The current restrictions on the authorisation of seclusion and restraint should be maintained.

31. Further safeguards should be provided for the use of restraint and seclusion including:

- notification of the patient's relevant support people including their guardian, carers, family members, advocate and/or legal representative, as well as the independent patient companion and community visitor when an instance of restraint or seclusion is used; and
- a compulsory debriefing by the treatment team after every instance of the use of restraint or seclusion, the results of which are included in the patient's file.

32. Tribunal oversight should be retained for the performance of non-ablative procedures such as deep brain stimulation.

33. The proposed *Mental Health Act 2014* should incorporate provisions with respect to the definition of and requirements for informed consent similar to the provisions in the *Mental Health Act 2014* (Vic).

34. The independent patient companion scheme must be adequately resourced, comprised of people independent from the mental health service, and available to people detained in the Forensic Disability Service. Independent patient companions must have a positive obligation to recognise and consult with not only guardians and attorneys, but also other formal and informal decision-makers and other family, carers and supporters.

35. The Review must develop a procedure for ensuring the provision of legal advice that is timely, comprehensive and valuable to the patient.

36. The Review must consider what assistance can be provided to lawyers to direct them in addressing or overcoming the barriers identified in this submission.

37. The Review must consider the resourcing needs of these proposals as they relate to other entities and ensure that they are adequately addressed.
38. The proposed *Mental Health Act 2014* must clarify the overlap between guardianship orders and orders authorising involuntary treatment.
39. The proposed *Mental Health Act 2014* must clarify the role of a substitute decision-maker and a lawyer during a special hearing, particularly with regard to decisions about the running of the hearings and determinations of what is in the patient's best interests.
40. The proposed *Mental Health Act 2014* must not curtail the ability of family, carers or supporters to legitimately question or disagree with treatment decisions. The ability of a support person to assist the person to seek a review of the treatment and a second psychiatric opinion should be explicitly recognised.
41. The needs of victims who may be particularly vulnerable or have difficulty communicating due to mental illness or intellectual disability should be incorporated into the new proposed principles.
42. A statement of reasons and a summary of a risk assessment should not be incorporated into the information made available pursuant to forensic information orders and classified patient information orders.

Position of the Public Advocate

Principles

The following principles inform the Public Advocate's response to the Discussion Paper:

- Mental health legislation should have an ethical foundation that includes both a rights-based and recovery-oriented approach to mental health treatment.
- A reduction in stigma and discrimination against people with mental illness should be a key objective of mental health legislation.
- Mental health legislation should balance respect for autonomy and self-determination of people with mental illness with the need to protect the person and the community from harm.
- Consultation, advocacy and patient involvement is not a substitute for safeguards in mental health legislation.
- The criminal justice system should not be discriminatory in the way it responds to offenders and alleged offenders.
- Mental health legislation should be workable and practicable for those practitioners who work in the system.
- An empirical approach to the monitoring, review and evaluation of legislative schemes as they apply to vulnerable people with mental illnesses and intellectual impairments is crucial.

A strong ethical foundation for mental health legislation

Without a strong ethical framework or underlying principles, there is a lack of cohesiveness to the regulatory framework for mental health treatment, resulting in a lack of integrity and underlying purpose and thus a lack of guidance for those interpreting and exercising legislative powers. The Public Advocate believes that the ethical framework should incorporate both a rights-based approach and a recovery-oriented approach to mental health treatment.

The *United Nations Convention on the Rights of Persons with Disabilities* (the Convention) imposes an

obligation on State parties to recognise that people with disability are equal before the law and are entitled to equal benefit and protection of the law. It requires State parties to prohibit discrimination on the basis of disability and to provide people with disability with protection from discrimination.⁴

In particular, the Convention provides that persons with disability have the right to equal recognition before the law,⁵ meaning that they must enjoy legal capacity on an equal basis and be provided with support to exercise their legal capacity where required.

There are also obligations to ensure that persons with disability are not deprived of their liberty unlawfully or arbitrarily;⁶ are free from torture or cruel, inhuman or degrading treatment or punishment;⁷ are protected from exploitation, violence and abuse;⁸ have their equal right to live in the community recognised, with choices equal to others;⁹ have access to information in accessible formats;¹⁰ and have the right to habilitation and rehabilitation, with services and programs, particularly ones related to health, employment, education and social services, offered at the earliest possible stage and in a way that is supportive of participation and inclusion in the community and society.¹¹

Involuntary treatment and care for a person with mental illness or intellectual disability necessarily impacts on a person's human rights, and can therefore only be justified where it necessary to protect the person or others from significant harm. Further, the impact must be proportionate (to the harm likely to be inflicted) and subject to appropriate safeguards. Ultimately, the restriction on a person's liberty to the degree authorised by an involuntary treatment order or forensic order must, in the exercise of the order, aim to result in an improvement in a person's functioning and their overall quality of life.

This is also consistent with a recovery-oriented framework for mental health legislation, which emphasises the value of the lived experience of people with mental illness alongside the expertise, knowledge and skills of clinicians. This framework challenges the conventional demarcations between consumers and clinicians, emphasising the importance of the active involvement of people with mental illness in their treatment and their empowerment rather than disempowerment in the treatment process.¹²

In practical terms, this means wherever possible working alongside the person and their carers to provide support, share information and communicate effectively; empowering the person to make choices; learning from consumers and their carers; and supporting the maintenance and development of social, recreational, occupational and vocational opportunities.¹³

Reducing stigma and discrimination

One of the key aims of any mental health legislation should be to reduce stigma in relation to mental illness, which in turn can lead to prejudice and discrimination against people with mental illness. This is also consistent with a rights-based and recovery-oriented approach.

There are many common misconceptions about people with mental illness, which are unfortunately often promoted by the media. These include that people with mental illness are dangerous; that people with mental illness cannot participate meaningfully in society, including that they cannot work; and that people with mental illness are all the same. Apart from having a negative impact on

⁴ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008) art 5 ('*Convention on the Rights of Persons with Disabilities*'); *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966 [1980] ATS 23 (entered into force 23 March 1976) art 26 ('*International Covenant on Civil and Political Rights*').

⁵ *Convention on the Rights of Persons with Disabilities*, art 12.

⁶ *Ibid* art 14.

⁷ *Ibid* art 15.

⁸ *Ibid* art 16.

⁹ *Ibid* art 17.

¹⁰ *Ibid* art 21.

¹¹ *Ibid* art 26.

¹² Dr Ian Freckleton QC, Public Lecture: *Mental Health Law Reform and Human Rights*, (Queensland University of Technology, 5 May 2014).

¹³ *Ibid*.

the person with mental illness, including on their recovery, stigma and discrimination can cause unnecessary fear in the community and underpin calls for further restrictions on the rights of people with mental illness.

Mental health legislation can play a significant part in either promoting or reducing stigma against people with mental illness. The proposed *Mental Health Act 2014* should ensure that it actively addresses stigma and prejudice against people with mental illness.

Balancing respect for autonomy with protection

Mental health legislation needs to balance a number of competing principles. In particular, while the principle of autonomy remains an important one for all health care, including mental health treatment, this must be balanced with the need to ensure that people receive the care and treatment they need.

The principle of autonomy has sometimes been subject to criticism with respect to the care of vulnerable people, including people with mental illness. This is due to some variants of the principle placing emphasis upon maximum non-interference,¹⁴ which some argue (in an oft-quoted comment) can pave the way for people with mental illness to 'rot with their rights on'.¹⁵

However, the principle can also be utilised to emphasise empowerment, capacity and agency building. Donnelly argues that this view of autonomy emphasises 'positive obligations to build and develop agency and to delivery adequate choice'¹⁶ to patients. The principle of autonomy also still provides the most effective way of keeping the central focus on the person.¹⁷ Therefore, balanced with the need for protection of people with mental illness, it remains an important guiding principle.

In practical terms, the incorporation of the principle of autonomy can mean: maximum emphasis on encouraging people with mental illness to participate in their treatment and treatment decisions regardless of their capacity; the provision of adequate information to make treatment decisions, in an appropriate format and with assistance in communication; the provision of actual options in treatment decisions; and opportunities to participate in and seek reviews of their treatment, or seek second opinions.

These types of positive rights should be an important element of the proposed *Mental Health Act 2014*. They should extend to patients in receipt of treatment of mental illness regardless of their capacity or lack of capacity, and their voluntary or involuntary status.

Consultation, advocacy and patient involvement is not a substitute for safeguards

While strategies that aim to empower and engage the patient are important, there will be some patients who, due to their mental impairment, cannot participate in decision-making about their treatment in a meaningful way. Further, people with mental illness in receipt of treatment such as psychotropic medication, whether involuntarily detained or not, are likely to be vulnerable and will not always have the wherewithal to enforce their rights. Therefore, it is important that strategies such as consultation, engagement, and the provision of the independent patient companion are not a substitute for safeguards, monitoring and reviews. These provide a crucial safety net for people who have difficulty exercising their positive rights. Further, these safeguards should not be overly dependent on patients initiating reviews and appeals. This approach is not well suited to vulnerable patients, who often have limited resources.

¹⁴ Mary Donnelly, *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge, 2010) 269.

¹⁵ P Appelbaum and T Gutheil, 'Rotting With Their Rights On: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients' (1979) 7 *Bulletin of the American Academy of Psychiatry and the Law* 306.

¹⁶ Donnelly, above n 14, 270-1.

¹⁷ *Ibid*, 47.

A non-discriminatory criminal justice system

Potential exists for Queensland’s current and proposed system of involuntary treatment to result in inequitable treatment for people with mental illness or intellectual disability who have contact with the criminal justice system, as opposed to those who do not present with these conditions.

The Convention recognises that equal treatment does not always result in the most favourable outcomes. In recognition of this, forensic mental health and criminal justice systems do not need to operate in the same way. However, there are some aspects of the involuntary treatment of people with mental illness who have committed an offence that can be discriminatory. These include:

- the indefinite nature of forensic orders;
- the imposition of non-revoke periods for involuntary treatment or forensic orders;
- the compulsory involvement in treatment programs;
- the indiscriminate use of involuntary treatment; and
- the potential for further infringement of rights once a person is made subject to an order; for example the arbitrary application of conditions that seriously impact on a person’s rights, such as monitoring (including GPS monitoring) and cancellation of limited community treatment for a ‘class’ of patients.

Practicable and workable legislation

Mental health legislation must enable the provision of effective care and treatment of people with mental illness, without unnecessary bureaucracy of legalistic processes that hinder people receiving the treatment and care they need.¹⁸

An empirical approach to monitoring, review and evaluation

The Convention includes an obligation on State parties to “collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect’ to the Convention”.¹⁹ There should be a continuing emphasis on collecting data and reporting to ensure the efficacy of the current approaches can be measured and assessed.

Monitoring, oversight and review are also particularly crucial wherever vulnerable people are subjected to involuntary treatment and detention. It is imperative that there is transparency in the way that treatment, support and services are provided to people with mental illness and intellectual disability under the proposed *Mental Health Act 2014*.

General comments

Principles of the Act

The principles in the *Mental Health Act 2000* should be reviewed in the light of both a rights-based and recovery-oriented approach, so that they can provide guidance to those who exercise powers and make decisions under the proposed *Mental Health Act 2014*.

¹⁸ Freckleton, above n 12.

¹⁹ *Convention on the Rights of Persons with Disabilities*, art 31(1).

In particular, the current principles do not place sufficient emphasis on a recovery-oriented approach, in that they do not emphasise the importance of:

- the provision of support and information to enable a person to make decisions about their treatment;
- the involvement of a person with mental illness in decisions affecting all aspects of their treatment including assessment, treatment and recovery; and
- a positive onus on those acting under the legislation to respect the views and wishes of the person, including those expressed in any advance statement about their care and treatment.

Recommendation 1: The current principles in the *Mental Health Act 2000* should be reviewed with a view to better reflect a rights-based and recovery-oriented approach.

The purpose of the Act

The *Mental Health Act 2000* is quite clearly directed toward the involuntary treatment of mental illness. This is particularly evident in the purpose of the Act, namely:

“to provide for the involuntary assessment and treatment, and the protection, of persons... who have mental illnesses while at the same time safeguarding their rights and freedoms and balancing their rights and freedoms with the rights and freedoms of other persons”.²⁰

The Act then goes on to say that the purpose will be achieved by:

- providing for the detention, examination, admission, assessment and treatment of persons having, or believed to have a mental illness;
- establishing the Mental Health Tribunal;
- establishing the Mental Health Court to, among other things, decide the state of mind of persons charged with criminal offences.²¹

The Act as a whole reads in such a way that people subject to orders arising out of the Act may feel as though they have been ‘criminalised’ or are ‘being punished’.

In fact, there are only a small number of people that are being treated for mental illness on an involuntary basis. For many patients treatment is either accessed voluntarily or, when a person is identified by some means as requiring treatment, the person then accepts that treatment voluntarily.

The voluntary nature of a great deal of treatment for mental illness should be better reflected in the proposed *Mental Health Act 2014*. In particular, the voluntary nature of treatment should be reflected in the purpose of the Act and the way in which the purpose is to be achieved. The Victorian *Mental Health Act 2014* provides valuable guidance regarding how the purpose of the Act could be reframed. That Act includes the following objectives:

- to provide for the assessment of people who appear to have a mental illness and the treatment of people who have a 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;
- to enable and support persons who have a mental illness or appear to have a mental illness-
 - to make, or participate in, decisions about their assessment, treatment and recovery; and

²⁰ *Mental Health Act 2000* (Qld) s 4.

²¹ *Mental Health Act 2000* (Qld) s 5.

- to exercise their rights under this Act;
- to provide oversight and safeguards in relation to the assessment of persons who appear to have mental illness and the treatment of persons who have mental illness;
- to promote the recovery of persons who have a mental illness;
- to ensure that persons who are assessed and treated under the Act are informed of their rights under the Act;
- to recognise the role of carers in the assessment, treatment and recovery of persons who have mental illness.²²

Recommendation 2: The current purpose of the *Mental Health Act 2000* should be amended to better reflect a positive right to treatment and a rights-based and recovery-oriented approach to the assessment and treatment of all people with mental illness, not just those subject to involuntary treatment and forensic orders.

Positive rights for voluntary patients

In order to ensure that all individuals understand that they can voluntarily access treatment and will not be made to feel criminalised in doing so, the proposed *Mental Health Act 2014* should include positive statements regarding the rights of all persons to access treatment. This would accord with human rights instruments, particularly the Convention²³ and the *Universal Declaration of Human Rights*.²⁴

The Act should more overtly acknowledge the rights of persons with mental illness, and particularly the right of all persons to voluntarily access mental health care. There are many people who receive voluntary treatment for mental illness (that is, those not subject to an involuntary treatment order or a forensic order), but there are limited safeguards and rights enumerated for them in the *Mental Health Act 2000*.

In many instances, involuntary assessment provides a ‘way in’ to the mental health system. There is evidence that some aspects of the involuntary assessment process, particularly justices examination orders, are misused and often do not result in involuntary treatment.²⁵ However, many of these orders do lead to voluntary treatment, with 40% of people who did not meet the assessment criteria in 2012-13 voluntarily accepting mental health services within the following 14 days.²⁶ This appears to be a positive outcome, in that people are brought into contact with the mental health system and are able to access treatment on a voluntary basis.

It is likely that the proposed *Mental Health Act 2014* will make it more difficult to obtain an authority for involuntary assessment. This is understandable given the need to ensure that the system is not abused, and the above data may arguably show that such restriction is warranted. However, it may have an unforeseen impact in that it is also more difficult to bring those people who do not meet the assessment or treatment criteria, but do require support or treatment for a mental illness, into contact with the system.

To counteract this unforeseen impact, the proposed *Mental Health Act 2014* should better reflect the rights and ability of people to access mental health treatment on a voluntary basis. Further, there may be a need to consider some form of public education regarding both access to voluntary treatment, and situations in which it may be suitable to use the involuntary treatment provisions.

²² *Mental Health Act 2014* (Vic) s 10.

²³ *Convention on the Rights of Persons with Disabilities*, art 25.

²⁴ *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd session, 183 plen mtg, UN doc A/810 (10 December 1948), art 25.

²⁵ Review of the *Mental Health Act 2000*, Background Paper 1, 5.

²⁶ *Ibid* 6; citing Department of Health data.

Recommendation 3: The proposed *Mental Health Act 2014* should emphasise the right to treatment for people with a mental illness and include positive rights that extend to people who are being voluntarily treated for mental illness.

Providing a framework for voluntary treatment and enumerating positive rights for people who are in receipt of treatment on a voluntary basis, such as the right to take part in their treatment decisions and participate in the development and review of treatment plans, will assist in addressing the stigma that can be associated with receiving treatment under the *Mental Health Act 2000*. It is also arguably more consistent with a principled approach to mental health regulation that focuses on realising and enhancing a person's autonomy.

People with intellectual disability

The purpose of the *Mental Health Act 2000* "is to provide for the involuntary assessment and treatment, and the protection, of persons (whether adults or minors) who have a mental illness while at the same time safeguarding their rights and freedoms and balancing their right and freedoms with the rights and freedoms of other persons".²⁷ Therefore, it is evident that the cohort to whom the *Mental Health Act 2000* is intended to apply is people with mental illness.

In the previous review of the *Mental Health Act 2000* conducted by Brendan Butler AM SC in 2006, it was recognised that despite the purpose, principles and schema of the Act only applying to people with mental illness, people with intellectual disability were also being captured by the provisions of the Act. It was identified that this was primarily because of those provisions of the Act dealing with criminal charges and forensic orders. In addition to identifying the inappropriateness of detaining people with intellectual disability and no mental illness in authorised mental health services, Butler AM SC stated that:

"(i)t would appear that the reason people with an intellectual disability who commit serious offences are dealt with under the *Mental Health Act 2000* is that there are no alternative legislative or service arrangements for people with an intellectual disability who require secure care. The *Disability Services Act 2006* (and its predecessor) does not contain analogous provisions to the civil or forensic provisions in the *Mental Health Act 2000* for the involuntary care and treatment of people with a mental illness".²⁸

In his final report, *Promoting Balance in the Forensic Mental Health System: Final Report Review of the Queensland Mental Health Act 2000* (the Butler Report), Butler AM SC recommended that

"a review of the provisions of the *Mental Health Act 2000* affecting people with intellectual disability be conducted as part of any reform to provide secure care for people with intellectual or cognitive disability who exhibit severely challenging behaviour".²⁹

In 2006, the Honourable William Carter QC commenced a review in relation to the "existing provisions for the care, support and accommodation of people with an intellectual or cognitive disability who represent a significant risk of harm to themselves or the community".³⁰ His final report *Challenging Behaviour and Disability: A Targeted Response* (the Carter Report) identified the inappropriateness of placing people with intellectual disability in Authorised Mental Health Services, as well as the fragmented response to people with intellectual disability who exhibit challenging behaviours generally, regardless of whether they are subject to a forensic order.³¹

The Carter Report³² recommended a legislative framework for restrictive practices inclusive of

²⁷ *Mental Health Act 2000* (Qld) s 4.

²⁸ B Butler AM SC, *Promoting Balance in the Forensic Mental Health System: Final Report Review of the Queensland Mental Health Act 2000* (2006) 101.

²⁹ *Ibid* 102.

³⁰ W Carter QC, *Challenging Behaviour and Disability: A Targeted Response*, (Report to Warren Pitt MP, Minister for Communities, 2006, 4.

³¹ *Ibid* 87.

³² *Ibid*.

provisions for detention (where a person was not subject to a forensic order or another order of a court). However, this was only one of many recommendations aimed at

“a fundamental process of reform, renewal and regeneration of the DSQ and disability sector’s response [to] provide an efficient, cost effective and financially sustainable outcome for the proper care and support of persons with intellectual disability and challenging behaviour across Queensland”.³³

The current scheme for involuntary treatment of people with intellectual disability is now fragmented across the:

- Mental Health Act 2000 (forensic orders for people who have been found unfit to plead or unsound of mind);
- Disability Services Act 2006 and the Guardianship and Administration Act 2000 (in approving the use of restrictive practices);
- Forensic Disability Act 2011 (detention in the Forensic Disability Service, including provisions for behaviour control medication); and
- health care provisions of the *Guardianship and Administration Act 2000*.

This fragmentation creates confusion, leaves gaps and often results in sub-optimal responses to people with intellectual disability who come into contact with the criminal justice system, as further outlined below.

The establishment of the Forensic Disability Service and the commencement of the *Forensic Disability Act 2011* went some way towards addressing the concerns raised in the Butler and Carter Reports. This response provided a more appropriate model of care for people with intellectual disability or cognitive impairment who are found to be unsound of mind or unfit for trial by the Mental Health Court. However, the response is not sufficient. The *Forensic Disability Act 2011* only provides the legislative framework for the ten-bed Forensic Disability Service (that quickly reached its full capacity); it does not provide a holistic system response to enable coherent, consistent and integrated care and support options for this cohort.

Despite the Carter and Butler Reports being released over seven years ago, there continues to be people with intellectual disability and no “mental illness requiring involuntary treatment” residing in mental health facilities. Some of these people are subject to a forensic order, and some are not. Some people with intellectual disability are subject to approval for containment and seclusion by Queensland Civil and Administrative Tribunal (QCAT), where they are held in detention-like conditions in the ‘community’. Some of these people are also subject to forensic orders, and are receiving limited community treatment whilst subject to containment.

There are also people where the nature of their criminal offences does not bring them before the Mental Health Court, yet their pattern of escalating behaviours also indicates a need for support. People who commit summary offences, particularly multiple summary offences, may never come before the Mental Health Court but may still be in need of support to mitigate against recurrent contact with the criminal justice system or escalating harmful behaviours.

Some of the proposals for the *Mental Health Act 2014* will have an impact on people with intellectual disability (such as the ability for a Magistrate to discharge a person unconditionally and/or refer them to the Department of Communities, Child Safety and Disability Services (DCCSDS)). However overall, the proposals do little to address the current inequitable approach to people with intellectual disability in the criminal justice system.

The expansion of the types of orders that the Mental Health Court can make, for example, allowing the Court to make either a Forensic Order or an Involuntary Treatment Order will have no relevance for people with intellectual disability unless they also have a mental illness requiring involuntary

³³ Ibid 9.

treatment. The transfer of responsibility for all those people subject to a forensic order (disability) to DCCSDS will also have little benefit without an enhanced systemic response inclusive of 'step down' or 'transitional' services to assist people to make the transition back to community living in less restrictive environments.

Consideration should be given to the commencement of a full review of the legislative framework for this group; inclusive of the clinical, accommodation and support services available throughout Queensland. The review of the *Forensic Disability Act 2011* (now due) could provide the opportunity for this review.

A distinct, but related issue is the lack of safeguards and oversight with respect to the use of medication, including psychotropic medication and other medication to control a person's behaviour (such as anti-libidinal medication), for people with intellectual disability subject to the mental health system. The Review acknowledges the continuing lack of clarity with respect to treatment of people with an intellectual disability who are subject to a forensic order (disability). The Public Advocate is aware that people with intellectual disability continue to be administered a range of medication, including psychotropic medication, even where they do not have a mental illness. This medication is often administered in lieu of appropriate support services designed to address 'challenging' but purposeful behaviours that have been learnt over time and that put themselves and others at risk of harm.

The Review should take a very cautious approach towards achieving a 'quick fix' by allowing a 'standard' forensic order (which permits involuntary treatment) to be made for a person with intellectual disability. The Public Advocate is not supportive of 'standard' forensic orders being applied to people with intellectual disability if the criteria for involuntary treatment are not met. This could have the result that people with intellectual disability can be subject to chemical restraint (that is, medication to control their behaviour) without appropriate safeguards.

Ultimately, the overall aim must be the provision of adequate and integrated systems of support that can be tailored to the specific needs of the person with intellectual disability. There must be a view toward reducing and/or eliminating the use of medication as a means of attending to complex needs that might more appropriately be addressed by different models of support.

Recommendation 4: There should be a full review of both the legislative and service system responses to people with intellectual disability who engage in offending behaviours and are in contact with the criminal justice system, in order to address the current inequitable response.

Response to specific proposals

Involuntary assessment and treatment

This section relates to the involuntary assessment and treatment of people with mental illness.

Presently, an involuntary assessment can occur by way of a request and recommendation for assessment,³⁴ a justices examination order³⁵ or an emergency examination order.³⁶ If an assessment determines that the treatment criteria under the *Mental Health Act 2000*³⁷ apply to the person, then an involuntary treatment order can be made for that person.³⁸ It is proposed to simplify and streamline the procedures for involuntary assessment and treatment.

³⁴ *Mental Health Act 2000* (Qld) ss 17, 19.

³⁵ *Mental Health Act 2000* (Qld) s 27.

³⁶ *Mental Health Act 2000* (Qld) s 35.

³⁷ *Mental Health Act 2000* (Qld) s 14.

³⁸ *Mental Health Act 2000* (Qld) s 108.

Involuntary assessment process

At present, the provisions of the *Mental Health Act 2000* regarding involuntary assessment are complex, and there can be difficulties in utilising those provisions to have a person involuntarily assessed.

Involuntary examination authority and recommendation for assessment

The proposed *Mental Health Act 2014* would simplify the assessment process. For an involuntary assessment to occur there would need to be an involuntary examination authority made by a Magistrate or an authorised justice of the peace, and a recommendation for involuntary assessment made by a doctor or authorised mental health practitioner.³⁹

Before seeking this authority the person making the application must obtain and document advice from a doctor or authorised mental health practitioner regarding the person's potential mental illness, treatment and care options, how the person may be encouraged to seek voluntary treatment and care, and the treatment criteria.⁴⁰ This process will assist with public education regarding access to voluntary treatment.

A Magistrate or Justice of the Peace must obtain written or oral advice from a doctor or authorised mental health practitioner⁴¹ and must only issue the authority if satisfied of the following:

- a) the person appears to have a mental illness;
- b) the person appears to lack capacity to consent to be treated;
- c) attempts at encouraging the person to be treated voluntarily have not succeeded or are not practicable; and
- d) there is an imminent risk that the person may cause harm to himself, herself or someone else, or suffer serious mental or physical deterioration because of the illness if the person does not receive involuntary treatment.⁴²

A doctor or authorised mental health practitioner may make a recommendation for assessment if they reasonably form the view that the treatment criteria (discussed below) apply to the person.⁴³

A person for whom an involuntary examination authority is made may apply to the Director of Mental Health for a review of the making and implementation of that authority.⁴⁴

Feedback regarding these proposals

These proposals were discussed amongst stakeholders at the Roundtable. In particular, stakeholders questioned whether the proposed model was the preferred approach.

Under the proposed model, a person would need to obtain and document advice from a doctor or authorised mental health practitioner before approaching a Magistrate or Justice of the Peace. That Magistrate or Justice of the Peace must also obtain oral or written advice from a doctor or authorised mental health practitioner before issuing the authority. There appears to be some duplication of, and therefore potential for conflict in, medical advice. Further, it would appear that a large part of the decision made by the Magistrate or Justice of the Peace would be based on medical advice.

Stakeholders suggested that a more appropriate approach may be for a doctor or authorised mental health practitioner to have the power to make an involuntary examination authority. The person should have a right of review of that authority to the Director of Mental Health or the Magistrates Court.

³⁹ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 1.1.

⁴⁰ Ibid 1.2-1.3.

⁴¹ Ibid 1.5.

⁴² Ibid 1.6.

⁴³ Ibid 1.16.

⁴⁴ Ibid 1.8.

This approach has recently been adopted by Victoria in the *Mental Health Act 2014 (Vic)*. In Victoria, a registered medical practitioner or a mental health practitioner may make an assessment order if they have examined the person and are satisfied that the assessment criteria apply. The criteria for an assessment order are that:

- a) the person appears to have a mental illness;
- b) because the person appears to have a mental illness, the person appears to need immediate treatment to prevent:
 - (i) serious deterioration in the person's mental or physical health; or
 - (ii) serious harm to the person or another person;
- c) if the person is made subject to an assessment order, the person can be assessed; and
- d) there is no less restrictive means reasonably available to enable the person to be assessed.⁴⁵

A person will then be assessed by an authorised psychiatrist and, if the treatment criteria are found to apply, the person will be made subject to a temporary treatment order.⁴⁶ This order will remain in force for 28 days, during which time the Mental Health Tribunal will conduct a hearing and determine whether to make a treatment order for the person.⁴⁷

If this approach were adopted in Queensland, it may have the effects of reducing the administrative 'red tape' and bureaucracy associated with accessing an involuntary assessment, ensuring reliance on consistent medical advice, and ensuring that people have ready access to the treatment that they need. It may also mitigate against some of the issues identified by the Review, such as a lack of understanding by Justices of the Peace and the practice of 'JP shopping',⁴⁸ both of which could be carried over into a new system and could extend to Magistrates.

Recommendation 5: Consideration should be given to providing for a doctor or authorised mental health practitioner to make an involuntary examination authority in place of a Magistrate or Justice of the Peace.

Treatment criteria

The proposed *Mental Health Act 2014* would incorporate the following recommendations regarding treatment criteria:

The treatment criteria be as follows:

- a) the person has a mental illness;
- b) the person lacks the capacity to consent to be treated for the illness;
- c) because of the person's illness, the absence of involuntary treatment (or continued involuntary treatment) is likely to result in:
 - (i) imminent serious harm to the person or someone else; or
 - (ii) the person suffering serious mental or physical deterioration.

A person has capacity to consent to treatment, if the person is able to:

- a) understand the nature and purpose of the treatment;
- b) understand the benefits and risks of the treatment, and alternatives to the treatment;
- c) understand the consequences of not receiving the treatment;
- d) assess the advantages and disadvantages of the treatment in order to arrive at a decision; and

⁴⁵ *Mental Health Act 2014 (Vic)* ss 29-30.

⁴⁶ *Mental Health Act 2014 (Vic)* s 46.

⁴⁷ *Mental Health Act 2014 (Vic)* s 55.

⁴⁸ Review of the *Mental Health Act 2000*, Background Paper 1, 8.

e) communicate the decision.

An authorised psychiatrist may maintain a person on an involuntary treatment order, notwithstanding that a person appears to have capacity to consent, if the psychiatrist reasonably believes that revoking the order is likely to result in the person:

- a) causing harm to himself, herself or someone else; or
- b) suffering serious mental or physical deterioration.⁴⁹

These treatment criteria will be relied upon by doctors or authorised mental health practitioners when making a recommendation for assessment (see above), by an authorised doctor when determining if a person should be made or continue to be subject to an involuntary treatment order, and by the Mental Health Review Tribunal when reviewing an involuntary treatment order.

Balancing protection with individual rights

As outlined in the Introduction, any mental health legislation must achieve a delicate balance between protecting the person and the community from harm and protecting a person's rights and autonomy, including their right to consent to or refuse treatment. Ideally the balance should err toward a focus on the needs of the particular individual and empowerment of the person to make their own decisions or be involved in decisions about their own treatment.

Stakeholders at the Roundtable felt that in some instances, the right of individuals to refuse treatment was not adequately protected. In particular, this issue exists because there is no space for a person to disagree with a diagnosis yet be considered to have capacity. Stakeholders advised that presently, if a person disagrees with a diagnosis, that person is deemed not to have insight into their condition and therefore to lack capacity.

Stakeholders felt this would still be an issue under the proposed reforms. This is particularly because the proposed treatment criteria refers to "understanding the benefits and risks of the treatment".⁵⁰ That is, disagreement with proposed treatment may be seen as a failure to appreciate the benefits of that treatment, and therefore as a lack of capacity.

It is imperative that the proposed *Mental Health Act 2014* adequately recognise the rights of individuals to make their own decisions, including decisions with which others do not agree. This means that a person's capacity must not be considered in light of whether benefits and consequences are appreciated by the person in the same way as they are by authorised doctors and responded to as expected, but rather in light of whether the person has properly understood all of those relevant factors. Arguably if 'alternatives to treatment' was also added to point (d) of the criteria ('assess the advantages and disadvantages of the treatment in order to arrive at a decision') this could adequately and objectively address whether the person can assess the likely advantages and disadvantages of the treatment without the addition of the more subjective 'benefits and risks' criteria.

Recommendation 6: The definition of capacity should be amended to exclude 'understand the benefits and risks of the treatment and alternatives to the treatment'. Rather an ability to assess the alternatives to the treatment should be added to point d) of the definition.

The meaning of capacity

At first glance, the proposed involuntary treatment criteria incorporate what is known as a 'capacity-based approach' to involuntary mental health treatment. This means that a lack of capacity is the defining criteria for treating a person involuntarily for mental illness.

The use of capacity-based approaches to involuntary mental health treatment has been the subject of numerous and extensive debates between those who emphasis the importance of autonomy and

⁴⁹ Review of the *Mental Health Act 2000* Discussion Paper, recommendations 1.17-1.19.

⁵⁰ Ibid 1.17.

those that emphasise protection. For example, when the *Mental Health Bill 2006* (UK) was introduced into Parliament, the issue of capacity-based criteria for civil detention was hotly contested. Initially, the House of Lords added a clause requiring that the person's decision-making is 'significantly impaired' as a pre-condition to involuntary treatment. The House of Commons (in committee stage) reversed this clause, following arguments that took up one and half of the 12 sittings of the Committee, with 'one side emphasising risk and the other emphasising autonomy and the need to avoid discrimination as between physical and mental illness.'⁵¹

The definition of capacity is a crucial concept. It is potentially a 'gatekeeper' to involuntary treatment. In the proposed criteria, the definition of capacity is fairly comprehensively defined. However, it is subject to an exception that a person may be maintained on an order even if they appear to have capacity, if the doctor reasonably believes that revoking the order is likely to result in the person causing harm to themselves or another person, or suffering serious mental or physical deterioration.⁵²

This exception, which has the effect of contradicting the capacity-based approach to involuntary treatment described above, is an acknowledgement of the inherent difficulties in adopting capacity-based approaches for people with mental illness who may have fluctuating capacity.

The Review notes that the exception is part of a 'longitudinal diagnoses' approach, and explains why this is required.

Cross-sectional v longitudinal diagnosis

The criteria in the Act require an authorised doctor to take a cross-sectional (or 'point-in-time') diagnosis of a person. This is required due to the 'immediate treatment' element of criteria (b) and the 'imminent risk' element of criteria (d)(i). While this approach may work satisfactorily on initial diagnosis, it becomes problematic after this point. Once a person becomes stable on medication, the immediacy of the treatment or care passes and, on proper interpretation of the criteria, an authorised doctor must revoke the order. This is also the case once the person has recovered sufficiently to regain capacity.

Revoking an involuntary treatment order would be appropriate in circumstances where the treating clinician is of the view that the person will return to the community and engage voluntarily in a treatment and care program to manage their illness as required, or where no further treatment is warranted.

However, a constant theme from stakeholders consulted in the Review is the high risk of serious deterioration of patients when they are removed from an involuntary treatment regime. Clinicians have advised the Review that predictive factors in this regard are:

- failure to continue to take medication (especially where persons have a history of this)
- use of illicit drugs or excessive use of alcohol (especially where persons have a history of this), and
- returning to an unstable living environment in the community.

For these reasons, a cross-sectional approach to diagnosis is likely to result in many persons 'cycling' on and off involuntary treatment orders. This is not in the interests of the patient or the community and does not, over time, support a least restrictive approach to the person's treatment.

For these reasons, it is proposed that the treatment criteria in the new legislation support a more longitudinal diagnosis of patients.⁵³

⁵¹ Kris Gledhill, 'The role of capacity in mental health laws – recent reviews and legislation' (2010) *Journal of Mental Health Law* (special issue) 134.

⁵² Review of the *Mental Health Act 2000* Discussion Paper, recommendation 1.19.

⁵³ Review of the *Mental Health Act 2000*, Background Paper 1, 13-14.

Fluctuating capacity

In the background papers, the Review has discussed the issue of fluctuating capacity and provided the following reasoning for including the exception to capacity:

(The treatment) criteria maintain the primacy of a person's right to consent to treatment if the person has capacity to do so. If a person did not have insight into his or her condition, the criteria may be met as 'capacity to consent' requires a person to understand the consequences of not receiving treatment to have capacity. However, whilst having more robust criteria of what constitutes capacity to consent will assist clinicians in making assessment against the treatment criteria, definitively assessing a person's capacity can be uncertain and changeable. Where a person's capacity fluctuates, risk to the person's health may arise.

To provide clarity in this matter, it is also proposed to expressly state that an authorised psychiatrist may maintain a person on an involuntary treatment order, even if the person appears to have capacity, if the doctor reasonably believes that revoking the order would place the person or others at serious risk of harm, or the person's physical or mental state would deteriorate in a serious way.⁵⁴

This approach gives rise to a number of concerns.

Firstly, the exception is too broad. The exception applies where revoking the order would give rise to a serious risk of harm or serious deterioration in a person's physical condition. Those criteria are very broad in scope and there is no qualification stating that they apply only where there is a concern as to fluctuating capacity. It therefore appears that the exceptions could apply in many situations where a person's capacity did not fluctuate. On that basis, this exception is not considered appropriate to address the issued of fluctuating capacity.

Secondly, the exception introduces a hybrid approach with contradictory elements. That is a person who has capacity cannot be subject to involuntary treatment. Yet, if a person may be at serious risk of harm or at risk of their condition deteriorating, then regardless of their capacity they may be involuntarily treated. The result is that the harm criteria again trumps capacity.

At the Roundtable, stakeholders engaged in discussion regarding the issue of fluctuating capacity. It was generally acknowledged that fluctuating or momentary capacity can pose a risk to the person and may not be viewed as 'true' capacity.⁵⁵ However, it was not accepted that including an exception to the definition of capacity was the proper means of addressing this issue.

Some alternate approaches could be taken to address the issue of fluctuating capacity. First, rather than having an exception to the definition of capacity, the definition could be made more specific. One means of achieving this could be to require that a person arrive at a decision "that is sufficiently stable for it to be followed".⁵⁶ The term 'sufficiently stable' is a subjective one,⁵⁷ but it could be guided by legislative considerations if desired and to some extent, given the nature of the decisions, it could be guided by whether medical practitioners could consistently act on the person's decision (for example, could they consistently provide the person with treatment). The inclusion of this phrase may address the issue of fluctuating capacity, in that a person who cannot maintain a consistent decision due to fluctuations in capacity would not be deemed to have capacity.

An alternative suggestion is to substitute the test of 'capacity' with the test of 'significantly impaired

⁵⁴ Ibid 14.

⁵⁵ See Review of the *Mental Health Act 2000*, Background Paper 1, 14.

⁵⁶ G Szmukler, R Daw and J Dawson, 'A Model Law Fusing Incapacity and Mental Health Legislation' (2010) *Journal of Mental Health Law* (special issue) 11, 13.

⁵⁷ A Buchanan, 'The Treatment of Mentally Disordered Offenders Under Capacity-Based Mental Health Legislation' (2010) *Journal of Mental Health Law* (special issue) 40, 41.

decision-making'.⁵⁸ It is argued that this is preferable because there may be some people on the border who would 'pass' a capacity test, but with significant impairments for which they may not receive adequate assistance.⁵⁹ This is a broader test and one that specifically refers to 'impaired decisions', so it may better capture people whose decision-making is affected by fluctuations in their capacity.

The first suggestion is arguably more consistent with an approach that respects the autonomy of the person, as well as the rights-based approach in the Convention. The Convention's approach to autonomy places less importance on the traditional liberal view of autonomy and the associated distinction between capacity and lack of capacity. In placing the emphasis on 'a sufficiently stable' decision, the focus is on the development of a person's decision-making capacity, and an acknowledgement that capacity may not always be a 'black or white' concept. However, it is crucial that such an approach is supported by 'adequacy of choice and with the development of autonomy-building measures aimed at enhancing individual agency and affecting a shift in decision-making power to the individual'.⁶⁰ Here, the focus is on the quality of the process, and the overall aim at enhancing the decision-making capacity of the person.

For this reason, if such an approach were followed it should be accompanied by a suite of positive legislative obligations associated with engagement of the person in their treatment and their treatment decisions.

Recommendation 7: The current exception to the capacity-based approach to involuntary treatment should be amended. Rather, consideration should be given to requiring that a person arrive at a decision 'that is sufficiently stable for it to be followed'. If this criterion is adopted, it must be accompanied by a suite of legislative and non-legislative measures aimed at engaging the person in their treatment and treatment decisions.

Capacity and support

The concept of capacity must also refer to the concept of support. This is discussed in more detail below, however it is important to acknowledge that many people who may not have capacity alone, may have capacity with support.

It is noted that for the purposes of section 14(1)(f)(i) of the *Mental Health Act 2000* (Qld) it is only the person's own consent that is relevant, despite the existence of the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*. However, there may be situations in which a person is able to give their own consent if they have the support of another person. This is a concept that has been given consideration by the Office of the Public Advocate⁶¹ and which should be recognised by relevant mental health legislation.

As such, the concept of support should be introduced into the definition of consent and a person's capacity to consent should be assessed in light of any support that is regularly available and easily accessible to that person.

In the workshop hosted by the Queensland Mental Health Commission and facilitated by Dr Penny Weller, participants' attention was drawn to the principle in the *Mental Capacity Act 2005* (UK) that 'a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success'.⁶² This is an example of a positive obligation to provide a person with support and assistance to make a decision, prior to overriding the person's decision-making autonomy, which could be incorporated into the approach taken by the proposed *Mental Health Act 2014*.

⁵⁸ J Atkinson and H Patrick, 'Balancing Autonomy and Risk: The Scottish Approach' (2010) *Journal of Mental Health Law* (special issue) 78, 79-80.

⁵⁹ Ibid.

⁶⁰ Donnelly, above n 14, 257.

⁶¹ See the Office's project on 'Decision-Making Support in Queensland', at <<http://www.publicadvocate.qld.gov.au>>.

⁶² *Mental Capacity Act 2005* (UK) s 1.

Recommendation 8: The proposed *Mental Health Act 2014* should incorporate a positive obligation to provide a person with support and assistance to make a decision about treatment before the person's decision or refusal can be overridden. The definition of capacity should explicitly state that a person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.

Capacity and criminality

Stakeholders at the Roundtable also noted that the exception to the definition of capacity may exist because, if other recommendations for reform are accepted, many people who commit criminal offences would then have their case proceed through the Magistrates Court and ultimately be made subject to an involuntary treatment order by a presiding Magistrate. It was noted by stakeholders that some of these people may have capacity, but due to those criminal charges, there will be a desire to continue involuntary treatment to assuage concerns regarding harm to others. This appears to be supported by the reference the Review makes to the 'fragility' of involuntary treatment orders and the fact that they do not guarantee ongoing treatment and care where community protection is a consideration.⁶³

If this exception exists to provide a means of ensuring those people who have committed a criminal offence can be maintained on an order, then the proposed *Mental Health Act 2014* should acknowledge and explicitly state that this is the case. This should not operate as a general exception to the concept of capacity. More importantly, serious consideration should be given to whether such a provision should exist. There is an intention to provide a less restrictive response to some less serious offences.⁶⁴ However, if a person can be indefinitely maintained on an involuntary treatment order on the basis that they pose a risk of harm and despite having capacity, this is arguably not a less restrictive response and is a serious breach of human rights.

Involvement of supporters

The treatment criteria, including the definition of capacity, refers only to the 'person'. It does not take into account that a person exists within a wider environment and often within a network of supports. An assessment of a person, in an unfamiliar environment and on a doctor-patient basis, may not be a true reflection of a person's mental state or capacity.

This could result in a misapplication of the treatment criteria. For example, a person could be assessed at a particular time of day when they appear relatively well, resulting in a determination that they do not meet the treatment criteria, when in fact they are quite mentally unwell. Equally, a person could require support to demonstrate their capacity (for example, the provision of simple explanations or assistance in communicating) and without that support be unable to display their capacity, resulting in a determination that they do meet the treatment criteria when in fact they generally would not.

In many instances, a misapplication could result from an issue over which the assessing doctor has little control (such as the time of assessment) or an issue of which the assessing doctor is not aware (such as the usual presence of a support person). To counter this, there should be a requirement that people in the person's support network, particularly family, carers or close friends, are able to speak to the assessing doctor and advise of any relevant matters.

Given that the time in which an assessment must take place is limited, extensive consultation with supporters would not be possible. However in many instances, the person who made the application for assessment is a member of the adult's support network, and at least in those instances the applicant should be consulted. Further, the person subject to assessment should be given the opportunity to nominate a person or persons with whom they believe the assessing doctor should consult.

⁶³ Review of the *Mental Health Act 2000*, Background Paper 4, 4.

⁶⁴ Ibid, 5-6.

Recommendation 9: The assessment of capacity should also be informed by consultation with members of the adult's support network, particularly family, carers or close friends.

Review periods

It is proposed that the review periods for involuntary treatment orders be amended. Under the proposal, the initial six week review will be retained as will the right of the patient or their representative to apply for a review at any time. However, it is proposed that automatic reviews would occur on a 12-monthly basis, as opposed to the current six-monthly basis.

Whilst accepting that in some instances six-monthly reviews may be too frequent, possibly leading to stress and representing an unnecessary or unwise use of resources, substantially lengthening the review period will also have associated difficulties. Several stakeholders opined that 6-monthly reviews were an important safeguard, often acting as a 'prompt' to clinicians to review and in many instances revoke an order. With reviews occurring on a 12-monthly basis, this safeguard would be reduced or lost.

There is an argument that other safeguards will compensate for this loss. Most notably, the independent patient companion (discussed below) can assist in prompting assessment or in making applications for review. Further, it can be argued that with a longer period between Tribunal reviews, clinicians will be forced to consider the applicability of orders and act accordingly.

However, this approach is dangerous for vulnerable people with mental illness subject to involuntary treatment. The reliance on patients who are often subject to psychotropic medication on an involuntary basis and may be detained in an authorised mental health service with a lack of resources initiating their own review, or gaining the support and attention of the independent patient companion is fraught.

Further, if these other safeguards do not operate as required and people are unnecessarily retained on orders, the implications are serious. Firstly and of most concern, the rights of the people subject to these orders will be significantly and unacceptably infringed upon. Further, there would be a significant loss of resources in maintaining these unnecessary orders.

To strike a balance between the need for safeguards and the need to use resources wisely, it is recommended that the proposed *Mental Health Act 2014* adopt an approach whereby review periods are gradually tapered. For example, following the initial six-week review, the Tribunal could conduct reviews at three, six and 12 months and thereafter 12-monthly. This approach ensures that, for those people who do not need to be on an order for a lengthy period, there are reasonably frequent reviews that could prompt or result in revocation. It also ensures that, where orders do continue over a longer period, reviews are adequately timed to reduce stress and effectively utilise Tribunal resources. Stakeholders at the Roundtable who viewed six-monthly reviews as a necessary prompt were willing to consider this as a possible compromise.

Recommendation 10: The proposed *Mental Health Act 2014* should adopt a review process characterised by gradually tapering reviews. Following the initial six-week review, the Tribunal should conduct reviews at three, six and 12 months and thereafter 12-monthly. This should be accompanied by a strong obligation on authorised doctors to review the person's treatment at regular intervals.

The courts and mental health

This section relates to the responses that are available where a person with a mental illness or an intellectual disability is alleged to have committed a criminal offence.

Currently, if the alleged offence is an indictable offence, it may be heard by the Mental Health Court. If that Court determines that the person was of unsound mind at the time of the offence or is unfit

for trial, then the person may be made subject to a forensic order. If the unsoundness or unfitness is a result of mental illness, this will be a forensic order and will permit the person's detention for involuntary treatment or care. If the unsoundness or unfitness is a result of intellectual disability, this will be a forensic order (disability) and will permit the person's detention for care. In either instance, the person may be detained in an appropriate service or reside in the community.

If the alleged offence were a summary offence, or an indictable offence that is heard summarily, the offence would be determined by the Magistrates Court. The Magistrates Court has no procedures for determining fitness for trial or unsoundness of mind, and no corresponding diversionary options are available. While the common law would apply, so that the Magistrates Court could hear evidence and determine if a defendant is fit to plead or to stand trial in relation to simple offences, there are no statutory provisions setting out the procedure to be followed. Further, even if the Magistrates Court found that the person was of unsound mind and acquitted the defendant, there are no statutory provisions that enable the Magistrates Court to order treatment, care or other interventions to prevent further offending. Finally, there is no power for the Magistrates Court to refer the question of the defendant's mental condition to the Mental Health Court.

Jurisdiction of the Mental Health Court and the Magistrates Court

The Review proposes that the Mental Health Court have jurisdiction to hear matters that must be heard on indictment, as well as a limited number of prescribed indictable offences, such as stalking.⁶⁵ The Mental Health Court would also have jurisdiction to determine indictable offences that have been referred from the Magistrates Court.⁶⁶

The Review proposes that the Magistrates Court have jurisdiction to hear the balance of matters; that is, matters that must be heard summarily and indictable offences that can be heard summarily.⁶⁷ Magistrates will also have discretion to refer indictable offences to the Mental Health Court. This discretion can be used when a Magistrate is satisfied that a person is of unsound mind or is unfit for trial, and considers that an ongoing risk to other persons or their property is so serious that a forensic order may be warranted. The referral would be made to the Director of Mental Health or the Director of Forensic Disability, for an assessment of whether the matter should proceed to the Mental Health Court.⁶⁸

Feedback regarding this jurisdictional division

Stakeholders at the Roundtable did not entirely support the proposed jurisdictional division. There was support given to the proposal that the Magistrates Court have powers to hear and determine summary offences on the basis that a person is of unsound mind or unfit for trial. However, it was strongly argued by stakeholders that the Mental Health Court should have a much broader jurisdiction than is proposed. The following supporting arguments were put forward by stakeholders:

- The Mental Health Court has significant expertise in hearing and determining such matters, and this experience and expertise should be retained and drawn upon for a broad range of offences. Magistrates do not have the necessary training or expertise to take on this role.
- There is no need for an offence committed by a person with mental illness or disability to be dealt with by the same court that would deal with the offence when committed by a person of sound mind. The Mental Health Court is not an arm of the Supreme Court and its jurisdictional 'level' should not be equated with the Supreme Court. Rather, the Mental Health Court is a separate statutory creation of which Judges of the Supreme Court may be appointed members.⁶⁹

⁶⁵ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 4.2; Review of the *Mental Health Act 2000*, Background Paper 4, 5.

⁶⁶ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 4.2; Review of the *Mental Health Act 2000*, Background Paper 4, 12.

⁶⁷ Review of the *Mental Health Act 2000*, Background Paper 4, 12.

⁶⁸ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 4.29; Review of the *Mental Health Act 2000*, Background Paper 4, 12.

⁶⁹ *Mental Health Act 2000* (Qld) ch 11 (particularly ss 381, 385).

- Many quite serious offences can be heard on indictment or on a summary basis. There is therefore the potential for significant offences to be determined in the Magistrates Court and without the necessary expertise. This may result in an inadequate response, or in people ‘slipping through the cracks’ and not receiving the support they require and the community being without adequate protection.
- Many people with mental illness or disability are in the Mental Health Court for less serious offences but those offences may be a precursor to or indicia of future serious offending, or may only be less serious due to external intervention (for example, a person is charged with an assault that is non-serious only because they were stopped). These people would still benefit from and should receive the specialist attention of the Mental Health Court.
- The appropriate response to a simple offence should not be artificially determined by jurisdiction, but by taking into account the person’s criminal and mental history. This history may mean that, even for summary offences, a referral to the Mental Health Court is warranted. This is also more consistent with the longitudinal approach advocated for by the Review.
- Where offences are heard in the Magistrates Court and there is a dispute regarding whether a person is of unsound mind or unfit for trial, this will essentially result in a situation where a Magistrate must hold a summary trial to determine that matter. This is not an ideal situation.

It should also be noted that the Mental Health Court operates on a model of therapeutic jurisprudence, where the focus is not on punishing a person for a criminal act, but rather on the treatment and wellbeing of those people to address the issues underlying and leading to that criminal act. The Magistrates Court does not have such a focus, and as such is not the most appropriate court to hear and determine matters where a person may be of unsound mind or unfit for trial.

In order to go some way toward countering these concerns, stakeholders advocated for the discretion to refer offences to the Mental Health Court to be widened. Specifically, it was argued that a Magistrate should have the power to refer both summary and indictable offences to the Mental Health Court and that this discretion should be broad in nature. That is, the discretion should be able to be used not only where there is a serious risk, but also where another circumstance exists such that a Magistrate feels a referral is warranted. Examples of other relevant circumstances include where a person is seriously ill, has a significant or complicated history, or presents with some relevant circumstance such that the Magistrate feels the matter is better decided by the Mental Health Court.

It is also suggested that the discretion given to Magistrates should not be one that is subject to the approval of the Director of Mental Health or the Director of Forensic Disability. A Magistrate will have had the benefit of hearing relevant evidence before making a decision and this, coupled with their judicial position and decision-making experience, should mean that they are able to make a direct referral when they believe it is required. This will also reduce administrative costs and procedures associated with a matter.

Recommendation 11: A Magistrate should have the power to refer both summary and indictable offences to the Mental Health Court. The discretion to make such a referral should not be subject to the approval of the Director Mental Health or the Director Forensic Disability.

Mandatory psychiatric reports

Presently, if a person is subject to a forensic order or an involuntary treatment order and is charged with an offence, then arrangements must be made for a person to be examined by a psychiatrist. The psychiatrist must prepare a report that addresses the person’s fitness for trial and their soundness of mind at the time of the alleged offence.⁷⁰

⁷⁰ *Mental Health Act 2000 (Qld)* s 238.

The Review has identified that there are significant expenses and delays associated with the preparation of these reports, and that in some instances they may breach a person's right to make their own decisions regarding pursuing a mental health defence.⁷¹ As such, it is proposed to discontinue the requirement for mandatory psychiatric reports and implement an alternate system.

Where a person is charged with a summary offence, including an indictable offence that can be heard summarily in certain circumstances, there will be no requirement or indeed scope to obtain a psychiatric report (unless this is done privately).⁷²

Where a person is charged with an offence that must be heard on indictment or another prescribed offence, and was subject to an involuntary treatment order or a forensic order at the time of or since the commission of the offence, a report will not automatically be prepared.⁷³ However, in that instance the person may request a psychiatric report⁷⁴ or if they are unable to consent then their representative, such as a guardian or attorney, may make the request.⁷⁵ Further, where an offence must be heard on indictment or is a prescribed offence, the Director of Mental Health may request that a psychiatric report be prepared if it is in the public interest⁷⁶ and may then make a referral to the Mental Health Court if required.⁷⁷

Feedback regarding mandatory psychiatric reports

While the recognition of a person's rights is supported, specifically recognition that they should be permitted to choose whether they obtain a psychiatric report and pursue a mental health defence, it is arguable that the circumstances in which this choice can be made are too restricted.

Stakeholders at the Roundtable acknowledged that there was essentially an 'industry' associated with the creation of mandatory psychiatric reports, and that this industry could not be maintained. It was also acknowledged that many reports are written in response to summary offences and are not able to be completed within the requisite timeframes.

Whilst accepting that the current system for mandatory psychiatric reports had difficulties, stakeholders did not fully accept the proposals made by the Review. Feedback was similar to that given in relation to the jurisdictional division between the Magistrates Court and the Mental Health Court. That is, stakeholders opined that the division between offences that 'must be indicted' and other offences was artificial and that there are many people who commit summary offences of a serious nature, or commit summary offences but have other factors at play that point to the seriousness of their offending. These people must also be identified, and a psychiatric report may be useful in those instances. With this artificial division, it is again the case that people may 'slip through the cracks'.

Stakeholders also opined that the reduction in the preparation of mandatory psychiatric reports would place a greater burden on lawyers to act as a 'gatekeeper' and identify where a person may have mental health issues, particularly in the Magistrates Court. In that instance, it is not so much the report itself that operates as an identifier of possible unsoundness or unfitness, but rather the initial process undertaken by the courts of identifying those people who are subject to an involuntary treatment order or a forensic order. It appears to be the case that this initial process of identification will not be lost, but rather that a psychiatric report will no longer be mandatory following identification. It is important to retain (and as discussed below, improve) this checking process to ensure the continued identification of people who may be of unsound mind or unfit for trial.

The Review should consider what scope there is for expanding the provision of psychiatric reports. As a starting point, where a Magistrate uses their discretion to refer a matter to the Mental Health Court, the option to pursue a psychiatric report should then become available to the person.

⁷¹ Review of the *Mental Health Act 2000*, Background Paper 3, 5-7.

⁷² Ibid 9-10; Review of the *Mental Health Act 2000* Discussion Paper, recommendation 3.1.

⁷³ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 3.2.

⁷⁴ Ibid 3.3.

⁷⁵ Ibid 3.4.

⁷⁶ Ibid 3.5.

⁷⁷ Ibid 3.6.

Arguably, such a report would be necessary to inform the Mental Health Court's decision.

The availability of psychiatric reports should also be expanded into the Magistrates Court, where a person intends to pursue a defence of unsoundness or unfitness. The Review acknowledges that, in order for arrangements in the Magistrates Court to operate effectively, Magistrates will need to receive evidence that a person was of unsound mind or is unfit for trial. It is stated that "this information would need to be provided by defence lawyers supported by court liaison officers".⁷⁸ This refers to the existing mental health court liaison officers, who presently operate in the Magistrates Court. It is questionable whether these arrangements will be sufficient to support the proposed reforms.

Where a person is already subject to an order, it is undoubtedly important for a Magistrate to have some information regarding the person's mental state and treatment or care to date. Similarly, where a person is not subject to any orders, it will be necessary for the Magistrate to have information about the person's mental illness. A Magistrate generally does not have any psychiatric training or experience in mental health, so a report would no doubt be required to inform their decision-making. Further, the threshold for a finding of unsoundness or unfitness is that a Magistrate must be "satisfied a person is likely to be, or appears, unfit for trial or of unsound mind".⁷⁹ This is a high standard to meet, and arguably one that would require the provision of medical evidence.

A report in the Magistrates Court may not need to be of the same length or depth as reports produced for people appearing before the Mental Health Court. However, given the seriousness of the issue and the height of the threshold, a comprehensive report should be able to be provided to the Magistrate to inform their decision-making.

Recommendation 12: The proposed restriction of the provision of mandatory psychiatric reports (where a person is already subject to a forensic order or involuntary treatment order) to situations where a person is charged with an offence that must be heard on indictment and where they, or their representative requests a report, should be broadened to include:

- those matters referred to the Mental Health Court by a Magistrate; and
- those matters where a person intends to pursue a defence of unsoundness or unfitness in the Magistrates Court.

Clinical assistance in the courts

The Mental Health Court

Where a person appears before the Mental Health Court then (as discussed immediately above) they will be able to request a psychiatric report, or a report may be requested by the Director of Mental Health. The Mental health Court would then have the benefit of this report.

A judge sitting in the Mental Health Court is presently assisted by two psychiatrists,⁸⁰ primarily to provide clinical advice to the Judge. The Review proposes that, where proceedings involve a person with intellectual disability, the Mental Health Court may be assisted by a person with expertise in the care of people with intellectual disability, such as a forensic psychologist.⁸¹ This proposal is supported.

The Magistrates Court

The Review proposes that Magistrates receive information regarding unsoundness or unfitness from defence lawyers, supported by court liaison officers.⁸² This is insufficient to inform whether someone

⁷⁸ Review of the *Mental Health Act 2000*, Background Paper 4, 12.

⁷⁹ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 4.24.

⁸⁰ *Mental Health Act 2000* (Qld) s 382.

⁸¹ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 11.4.

⁸² Review of the *Mental Health Act 2000*, Background Paper 4, 12.

should be placed onto an ongoing order that authorises treatment without his or her consent.

In relation to people with mental illness, the provision of psychiatric reports at the Magistrates Court level is discussed above. These reports would provide an important form of clinical assistance. Given that a Magistrate is not assisted by a psychiatrist, such a report would be the primary (potentially only) source of clinical assistance regarding a person's mental illness. For this reason, a report should be required.

In relation to people with intellectual disability, the Review has not considered the systems changes and supporting services that would be required to support the proposals. Reviews and inquiries in other jurisdictions have consistently found that without effective mechanisms to identify offenders with disability, as well as case management to support diversion and available services to divert people to, legislative provisions will be of limited effectiveness in preventing re-offending. Without such services, the proposed legislative changes could see people continue to 'fall between the cracks' with serious impacts both for their own rehabilitation and community safety.

Whilst there are currently mental health court liaison staff, which may identify some people subject to a forensic order (disability), there is no such service for offenders with intellectual and cognitive impairments that would assist in identification, assessment, referral and case management. Therefore, it is recommended that the proposed *Mental Health Act 2014* be accompanied by a state-wide court liaison service for people with intellectual and cognitive impairment. Alternatively, the current mental health court liaison service must be expanded to encompass people with intellectual and cognitive impairments.

Stakeholders at the Roundtable suggested that, as a starting point, court liaison officers could be given access to information held by QCAT regarding people who are subject to an order relevant to the *Guardianship and Attorney Act 2000*. This will not always be an indicator that a person was of unsound mind or is unfit for trial, but could be a useful means of identifying that a person may have some impairment and should be considered for further assistance.⁸³

Further, a Magistrate will require information about a person with intellectual disability. As such, the Review should also consider the provision of a report to Magistrates in those circumstances.

Recommendation 13: The proposed *Mental Health Act 2014* should include a requirement that Magistrates receive a report about a person with mental illness or intellectual disability to inform their decision about whether a person is likely to be, or appears, unfit for trial or of unsound mind.

The proposed *Mental Health Act 2014* should also be accompanied by a state-wide court liaison service for people with intellectual and cognitive impairment. Alternatively, the current mental health court liaison service must be expanded to encompass people with intellectual and cognitive impairments.

Outcomes in the Mental Health Court

Orders that may be made by the Mental Health Court

The Review proposes that the Mental Health Court have access to a number of options when it finds that a person was of unsound mind or is unfit for trial. Under the proposed *Mental Health Act 2014*, the Mental Health Court would be able to make forensic orders and involuntary treatment orders that can only be revoked by the Mental Health Review Tribunal ('the Tribunal').⁸⁴

The Mental Health Court may make an involuntary treatment order that can only be revoked by the Tribunal if, following an assessment of risk, it is determined that a standard involuntary treatment order would not adequately protect the community from serious harm to others, serious property

⁸³ The issue of the threshold for diversion for people with intellectual or cognitive impairment is discussed further below.

⁸⁴ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 4.3.

damage or repeat offending of the same type.⁸⁵ This ‘non-revokable order’ will otherwise be the same as a standard involuntary treatment order.⁸⁶

The Mental Health Court may make a forensic order (including a forensic order (disability)) if, following an assessment of risk, it is determined that an involuntary treatment order only revokable by the Tribunal would not adequately protect the community from serious harm to others, serious property damage or repeat offending of the same type.⁸⁷

Presumably, given that an assessment of risk may result in the conclusion that a standard involuntary treatment order would be sufficient, the Mental Health Court will be given an additional power to make a standard involuntary treatment order in those circumstances.

The Public Advocate is generally supportive of this proposal to provide the Mental Health Court with these additional options, as were stakeholders at the Roundtable. However, it would appear that the proposal is largely beneficial to people who are unsound or unfit because of mental illness and does not benefit people with intellectual disability. This is because an involuntary treatment order is designed to facilitate treatment of a mental illness, not the care of a person with disability. Therefore, for people with disability, there are still arguably no less restrictive options than a forensic order (other than to make no order, which may not be appropriate).

A proposal that the Mental Health Court have the same powers as a Magistrate to refer a person to the DCCSDS may go some way toward addressing this issue. However, this response may also be inappropriate or insufficient in some instances.

The Review should further consider the options available to the Mental Health Court when the person before the court has an intellectual disability. As emphasised above, the Mental Health Court is based on a therapeutic or problem-solving model of justice. Its existence is based upon the recognition that traditional courts or the traditional criminal justice system will often fail to deliver positive outcomes for offenders with mental illness or intellectual disability (including a reduction in their offending behaviour), and therefore has a greater focus on earlier interventions and on creating linkages to treatment and support.

People with disability must be treated equitably, meaning that a range of options or outcomes that address their offending behaviours and assist with their rehabilitation is also required for this group.

Recommendation 14: Further options, other than forensic orders, should be considered for people with intellectual disability in the Mental Health Court, including orders that link people to the support they need.

Non-revokable periods

The Review proposes that, to provide greater stability and certainty during the early stages of a forensic order, the Mental Health Court may impose a non-revokable period of up to three years, or up to seven years if the charge is murder or attempted murder.⁸⁸ After any non-revokable period, the Tribunal can:

- continue a forensic order or involuntary treatment order;
- revoke a forensic order and replace it with an involuntary treatment order that can only be revoked by the Tribunal;
- revoke a forensic order and replace it with a standard involuntary treatment order;
- revoke an involuntary treatment order that can only be revoked by the Tribunal and replace it with a standard involuntary treatment order; or

⁸⁵ Ibid 4.4.

⁸⁶ Ibid 4.8.

⁸⁷ Ibid 4.5.

⁸⁸ Ibid 4.13.

- revoke a forensic order or involuntary treatment order that can only be revoked by the Tribunal and make no replacement order.

In making these decisions, the Tribunal must assess risk. To replace a forensic order with a non-revokable involuntary treatment order, the Tribunal must determine that the community can be adequately protected from serious harm to others, serious property damage or repeat offending of the same type.⁸⁹ In relation to replacing an order with a standard involuntary treatment order or revoking an order, the Tribunal must determine that the community no longer requires protection from serious harm to others, serious property damage or repeat offending of the same type.⁹⁰

The use of non-revokable periods for forensic orders or involuntary treatment orders is not supported. The imposition of such an order is not a punishment, and as such should not be expected to go for any defined period. Further, the length of time for which a person requires treatment on an involuntary basis is variable, and will depend upon numerous factors. That period should not be extended beyond what is required for the person's treatment. Finally, a non-revokable period, particularly where it extends beyond what is required for treatment, does not accord with the requirements to:

- safeguard a person's rights;
- adversely affect a person's rights and liberties only if there is no less restrictive way to protect the health and safety of themselves and others; and
- promote the person's recovery and ability to live in the community without the need for involuntary treatment and care.⁹¹

Recommendation 15: The current proposal to impose non-revokable periods on forensic orders or involuntary treatment orders should be removed.

Conditions attached to orders

The Review proposes that the Mental Health Court be able to attach conditions to forensic orders, directing that a service consider specific interventions for a person.⁹² The implementation of this condition, including the person's willingness to participate in such programs, is to be considered during reviews by the Tribunal.⁹³

While supportive of the Mental Health Court being able to recommend that a service consider the use of certain interventions, particularly given the expertise that is held by the Judge and the assisting psychiatrists, it must be ensured that these operate only as recommendations. They should not be treated by the Tribunal as conditions with which the person must comply before an order can be amended or revoked. First, this is because a forensic order is not a form of punishment, and as such, a person should not suffer any punishment or detriment due to non-compliance with a condition or recommendation. Further, a person's condition and their treatment needs may change, and compliance with that program may no longer be necessary or beneficial.

Recommendation 16: Any 'conditions' imposed by the Mental Health Court should be in the form of recommendations that can be subject to review.

Special hearings

The Review has proposed that where the Mental Health Court makes an order following a finding of permanent unfitness for trial, or where a finding of temporary unfitness extends over 12 months, then a special hearing may be held. A lawyer representing the person, in consultation with a

⁸⁹ Ibid 4.16.

⁹⁰ Ibid 4.17-4.18.

⁹¹ See Review of the *Mental Health Act 2000* Discussion Paper, recommendation 21.1.

⁹² Review of the *Mental Health Act 2000* Discussion Paper, recommendation 4.11.

⁹³ Ibid 4.12.

substitute decision-maker, may elect to have a special hearing heard by the District Court or by the Mental Health Court sitting as a judge alone.⁹⁴ A lawyer may also elect to waive the right to a special hearing, which would not amount to a plea of guilty.⁹⁵

At a special hearing, the prosecution will present evidence and the lawyer representing the person may challenge the evidence and lead evidence. The lawyer must act in the best interests of the person,⁹⁶ in consultation with the person as far as is possible and in consultation with any appointed substitute decision-maker.⁹⁷ The court may adjust the normal trial process as is appropriate to the circumstances.⁹⁸

The purpose of the special hearing is to determine whether the person did the act that constituted the offence. If the finding is yes, the order is confirmed. If the finding is no, the person is discharged and the order is revoked.⁹⁹

Stakeholders at the Roundtable appeared to have mixed views about the use of special hearings. Some expressed difficulty with understanding the need for this process; accepting that it is useful in other jurisdictions, but simultaneously noting that Queensland differs from some of those other jurisdictions in that unsoundness is determined before unfitness is given consideration.

There were some practical difficulties noted by some stakeholders. Firstly, witnesses may be required to give evidence twice, noting that first time there would be no prospect of conviction. Secondly, it would be very difficult for a lawyer to take instructions and proceed with a case. It is noted that, in part as a response to this difficulty, no conviction can result.

Other stakeholders however were supportive of the introduction of the process. It was believed by these stakeholders that, even if special hearings would be relevant to only a small number of people they were an important safeguard.

Recommendation 17: The Review take into account the feedback provided by stakeholders and give further consideration to the proposal for special hearings.

Dual diagnosis

The Review has noted that a forensic order (disability) only authorises a person's involuntary care for a disability. This limitation can create problems for the Mental Health Court when considering people with a dual diagnosis of both mental illness and intellectual disability.

First, this can cause difficulties for the Mental Health Court in determining whether a person was of unsound mind or unfit for trial due to mental illness or intellectual disability, and in delineating between the two for the purposes of making a forensic order or a forensic order (disability).¹⁰⁰

Second, because of the lack of clarity in the *Mental Health Act 2000* regarding whether an involuntary treatment order and a forensic order (disability) can co-exist, a person with a dual diagnosis cannot receive involuntary treatment for a mental illness if they are subject to a forensic order (disability).

To address this, the Review proposes that when making order the Mental Health Court be able to take into account a person's overall treatment and care needs. The Mental Health Court could make a 'standard' forensic order for a person with dual diagnosis, if the Court believes that the person requires involuntary treatment and care for a mental illness as well as care for an intellectual disability.¹⁰¹ If on review the Tribunal concludes that the person no longer requires involuntary

⁹⁴ Ibid 4.21.

⁹⁵ Review of the *Mental Health Act 2000*, Background Paper 4, 10.

⁹⁶ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 4.23.

⁹⁷ Review of the *Mental Health Act 2000*, Background Paper 4, 10.

⁹⁸ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 4.23.

⁹⁹ Ibid 4.22.

¹⁰⁰ Review of the *Mental Health Act 2000*, Background Paper 11, 2.

¹⁰¹ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 11.1.

treatment for the mental illness, the order can be amended to a forensic order (disability).¹⁰²

Related to this, the Review proposed to clarify that an involuntary treatment order and a forensic order (disability) can co-exist for a person, regardless of which order is made first.¹⁰³

Feedback regarding this proposal

Some stakeholders were supportive of this proposal, noting that an issue does exist in that a person subject to a forensic order (disability) may be medicated for a mental illness without consideration having been given to whether consent is required or forthcoming. Other stakeholders disagreed that this was an issue, citing the ability to consult a guardian or statutory health attorney.¹⁰⁴

Some stakeholders suggested that, as an alternative, a forensic order (disability) could include a condition that a person may be medicated for a particular mental illness, as prescribed by a treating doctor and authorised by a guardian. However, this does not solve the problems faced by the Mental Health Court when making decisions and brings with it questions regarding the power of a guardian, as well as an ongoing need for a guardian to be appointed.

Other stakeholders suggested that the problem could be solved by having only one category of forensic order, which applies to both people with mental illness and people with intellectual disability. This order should authorise treatment, but only if the treatment is linked to a diagnosed mental illness. Whilst this solution would arguably resolve the issues faced by the Mental Health Court, it provides for a very broad power to treat mental illness and is arguably not consistent with the least restrictive alternative.

Safeguards

There may be some instances where a person with a dual diagnosis of intellectual disability and mental illness requires involuntary treatment for a mental illness. This could be addressed by allowing the Mental Health Court to make a standard forensic order if, for example, the court considers this better meets the person's overall treatment and care needs. However, there must be stringent controls around the use of such orders.

First, where the Mental Health Court wants to impose a standard forensic order on a person with dual diagnosis, there should be a requirement that the person meet the treatment criteria used in relation to involuntary treatment for a mental illness. If a person does not meet the treatment criteria, or if treatment can be provided using a less restrictive means, then a standard forensic order should not be imposed. This would accord with both the proposed approach in relation to forensic orders¹⁰⁵ and the proposed objectives of the legislation.¹⁰⁶

Second, the forensic order must authorise treatment for a mental illness only. It must not authorise treatment for other purposes, such as the use of anti-psychotic medication solely for behaviour control (chemical restraint) or the use of anti-libidinal medication such as Androcur to control sexual urges. Some stakeholders noted that behaviour control could be a 'grey area'. For example, a person may have anxiety that affects their behaviours, and the anxiety can be improved with medication. In some instances, this may result in a diagnosis of anxiety. However, in other instances, the medication may be perceived as for controlling behaviour, and the person would not receive any diagnosis.

Any other approach will be discriminatory and represent a much more restrictive approach for people with intellectual disability. Expanding the authority of an involuntary treatment order (either applied by the Mental Health Court or made by an authorised doctor) to apply even though a person does not meet the criteria for involuntary treatment for a mental illness, removes the person's right to either consent to treatment themselves or to have their statutory health attorney or guardian for

¹⁰² Ibid 11.2.

¹⁰³ Ibid 11.5.

¹⁰⁴ However, see the following cases for discussion of whether a guardian can consent to treatment for mental illness: Re DKB [2012] QMHC 6.

¹⁰⁵ Review of the *Mental Health Act 2000* Discussion Paper, recommendations 4.4-4.6.

¹⁰⁶ Ibid 21.1.

health matters consent on their behalf. Chemical restraint of people should not be authorised by virtue of an involuntary treatment order.

Recommendation 18: If a ‘standard’ forensic order is to be made for a person with an intellectual disability, then (as for people with mental illness subject to involuntary treatment orders) the criteria for involuntary treatment for a mental illness must be satisfied.

In addition, the proposed *Mental Health Act 2014* should clarify that where the criteria for involuntary treatment for a mental illness are satisfied, that an involuntary treatment order can co-exist with a forensic order (disability).

An involuntary treatment order applied to a person with an intellectual disability should not authorise chemical restraint.

Outcomes in the Magistrates Court

Orders that may be made by the Magistrates Court

Mental illness

If a Magistrate is satisfied that a person is likely to be, or appears, unfit for trial or of unsound mind due to a mental illness, the Magistrate may:

- discharge the person unconditionally; or
- discharge the person and order an involuntary treatment order with a non-revoke period of up to six months for summary offences and up to 12 months for indictable offences.¹⁰⁷

If a Magistrate believes that a person may become fit for trial within six months, they may adjourn the charge and make an involuntary treatment order. If at the end of six months the person is still unfit for trial, the Magistrate must then take one of the above actions.¹⁰⁸

In making an involuntary treatment order with a non-revokable period, the Magistrate must be satisfied that the community cannot be adequately protected from harm, property damage or repeat offending of the same type by voluntary treatment or a standard involuntary treatment order.¹⁰⁹ At the expiration of any non-revokable period, the order will automatically become a standard involuntary treatment order.¹¹⁰

Stakeholders at the Roundtable were supportive of the Magistrates Court being given these options in relation to people with mental illness. However, as discussed above, stakeholders were concerned that the breadth of the Magistrates Court jurisdiction may be too broad, resulting in the expertise in the Mental Health Court being under-utilised. The Public Advocate shares these concerns with stakeholders.

While supportive of the Magistrates Court being given greater options in relation to defendants who present with mental illness, as discussed above in relation to psychiatric reports and clinical assistance, Magistrates and the Magistrates Court must be well supported by court staff and by clinical advice to effectively implement these options. Further, for the same reasons as discussed previously, the imposition of non-revokable periods are not supported.

As noted, to impose a non-revokable period, the Magistrate must consider protection of the community from “harm, property damage or repeat offending...”.¹¹¹ This contradicts with the criteria for the Mental Health Court when making a non-revokable or standard involuntary treatment order, which considers whether the community requires protection from “serious harm to other individuals,

¹⁰⁷ Ibid 4.24.

¹⁰⁸ Ibid 4.25.

¹⁰⁹ Ibid 4.26.

¹¹⁰ Ibid 4.27.

¹¹¹ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 4.26.

serious property damage or repeat offending...".¹¹² Similarly, the treatment criteria refer to "imminent serious harm".¹¹³ The criterion in the Magistrates Court presents a lower threshold and therefore opens the possibility that more people will be placed onto involuntary treatment. The criterion in the Magistrates Court should be amended to be consistent with that of the Mental Health Court. Again, Magistrates will require significant resources and support to make determinations under this criterion.

Recommendation 19: If non-revoke periods are able to be imposed in the Magistrates Court, the proposed criteria for a non-revokable involuntary treatment order imposed by a Magistrate should be identical to that imposed by the Mental Health Court – that is, that the Magistrate must consider whether the community requires protection from "serious harm to other individuals, serious property damage or repeat offending".

Intellectual disability

If a Magistrate is satisfied that a person is likely to be, or appears, unfit for trial or of unsound mind due to an intellectual disability, the Magistrate:

- must discharge the person unconditionally; and
- may refer the person to the Department of Communities, Child Safety and Disability Services ('DCCSDS') to consider whether appropriate care can be provided to the person.¹¹⁴

Stakeholders at the Roundtable were supportive of the fact that the Review had taken steps toward accommodating people with intellectual disability in the Magistrates Court, but felt that there was still more to be done in this space. In particular, it was stated that the proposals still left a risk of people with intellectual disability 'slipping through the cracks'.

The Magistrates Court must provide a response to people with intellectual disability who are charged with summary offences, but the response proposed by the Review appears to be insufficient. At best, the response provides for a referral to DCCSDS, but this does not a guarantee that any assistance will be provided. Further, if a person is already receiving care from DCCSDS, then this option will presumably do little or nothing to assist the person. This option needs to be strengthened, giving Magistrates the option to order that a person be given appropriate care.

When considered alongside the proposed restricted jurisdiction of the Mental Health Court, the risks to the individual person and the community are significantly increased by this lack of response. It is also unlikely to address the issue raised by the Court of Appeal in Appeal in the case of *R v AAM; ex parte A-G (Qld)* [2010] QCA 305.

In this case the appellant had been convicted of many simple offences, fifteen of which were the subject of the hearing. Subsequent to her conviction, the Mental Health Court had found that the appellant was permanently unfit for trial by reason of her intellectual disability. The Court of Appeal found that the appellant was also unfit to plead to all of the offences subject to the appeal that she had pleaded guilty to in the Magistrates Court. The Court of Appeal set aside the convictions on the basis that it would be a miscarriage of justice to allow these findings of guilt to stand. The Court of Appeal noted that: "It seems unsatisfactory that the laws of this State make no provision for the determination of the question of fitness to plead to summary offences". While the review addresses this issue it does not address the further issue of "suitable compassionate supervisory and supportive bail and sentencing orders to be made in appropriate cases" that the Court of Appeal also identified "may well be effective in assisting these vulnerable people".

¹¹² Ibid 4.16-4.18.

¹¹³ Ibid 1.17.

¹¹⁴ Ibid 4.28.

Whether the powers of Magistrates are strengthened or not, there must be an increase in the funding available to DCCSDS in order to be able to provide appropriate care to people who are referred by a Magistrate. As discussed previously, the Review has not considered the systems changes and supporting services that would be required to support the proposals. Without available services to divert people to and case management to support this diversion, legislative provisions will be of limited effectiveness. Without such services, the proposed legislative changes could see people continue to ‘fall between the cracks’ with serious impacts both for their own rehabilitation and community safety.

Recommendation 20: The Review must consider the implementation of additional legislative and supportive responses for people with intellectual disability who are accused of a criminal offence and appear in the Magistrates Court.

Standard of Proof for Unsoundness or Unfitness

In the Magistrates Court, the standard of proof is that the Magistrates “is satisfied a person is likely to be, or appears, unfit for trial or of unsound mind due to a mental illness/intellectual disability”.¹¹⁵ The standard of proof in the Mental Health Court is that the person “was of unsound mind... or is unfit for trial”.¹¹⁶ The standard of proof in the Magistrates Court is therefore lower than that of the Mental Health Court, but it is still a high standard to meet overall.

As has been discussed previously, it is firmly believed that in order for Magistrates to be able to make decisions of this type, they will require significant assistance. This will need to be in the form of court liaison officers that identify both people with mental illness and people with intellectual disability, psychiatric assessments and reports detailing a person’s mental illness, and assessments and reports regarding person’s with intellectual disability. This will require a significant investment in resources, and even with such an investment, the proposed standard of proof may cause difficulties.

One means of addressing this may be for the Review to consider implementation of an alternative model with a different threshold, such as that operating in New South Wales. Under that model, a Magistrate hearing a matter summarily cannot determine whether a person was of unsound mind or unfit for trial. However, the Magistrate does have a discretionary power when it appears to the Magistrate that:

- a person is (or was at the time of the offence) developmentally disabled, suffering from mental illness, or suffering from a mental condition for which treatment is available; but is not a person who requires care, treatment or control to protect themselves or others from serious harm; and
- taking into account the facts and other relevant evidence, it would be more appropriate to deal with the person under the Mental Health (Forensic Provisions) Act 1990 than otherwise in accordance with law.¹¹⁷

Using that discretionary power, the Magistrate may adjourn the proceedings, grant the person bail or make any other order considered appropriate.¹¹⁸ The Magistrate may make an order dismissing the charge and discharge the person:

- unconditionally;
- into the care of a responsible person, either unconditionally or subject to conditions; or
- on the condition that the person attend for assessment and/or treatment of their mental condition.¹¹⁹

If a similar approach were taken in Queensland, this would have the benefit of ensuring that people

¹¹⁵ Review of the *Mental Health Act 2000* Discussion Paper, recommendations 4.24, 4.28.

¹¹⁶ *Mental Health Act 2000* (Qld) s 288.

¹¹⁷ *Mental Health (Forensic Provisions) Act 1990* s 32(1).

¹¹⁸ *Mental Health (Forensic Provisions) Act 1990* s 32(2).

¹¹⁹ *Mental Health (Forensic Provisions) Act 1990* s 32(3).

with mental illness or intellectual disability could be discharged from criminal responsibility and ordered to undertake appropriate treatment or accept appropriate care, if required. Further, it would not necessitate a determination of unfitness or unsoundness and therefore, whilst a Magistrate would arguably still require information about a person's condition, that requirement may be mitigated by the fact that the information is not being provided to satisfy a legal standard. Finally, it would avoid a situation where a Magistrate can impose an involuntary treatment order, in many instances arguably with insufficient evidence for doing so.

A different threshold would be particularly beneficial for people with intellectual disability, who unlike many people with mental illness appearing in the Magistrates Courts, may not have access to a thorough assessment (such as that undertaken by the mental health liaison service). An assessment to accurately diagnose intellectual disability or another type of cognitive impairment (for example, as a result of acquired brain injury) is time consuming and costly, and as a result is very unlikely to be accessible in the Magistrates Court proceedings.

Recommendation 21: Particularly for people with intellectual disability and cognitive impairment, the threshold for unconditional or conditional discharge by a Magistrate should be reconsidered.

Appeals

It is critical that people subject to an involuntary treatment order by the Magistrates Court have a right of appeal. The Review proposes that, to ensure consistency, appeals from Magistrates Court decisions should be to the Mental Health Court.

This appeal process is supported; however, more clarification is required regarding the mechanism of appeal. In particular, clarification is required regarding whether this allows for an appeal 'as of right' or only in limited circumstances. Arguably, the appeal should be as of right. A right of appeal restricted to a question of law, for example, would be too restrictive, particularly given the serious impact on a person's rights of being made subject to a non-revokable involuntary treatment order.

Recommendation 22: An appeal should be available as of right to those people made subject to an involuntary treatment order.

Treatment

The definition of 'treatment'

The *Mental Health Act 2000* presently includes the following definition of treatment:

"treatment, of a person who has a mental illness, means anything done, or to be done, with the intention of having a therapeutic effect on the person's illness".¹²⁰

This definition should be clarified so that a person may only be given medication or other treatment in order to treat a mental illness that led to them being placed onto or maintained on an order authorising involuntary treatment. A person should not be given treatment for any other purpose. This need for clarification largely arises because the definition uses the term 'therapeutic effect', which is not defined and is therefore too subjective and open to broad interpretation.

The Review should amend the definition of treatment to make this clarification. The Victorian *Mental Health Act 2014* provides an example of a closer connection between treatment and the person's mental illness. It provides that:

¹²⁰ *Mental Health Act 2000*, dictionary, definition of 'treatment'.

“a person receives treatment for mental illness if things are done to the person in the course of the exercise of professional skills-

(i) to remedy the mental illness; or

(ii) to alleviate the symptoms and reduce the ill effects of the mental illness”.¹²¹

Recommendation 23: The Review should consider clarifying the definition of treatment to ensure that it is not used too broadly. There should not be scope for a person subject to an order authorising involuntary treatment to be given medication that is not directly related to treatment of the mental illness that led them to be placed on, or maintained on, an involuntary treatment order. A definition similar to that used in the *Mental Health Act 2014* (Vic) should be considered.

Treatment plans

The Review proposes to amend the requirements for treatment plans, particularly given that there is a high level of uncertainty regarding what constitutes a treatment plan and how it should be documented, which has led to many differing practices. The review states that treatment and care should align with good clinical practice, and that the purpose of statutory requirements regarding treatment and care should be to provide additional safeguards, given the involuntary nature of the detention and treatment.¹²²

As such, it is recommend that when an involuntary patient is admitted, an authorised doctor must decide and record in appropriate clinical records, the proposed treatment and care of the patient.¹²³ The doctor must ensure this treatment and care continues to be appropriate, including by regularly reviewing the patient’s needs.¹²⁴ The initial decision and reviews must occur in consultation with the patient and, as far as practicable, family, carers and other support persons.¹²⁵ As an additional safeguard, the administrator of an authorised mental health service must ensure that patients receive appropriate treatment and care for their mental illness and other illnesses or conditions, and that the systems for recording both proposed and provided treatment and care can be audited.¹²⁶

This recommendation is supported, if there are sufficient requirements in place to ensure that a patient’s proposed and provided treatment and care is adequately recorded and accessible. Further, there must also be clear legislative or policy guidelines in place that allow both the person and others (such as family, carers or supporters) ready access to those records. It is noted that the *Health Information: Disclosure and Access Policy* is referenced by the Review. This policy may be insufficient because a person with mental illness may not be able to request access or consent to another person having access, and there may be insufficient access rights given to family, carers or supporters.

It is also recommend that the Review ensure that treatment plans are reflective and supportive of a recovery-based model. To achieve this, it is recommended that the Review incorporate principles to be followed by treating staff when developing a treatment plan. In particular, the principles should include requirements that:

- treating staff must promote and enable the patient’s participation in any decision-making with respect to treatment and the development of the treatment plan;
- the person’s views and wishes, including any advance statements about their treatment should be respected;
- where possible, a treatment plan must be truly collaborative;

¹²¹ *Mental Health Act 2014* (Vic) s 6.

¹²² Review of the *Mental Health Act 2000*, Background Paper 5, 1-2.

¹²³ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 5.2.

¹²⁴ Ibid 5.3.

¹²⁵ Ibid 5.4.

¹²⁶ Ibid 5.5.

- a treatment plan should be signed by the patient, the authorised doctor and other members of the treating team; and
- the plan must incorporate a multi-disciplinary and holistic approach to treatment, which is inclusive of the patient’s life goals and also addresses psychosocial, social, cultural, educational, vocational, rehabilitative and recovery issues, as well as other relevant aspects of the patient’s life.

Recommendation 24: There must be sufficient policy requirements put into place to ensure that a patient’s proposed and provided treatment and care is adequately recorded and accessible by both the patient and others (such as family, carers or supporters).

The proposed *Mental Health Act 2014* should include principles that must be followed by treating staff to ensure that treatment plans are reflective and supportive of a recovery-based model.

Advanced statements

The Review has not given a great deal of consideration to the use of advanced statements by patients subject to involuntary treatment. This area should be given further consideration.

The current position in Queensland

In Queensland, a person may make an advanced health directive and thereby give directions about health matters for their future care.¹²⁷ It appears that a person could make an advanced health directive that is intended to operate at a time when, due to a mental illness, the person does not have capacity to make health care decisions.

Under the *Mental Health Act 2000*, an advance health directive is used when preparing a patient’s treatment plan. A treatment plan must take into account “any existing plan of treatment, or advance health directive under the *Powers of Attorney Act 1998*, for the patient”.¹²⁸ If a person made a common law directive regarding their health care, this would be properly described as an “existing plan of treatment”.¹²⁹

However, a treatment plan must be responsive to the patient’s particular needs at the time, meaning that any matters raised in an advance health directive or a common law directive are not binding on the health practitioner.¹³⁰ This is consistent with the *Powers of Attorney Act 1998*. That Act provides that where an involuntary patient has given a direction about their health care by way of an advance health directive or otherwise, an interpretation of the *Mental Health Act 2000* that is consistent with the *Powers of Attorney Act 1998* and the direction is to be preferred to any other meaning. However, in the case of inconsistency, the *Mental Health Act 2000* will prevail.¹³¹

Increased recognition of advanced statements

It is recommended that the Review consider incorporating explicit provisions regarding the recognition of advance statements and procedural provisions addressing the decision to override an advanced health directive in the proposed *Mental Health Act 2014*. This would provide greater recognition of and respect for a person’s autonomy. The Victorian model, which uses advanced statements, provides a useful reference.

In Victoria, when making treatment decisions a psychiatrist must have regard to a number of factors, including the views and preferences of the patient as expressed in their advanced statement.¹³² A psychiatrist can make a treatment decision that is not in accordance with the patient’s advance statement, but only if they are satisfied that the preferred treatment as expressed in the advance

¹²⁷ *Powers of Attorney Act 1998* (Qld) s 35(1).

¹²⁸ *Mental Health Act 2000* (Qld) s 124(4)(a); *Mental Health Act 2000 Resource Guide* (2013), 4-11.

¹²⁹ *Mental Health Act 2000* (Qld) s 124(4)(a); *Mental Health Act 2000 Resource Guide* (2013), 4-11.

¹³⁰ *Mental Health Act 2000 Resource Guide* (2013), 4-11-4-12.

¹³¹ *Powers of Attorney Act 1998* (Qld) s 38.

¹³² *Mental Health Act 2014* (Vic) s 71(4)(b).

statement is not clinically appropriate or is not ordinarily provided by the designated mental health service.¹³³ If this occurs, the patient must be informed of the decision and the reasons for the decision, and of their right to request written reasons.¹³⁴ If written reasons are requested, they must be provided within ten business days.¹³⁵

Recommendation 25: The proposed *Mental Health Act 2014* should more explicitly recognise advanced health directives, and clearly set out the process of considering the implementation of an advanced health directive and notifying a patient when that directive is not followed. This should be achieved through the incorporation of provisions similar to those in the *Mental Health Act 2014* (Vic).

Review of treatment

The Review noted concerns regarding the ability to review a person's treatment where the patient, their family or others supporters did not agree with the treatment being provided. The Review envisages that most disagreements will be resolved by discussions with the treating team, potentially with the assistance of the independent patient companion.¹³⁶

It is proposed that, as an additional accountability measure of last resort in instances of strong and unresolved disagreement, a patient or their representative (such as a family member, carer or supporter) could seek a review of the patient's treatment and care from the administrator of the authorised mental health service and, if the disagreement was still unresolved, apply to the Tribunal for a review of the treatment and care.¹³⁷ The Tribunal could not direct treatment, but could obtain or direct the service to obtain a second opinion. The Tribunal could also require the service to review the patient's treatment and care and report to the Tribunal.¹³⁸

Feedback regarding this review process

Stakeholders at the Roundtable were supportive of the inclusion of this review process. Stakeholders commented that it was a positive step, in that it gives people direction regarding where they can go or what action they can take when they disagree with a treatment plan. However, stakeholders did also note that if too strong an obligation or consultation were required, this could cause issues such as delays in the provision of treatment.

The introduction of this review process is supported, as it will provide an additional safeguard for those people subject to involuntary treatment or care and will provide more certainty regarding the review process for treatment decisions. However, patients should have ready access to a second opinion regarding the applicability of the involuntary treatment criteria and/or the treatment that is being provided to them.

In Victoria, the *Mental Health Act 2014* provides that an 'entitled patient'¹³⁹ or another person may seek a second psychiatric opinion at any time.¹⁴⁰ A psychiatrist giving a second opinion must consider whether the criteria for the order apply¹⁴¹ and whether any changes should be made to the patient's treatment.¹⁴² The psychiatrist giving the second opinion cannot override previous treatment decisions,¹⁴³ but must prepare a report regarding the applicability of criteria and any opinions or

¹³³ *Mental Health Act 2014* (Vic) s 73(1).

¹³⁴ *Mental Health Act 2014* (Vic) s 73(2).

¹³⁵ *Mental Health Act 2014* (Vic) s 73(3).

¹³⁶ Review of the *Mental Health Act 2000*, Background Paper 5, 3.

¹³⁷ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 5.8; Review of the *Mental Health Act 2000*, Background Paper 5, 3-4.

¹³⁸ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 5.9; Review of the *Mental Health Act 2000*, Background Paper 5, 4.

¹³⁹ *Mental Health Act 2014* (Vic) s 78. This means a patient who is subject to a temporary treatment order or treatment order; a security patient; or a forensic patient.

¹⁴⁰ *Mental Health Act 2014* (Vic) s 79(1).

¹⁴¹ Except where the patient is a forensic patient (*Mental Health Act 2014* (Vic) s 81(1)(a)).

¹⁴² *Mental Health Act 2014* (Vic) s 81(1).

¹⁴³ *Mental Health Act 2014* (Vic) s 81(2).

recommendations regarding treatment.¹⁴⁴ If necessary, the original psychiatrist must then re-assess the patient or review their treatment.¹⁴⁵ If this re-assessment does not result in the revocation of the order or adoption of the recommended changes to treatment, then the person may apply to the Tribunal or the chief psychiatrist respectively.¹⁴⁶

It is recommended that the Review consider adopting the approach taken in Victoria with respect to obtaining a second opinion. This would accord with a rights-based and recovery-oriented approach to involuntary treatment.

Recommendation 26: The proposed *Mental Health Act 2014* should incorporate provisions that enable patients to obtain a second opinion regarding the applicability of the involuntary treatment criteria and/or the treatment that is being provided to them. These should be similar to the provisions in the *Mental Health Act 2014* (Vic).

Treatment in the community

Limited community treatment and community-based orders

The Review proposes to align the arrangements that can be made in relation to involuntary treatment orders and forensic orders in relation to limited community treatment and community-based orders. That is, in relation to both orders, limited community treatment will be able to be approved for a period of up to seven days, and beyond that, a person may be placed onto a community-category order.¹⁴⁷

The Review also proposes that there be consistent criteria for the Mental Health Court, Mental Health Review Tribunal or Director of Mental Health when making a decision about limited community treatment or a community-based order for a person subject to a forensic order; and also for an authorised doctor when approving limited community treatment or a community-based order.¹⁴⁸ They must consider whether the community will be adequately protected from serious harm to others, serious property damage or repeat offending of a similar type. In doing so, they must have regard to matters such as the patient's psychiatric state, relevant unlawful acts, social circumstances, response to and willingness to continue treatment, and their compliance with previous community-based orders.¹⁴⁹ Those criteria may be met by limiting community access or placing conditions on an order.¹⁵⁰

Finally, the Review proposes to clarify that patients should only be subject to an in-patient involuntary treatment order if their own treatment and care needs, and the safety and well-being of the patient and other cannot be reasonably met using a community category order. The doctor must have regard to the same matters as in forensic orders.¹⁵¹ These same criteria apply when a doctor is considering granting limited community treatment to a person on an in-patient order.¹⁵²

Feedback regarding these proposals

Stakeholders at the Roundtable were generally not opposed to these recommendations. However, it was noted that the Review must ensure there will not be any unintended consequences from these changes. In particular, it was noted that the current arrangements for limited community treatment provide a degree of flexibility. That is, people can be granted limited community treatment, come back to an authorised mental health service if required, and then be granted limited community

¹⁴⁴ *Mental Health Act 2014* (Vic) s 84(1).

¹⁴⁵ *Mental Health Act 2014* (Vic) ss 85(1), 86(1).

¹⁴⁶ *Mental Health Act 2014* (Vic) ss 85(2), 86(3).

¹⁴⁷ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 6.2-6.3; Review of the *Mental Health Act 2000*, Background Paper 6, 2.

¹⁴⁸ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 6.4, 6.9-6.10.

¹⁴⁹ *Ibid* 6.4-6.9.

¹⁵⁰ *Ibid* 6.7.

¹⁵¹ *Ibid* 6.11.

¹⁵² *Ibid* 6.12.

treatment again. The Review must ensure that this remains the case; and in particular, it must not become the case that a person's order is not changed to 'in-patient status' each time they require a short admission, then requiring the person to remain an in-patient until the Tribunal again approved community-based treatment. Related to this, the Review must ensure that where the Mental Health Court or Tribunal order a person may live in the community, an authorised doctor will still have the power to make a person return to an authorised mental health service if required.

The Public Advocate agrees with this viewpoint. Whilst the streamlining of community-based treatment is not opposed, it must be ensured that this does not negatively impact upon the ability of the person to return for in-patient treatment and be released back to the community in a timely fashion. If this approach is not taken, the legislation will not be rights-based and will not operate on the basis of the least restrictive alternative.

Further, matters to which the Mental Health Court, Tribunal, Director of Mental Health and authorised doctors are to have regard must be expanded to incorporate things relevant to people with intellectual disability or cognitive impairment. At present, the criteria are largely focussed upon people with mental illness. In particular, the expanded criteria could include the patient's intellectual disability and the patient's behaviour in response to a plan for their care.

Recommendation 27: The criteria for limited community treatment must be expanded to incorporate factors relevant to people with intellectual disability or cognitive impairment.

Amendments to the provisions for limited community treatment must not negatively impact upon the ability of a person to return for in-patient treatment and then be released back to the community.

Arrangements for community-based treatment

The Review noted that arrangements for community-based treatment currently do not provide a clear plan for the person's treatment in the community or enable the person to understand their obligations whilst residing in the community.¹⁵³ As such, the Review proposes that before a person begins treatment in the community, an authorised doctor must:

- decide and document the treatment and care to be provide in the community in consultation with the patient and, as far as practicable, family, carers and other support persons;
- decide and document a statement about the patient's obligation in the community, including scheduled health appointments;
- provide the patient with a summary of the treatment and care that is to be provided in the community and that statement about the patient's obligations; and
- discuss with the patient and, as far as practicable, family, carers and other support persons, the treatment and care to be provided and the patient's obligations under the statement.¹⁵⁴

These recommendations, in particular the inclusion of the patient and those close to the patient in planning for their treatment and recovery, are supported. This inclusion supports a rights-based approach to mental health treatment.

Monitoring conditions

The Review proposes that the Director of Mental Health be able to apply monitoring conditions to any involuntary patient whilst he or she is in the community. This includes forensic patients, classified patients, court order patients and patients subject to an involuntary treatment order. The condition may be applied if:

¹⁵³ Review of the *Mental Health Act 2000*, Background Paper 5, 5.

¹⁵⁴ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 5.10.

- there is a significant risk that the patient would not return to the authorised mental health service as required; or
- the patient has not complied with previous obligations while in the community and this non-compliance has resulted in a significant risk of harm to the patient or others.¹⁵⁵

The imposition of a monitoring condition must be reviewed by the Tribunal within 21 days of the decision to apply the condition.¹⁵⁶

Feedback regarding these proposals

The expansion of the imposition of monitoring conditions to include people subject to an involuntary treatment order is not supported. This represents a significant expansion of the Director of Mental Health's powers, and will significantly increase the number of people whose rights could be adversely affected. It also arguably contributes to negative stereotypes and stigma associated with people with mental illness.

Stakeholders at the Roundtable raised several issues with regard to the imposition of monitoring conditions by the Director of Mental Health. Firstly, several stakeholders said that the process by which monitoring conditions was imposed caused difficulties for people subject to order. Many patients go through the following process:

- a panel considering community-based treatment assesses a person's situation and makes recommendations to the Tribunal regarding community-based treatment;
- community-based treatment is approved by the Tribunal without any monitoring conditions;
- the Director of Mental Health considers the person's release into the community and adds a monitoring condition;
- the person appeals to the Tribunal for re-consideration of the monitoring condition.

Stakeholders pointed out that people ended up in a circular situation, which causes frustration and delays a person's release into the community. This concern may be able to be addressed if the Director of Mental Health had a role earlier in proceedings, and instead of being able to impose a monitoring condition was able to make a recommendation to the Tribunal that a monitoring condition should be imposed. This would then ensure that the patient was able to address the issue of a monitoring condition at the initial hearing, improving procedural fairness and reducing the resources that would be utilised for reviewing the imposition of monitoring conditions. The suggestions of stakeholders are supported and it is recommended that the Review consider adopting this approach.

If the recommendation were to remain in this form, then stakeholders welcomed the inclusion of guidelines to drive the Director of Mental Health's decision-making with regard to the monitoring conditions, describing them as a 'vast improvement'. The inclusion of these guidelines is also supported, particularly as they provide clarity regarding the scope of the Director of Mental Health's power to impose a monitoring condition. However, stakeholders pointed out that the criteria with which the Tribunal reviewed monitoring conditions are different and it was argued that, without identical criteria, the Tribunal could not properly review the imposition of these conditions. It is recommended that the Review consider developing cohesive guidelines for the imposition and review of monitoring conditions.

¹⁵⁵ Ibid 6.13.

¹⁵⁶ Ibid 6.14.

Recommendation 28: The imposition of monitoring conditions should not be expanded to include people subject to an involuntary treatment order.

The procedure for imposing a monitoring condition should be amended. The Director of Mental Health should not be able to impose a monitoring condition, but rather should be able to make a recommendation to the Tribunal that a monitoring condition be imposed.

If that recommendation is not accepted, then the criteria upon which the Director of Mental Health may decide to impose a monitoring condition and the criteria upon which the Tribunal reviews a monitoring condition must be aligned.

Restrictive practices

There are currently a range of strategies at a national level aimed at reducing and eliminating the use of seclusion and restraint in mental health services. For example, eliminating the use of seclusion and restraint is one of the four priority areas of the National Safety Priorities in Mental Health: A National Plan for Reducing Harm.

While the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has called for an absolute ban on the use of seclusion and restraint in mental health facilities,¹⁵⁷ it is acknowledged that in the short-term this may not be achievable. However, the circumstances in which seclusion and restraint can be used must be severely restricted and subject to significant safeguards. This is particularly given the impact on a person's human rights, especially their right to bodily security and integrity.

Restraint

The definition of mechanical restraint will be changed to include: "...the restraint of the person by the use of any device or apparatus used to prevent the free movement of the person's body or a limb of the person".¹⁵⁸ A doctor may authorise the use of a mechanical restraint if the doctor is satisfied that it is necessary to protect the patient or other persons from imminent physical harm, and there is no less restrictive way of ensuring the safety of the patient or others.¹⁵⁹

Given that the current *Mental Health Act 2000* does not explicitly state that restraint may be re-authorised after 3 hours, it is proposed to clarify that re-authorisation can occur if the criteria continue to apply.¹⁶⁰ It is also proposed to clarify that the current provisions with respect to mechanical restraint in the *Mental Health Act 2000* do not prevent the use of a mechanical restraint if the use is lawful under other legislation (for example, the use of hand-cuffs by the police if the use is authorised under the *Police Powers and Responsibilities Act 2000*).¹⁶¹

Mechanical restraints will only be able to be authorised in a high security unit or another authorised mental health service first approved by the Director of Mental Health. The prior written approval of the Director Mental Health must be provided.¹⁶² The Director of Mental Health will provide direction to the Authorised Mental Health Services in relation to how and when the Director of Mental Health should be notified about the use of mechanical restraint.¹⁶³

In a high security facility, mechanical restraint may be used for longer than 3 hours without a reauthorisation if the Director of Mental Health has approved a management plan for the patient. A management plan must include strategies to reduce mechanical restraint for the patient and must be

¹⁵⁷ United Nations Human Rights Council, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E Mendez, A/HRC/22/53* (1 February 2013), 15
<http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf>.

¹⁵⁸ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 13.13.

¹⁵⁹ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 13.18.

¹⁶⁰ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 13.1.

¹⁶¹ Review of the *Mental Health Act 2000* Discussion Paper, recommendations 13.4-13.5.

¹⁶² Review of the *Mental Health Act 2000* Discussion Paper, recommendations 13.8-13.9.

¹⁶³ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 13.12.

reviewed monthly.¹⁶⁴

Seclusion

The definition of seclusion will be changed so that where a person consents to seclusion, this will not be considered seclusion. Seclusion will mean “...the confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented. It is not seclusion if a person consents to the seclusion. The ‘overnight’ confinement for security purposes of an involuntary patient in a high security unit or an in-patient facility of an Authorised Mental Health Service prescribed under a regulation for this subsection is not seclusion”.¹⁶⁵ The definition of what constitutes ‘overnight’ will also be clarified, with ‘overnight’ to be defined as a period of no more than 10 hours between 8.00pm and 8.00am, as determined by the administrator of the authorised mental health service.¹⁶⁶

As with restraint, given that the current *Mental Health Act 2000* does not explicitly state that seclusion may be re-authorised after 3 hours, it is proposed to clarify that re-authorisation can occur if the criteria continue to apply.¹⁶⁷ Similarly, it is proposed to clarify that the provisions with respect to seclusion in the *Mental Health Act 2000* do not prevent the use of seclusion if it is lawful under another law.¹⁶⁸

In a high security facility, the use of seclusion may be used for longer than 3 hours without a reauthorisation if the Director of Mental Health has approved a management plan for the patient. A management plan must include strategies to reduce seclusion for the patient and must be reviewed monthly.¹⁶⁹ The Director of Mental Health will provide direction to the authorised mental health service in relation to how and when the Director of Mental Health should be notified about the use of seclusion.¹⁷⁰

If a registered nurse places a patient in seclusion in an emergency situation, the nurse may also release the patient from seclusion without the authorisation of a doctor. However, the patient must still be examined by a doctor as soon as practicable.¹⁷¹

Consenting to seclusion

Stakeholders at the Roundtable expressed concerns about the ability for a person to ‘consent’ to the use of seclusion. These concerns are shared by the Public Advocate.

Apart from the ‘legal fiction’ that is associated with consent by a person subject to involuntary treatment for mental illness due to their lack of capacity to their own seclusion, the ability to consent to seclusion could have a number of other adverse outcomes. Stakeholders at the Roundtable stated that the ability to consent to seclusion will reduce the current transparency around seclusion and the ability to report on when seclusion occurs.

The practical and physical arrangements inside mental health services could be arranged so that people can obtain the privacy that they want without making these exclusions to the definition of seclusion.

Recommendation 29: The definition of seclusion should not be amended to exclude instances where a person consents to seclusion.

¹⁶⁴ Review of the *Mental Health Act 2000* Discussion Paper, recommendations 13.2-13.3.

¹⁶⁵ *Mental Health Act 2000* (Qld) s162J.

¹⁶⁶ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 13.16.

¹⁶⁷ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 13.1.

¹⁶⁸ Review of the *Mental Health Act 2000* Discussion Paper, recommendations 13.6-13.7.

¹⁶⁹ Review of the *Mental Health Act 2000* Discussion Paper, recommendations 13.2-13.3.

¹⁷⁰ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 13.12.

¹⁷¹ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 13.17.

Reducing the restrictions on seclusion and restraint

The 2012-13 Annual Report of the Director of Mental Health reports a reduction on instances of seclusion overall from the previous year.¹⁷² This is very positive and shows progress towards the various strategies at a national level to reduce and eliminate the use of seclusion and restraint in mental health services. Arguably, this has been partly due to the tight restrictions and reporting requirements placed on the use of seclusion.

Inter-jurisdictional studies of successful strategies to reduce the use of restraint and seclusion in mental health services have emphasised the following policy and legislative initiatives:

- reducing the maximum time periods for which seclusion and restraint can be ordered;
- placing tighter controls over the use of seclusion and restraint, such as the need for face-to-face evaluation by a physician or other licensed independent practitioner within an hour of the start of a seclusion or restraint event; and
- introduction of post-seclusion or post-restraint debriefings with staff and patients.¹⁷³

For this reason, it would be unfortunate to lessen the current restrictions on the use of seclusion and restraint.

Recommendation 30: The current restrictions on the authorisation of seclusion and restraint should be maintained.

Further safeguards

In accordance with the approach outlined above, a number of further safeguards should be added to the use of seclusion and restraint in mental health services.

First, when seclusion and restraint are used in relation to a person, there should be a requirement to notify (as soon as is practicable) the person's support people including their guardian, carers, family members, advocate and/or legal representative, as well as the independent patient companion. The community visitor should also be notified.

Second, every instance of the use of seclusion and restraint should be subject to a clinical debriefing by the treating team and the results of the debriefing recorded in the patient's file.

These extra safeguards will add further transparency to the use of restraint and seclusion in mental health services. They have been shown to be successful in other jurisdictions in reducing the use of restraint and seclusion.¹⁷⁴

Recommendation 31: Further safeguards should be provided for the use of restraint and seclusion including:

- notification of the patient's relevant support people including their guardian, carers, family members, advocate and/or legal representative, as well as the independent patient companion and community visitor when an instance of restraint or seclusion is used; and
- a compulsory debriefing by the treatment team after every instance of the use of restraint or seclusion, the results of which are included in the patient's file.

¹⁷² Queensland Government, *2012-2013 Annual Report of the Director Mental Health*, 32.

¹⁷³ Mental Health Commission Ireland, *Seclusion and Physical Restraint Reduction Knowledge Review and Draft Strategy* (June 2012), 12-13 <http://www.mhcirl.ie/File/SecandPPR_KnowRev.pdf?bcsi_scan_1074587e009e997d=97KkBX5YKZWCgTpKobrIYJ139VQmAAAANZiBHA==&bcsi_scan_filename=SecandPPR_KnowRev.pdf>.

¹⁷⁴ Ibid.

Deep brain stimulation

The Review has recommended that the term ‘psychosurgery’ be replaced with the term ‘neurosurgery for psychiatric conditions’ and that non-ablative procedures are excluded from this definition.¹⁷⁵ It is my understanding that both neurosurgery for psychiatric conditions and non-ablative procedures will not be authorised by any order for involuntary treatment.

Presently, neurosurgery includes non-ablative procedures and it can only be performed with a person’s informed consent and with the approval of the Tribunal.¹⁷⁶ If the definition of neurosurgery were amended as above, then non-ablative procedures would only be able to be performed in the following instances:

- with the person’s informed consent; or
- if the procedure is not to diagnose or treat a mental illness, with a guardian’s consent;¹⁷⁷ or
- if the procedure is to diagnose or treat a mental illness, under a direction made in an advance health directive.¹⁷⁸

Given the experimental nature of the use of techniques such as deep brain stimulation for the treatment of mental illness, Tribunal oversight should be retained for the performance of non-ablative procedures. Although they may be considered less invasive than ablative procedures, they are nonetheless extremely serious procedures and their use should be tempered by robust safeguards. Tribunal oversight will also assist with monitoring the use and effectiveness of this new treatment.

This approach would also be consistent with other jurisdictions such as Victoria.

Recommendation 32: Tribunal oversight should be retained for the performance of non-ablative procedures such as deep brain stimulation.

Informed consent

At present, informed consent is required for certain regulated treatments such as electro-convulsive therapy and will be required for deep brain stimulation. Therefore, informed consent is an important safeguard in the regulation of these invasive treatments.

At the workshop hosted by the Queensland Mental Health Commission, it was noted by Penny Weller and stakeholders that the proposed *Mental Health Act 2014* does not define the term ‘informed consent’. This maintains the current approach, as that term is also used but not defined in the current *Mental Health Act 2000*. Stakeholders at that workshop noted that it could be beneficial to define the phrase ‘informed consent’, although it was also noted that this could be a complex task and the result could fall short of what exists within the common law.

The Public Advocate would support the Review defining the term ‘informed consent’. In Victoria, the *Mental Health Act 2014* has included provisions that define ‘informed consent’ and provide guidance regarding whether a person has the capacity to give informed consent.¹⁷⁹ These provisions include requirements that the person has been given adequate information to enable the person to make an informed decision and a reasonable opportunity to make the decision.¹⁸⁰

This type of provision is consistent with a recovery-oriented approach and a rights-based approach, and for that reason it is proposed that such an approach also be incorporated into Queensland legislation.

¹⁷⁵ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 14.1-14.2.

¹⁷⁶ *Mental Health Act 2000* (Qld) s 230(1).

¹⁷⁷ *Guardianship and Administration Act 2000* (Qld) s 12 and sch 4, definition of ‘psychosurgery’.

¹⁷⁸ *Guardianship and Administration Act 2000* (Qld) ss 65(2)-65(4), sch 4 (definition of ‘psychosurgery’) and sch 2 (definition of ‘special health care’).

¹⁷⁹ *Mental Health Act 2014* (Vic) ss 68-69.

¹⁸⁰ *Mental Health Act 2014* (Vic) s 69.

Recommendation 33: The proposed *Mental Health Act 2014* should incorporate provisions with respect to the definition of and requirements for informed consent similar to the provisions in the *Mental Health Act 2014* (Vic).

Patient support, guardianship and advocacy

Independent patient companion

The Review has proposed discontinuing the allied person model that currently exists within the *Mental Health Act 2000*. Instead, the proposed *Mental Health Act 2014* will make provision for an ‘independent patient companion’. The Review proposes that each authorised mental health service be required to employ or engage (for example, from a non-government organisation) a person or persons as an ‘independent patient companion’. This person would report directly to the administrator of the service and would not be a part of the patient’s treating team.¹⁸¹

The Review proposes that the role of the independent patient companion would be to:

- advise involuntary patients, family, carers and other support persons of the patients rights and obligations under the Act;
- assist involuntary patients, family, carers and other support persons to constructively engage with the treating team regarding the patient’s treatment and care;
- advise patients, family, carers and other support persons of upcoming Tribunal proceedings, the patient’s rights at Tribunal proceedings, and engaging an advocate or legal representative for a hearing;
- attend Tribunal hearings as an advocate or support person, if requested by the patient;
- actively identify if the patient has a personal guardian or attorney and, if one exists, work cooperatively with the guardian or attorney to further the patient’s interests;
- advise patients, where appropriate, of the benefits of having an advance health directive or enduring power of attorney to address future times where the patient does not have capacity.¹⁸²

Support for the role of independent patient companion

Stakeholders at the Roundtable were supportive of the introduction of the independent patient companion. In particular, stakeholders noted that The Park Centre for Mental Health Treatment, Research and Education currently has a person employed in a similar capacity. The feedback from stakeholders was consistently that this was a very valuable role, and that the assistance provided by this person brought enormous benefit to Tribunal hearings and to patients generally.

The Public Advocate is also supportive of the introduction of the independent patient companion. However, the person should not be an employee of the service and must be engaged from an external non-government organisation. This will maximise the ability of the independent patient companion to be separate from the treating team, be frank in reporting to the administrator, and provide independent advice and support to patients and their supporters. If the separation and independence of this role is not maximised, then the effectiveness of the role will be decreased.

It is noted that the recommendations refer to an independent patient companion being appointed to each authorised mental health service. This does not take into account that some people placed on a forensic order (disability) are detained to the forensic disability service. The Review should ensure that the forensic disability service is also required to engage an independent patient companion, to ensure that people subject to a forensic order (disability) are given the same assistance.

¹⁸¹ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 7.6.

¹⁸² Review of the *Mental Health Act 2000* Discussion Paper, recommendation 7.7.

Scope of the role of the independent patient companion

The role of the independent patient companion is broad and challenging. Within each mental health service, there are numerous patients. These patients have come to be associated with the service in different ways, have different illnesses or conditions and differing states of capacity, require different levels and types of treatment or care, are at different stages of their treatment or care, and have differing levels of familial and external support. These, and many other factors, mean that each patient is different and will have differing requirements that must be addressed by the independent patient companion.

Many services have patients that are residing in the community, which may affect contact with the independent patient companion. Further, there is likely to be more frequent contact with the independent patient companion when a person first enters a service and some services have a relatively high 'patient turnover'. This could place a significant demand on the independent patient companion's time.

As a result, it is questioned whether the independent patient companion will have the time or resources to fulfil the intent of the Review and provide each patient with the individualised, high-quality assistance that is required. It is intended by the Review that the independent patient companion provide assistance with many facets of involuntary treatment, all of which will have competing timeframes and priorities. To take a simple example, how will the independent patient companion perform their role if two or more patients have an event scheduled for the same time?

The Review should carefully consider the scope of the role of the independent patient companion. In particular, the Review should consider what the independent patient companion will reasonably be able to achieve, and where necessary additional supports should be put into place.

Feedback regarding the functions of the independent patient companion

The Public Advocate is generally supportive of the proposed functions of the independent patient companion. If these are able to operate effectively, they will improve knowledge and understanding of the system and positively affect the outcomes for patients.

The requirement for an independent patient companion to identify and work cooperatively with a guardian or attorney must be expanded. In many instances, a person does not have a formally appointed guardian or attorney but they do have people in their lives who operate as a statutory health attorney, engage in decision-making informally or who provide the person with significant support to make decisions. Further, even where a person does not require a substitute decision maker or decision-making support, they may still have people in their lives that assist them and provide them with support. In all of these instances, the independent patient companion should identify and consult with those people in the same way as is proposed for guardians and attorneys. Otherwise, the treating team and Tribunal will lack valuable information and the patient will lack valuable support.

Recommendation 34: The independent patient companion scheme must be adequately resourced, comprised of people independent from the mental health service, and available to people detained in the Forensic Disability Service. Independent patient companions must have a positive obligation to recognise and consult with not only guardians and attorneys, but also other formal and informal decision-makers and other family, carers and supporters.

Legal representatives

Right to legal representation

The Review has noted that there is a very low rate of patients with representation at Tribunal hearings, and that the Attorney-General has a much higher rate of representation. There are concerns regarding the fairness of hearings where the Attorney-General is represented but a patient

is not, primarily because the patient cannot advocate for themselves with the same skill and knowledge as a lawyer and is therefore significantly disempowered.¹⁸³

The Review notes that the right to legal representation is a fundamental right under the *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of mental Health Care*, which states that:

“the person whose capacity is at issue shall be entitled to be represented by counsel (defined as legal or other qualified representative). If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment to that person to the extent that he or she does not have sufficient means to pay for it”.¹⁸⁴

Similarly, the *United Nations Convention on the Rights of Persons with Disabilities* requires State parties to recognise and accommodate the legal capacity of people with disability. State parties must provide people with disability with the support that they require to exercise their legal capacity.¹⁸⁵ State parties must also ensure access to justice for people with disability, including by providing suitable accommodations to facilitate their participation in the legal process.¹⁸⁶ This arguably includes providing the person with legal representation.

The Public Advocate strongly supports the recognition that this Review has given to the need for increased legal representation at Tribunal hearings.

Proposed Legal Representation

The Review has proposed that patients are to have legal representation at Tribunal hearings, without cost to the patient, for hearings involving minors, fitness for trial reviews and reviews where the State is legally represented by the Attorney-General.¹⁸⁷ The Review also refers to legal representations at special hearings in the District Court or Mental Health Court, but it does not appear to guarantee legal representation without cost for those hearings.¹⁸⁸

The Public Advocate is supportive of the provision of legal representation in these matters, particularly where it will go toward addressing the power imbalance that exists when the State is legally represented and the person is not. This approach gives recognition to the rights of people with mental illness or disability.

Appointment of legal representatives

Stakeholders raised some difficulties with regard to this proposal. First, stakeholders were of the opinion that a duty lawyer model could not be adopted in this instance. Given the volume and complexity of information, this would not provide the lawyer with sufficient time to adequately review the material, meet with the patient and prepare for a hearing. Stakeholders also noted that the duty lawyer model relies on a defendant engaging with the process, which is something that not all patients will be in a position to do.

Stakeholders opined that, in order to avoid a ‘duty lawyer model’ and ensure that the provision of legal representation is both effective and useful, it will be imperative that a lawyer is engaged with sufficient time for preparation. To achieve this, it will need to be known definitively and in advance whether the State is to be represented at a hearing. If a decision is made that the State will always be represented for some matters then this is achievable, but if representation is to be decided selectively then this will make for difficulties.

In summary, the Review must take steps to ensure that the provision of legal representation is effective and efficient. The need for legal representation must be identified in advance and

¹⁸³ Review of the *Mental Health Act 2000*, Background Paper 9, 2.

¹⁸⁴ Principle 1(6), cited in Review of the *Mental Health Act 2000*, Background Paper 9, 2.

¹⁸⁵ *Convention on the Rights of Persons with Disabilities*, art 12.

¹⁸⁶ *Ibid* art 13.

¹⁸⁷ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 9.2.

¹⁸⁸ *Ibid* 4.21-4.23.

responded to in a timely fashion, thereby enabling the legal representative to prepare the matter and be of greater assistance to the patient.

Recommendation 35: The Review must develop a procedure for ensuring the provision of legal advice that is timely, comprehensive and valuable to the patient.

Difficulties associated with legal representation

Stakeholders at the Roundtable identified a number of issues or questions that would routinely arise if legal representation were provided in these circumstances. These included:

- does the patient want to be legally represented (noting also that some people cannot state if they want any legal representation due to their mental illness or disability)?
- does the patient have capacity to give proper instructions?
- if the patient does not have that capacity, is there a guardian for legal matters and can they provide the requisite instructions?
- if there is not a guardian for legal matters, is there a guardian or appointee for other matters, and should arrangements be made to approach QCAT and have their appointment be extended?
- if there is no guardian or appointee, should QCAT be approached to appoint a guardian for legal matters?

These are questions that, when they arise, would be difficult to answer and potentially complex to resolve. The Review should consider how these questions might be able to be resolved, or where legal practitioners may be directed for assistance when such issues arise.

Recommendation 36: The Review must consider what assistance can be provided to lawyers to direct them in addressing or overcoming the barriers identified in this submission.

Resourcing

This proposal may have a significant impact upon resourcing. It is estimated that legal representation will be required in approximately 900 hearings.¹⁸⁹ Although other proposals are designed to reduce costs, this is still a significant investment of resources that must be made.

This may also have an impact upon resourcing within the guardianship system. There is a possibility that QCAT will be relied upon to make an increased number of appointments for legal matters, which may necessitate a hearing and, if the appointment is continued, regular reviews. Further, the appointment of the Public Guardian as a guardian for legal matters may also increase, placing additional resourcing requirements on that Office.

Recommendation 37: The Review must consider the resourcing needs of these proposals as they relate to the other entities and ensure that they are adequately addressed.

Patient support

Interface with the guardianship system

The recognition of an appointed guardian by the *Mental Health Act 2000* is limited. For example, a person's capacity to consent is referenced in both the assessment and treatment criteria under the current *Mental Health Act 2000*, but it is specified that it is only the person's own consent that is relevant. A guardian's consent to the person's assessment or treatment will not be effective.¹⁹⁰

Some provision is made for guardians and attorneys to be notified of a person's status or of

¹⁸⁹ Review of the *Mental Health Act 2000*, Background Paper 9, 3

¹⁹⁰ *Mental Health Act 2000* (Qld) ss 13(3), 14(2).

particular events. For example, an attorney or guardian must be notified when a person becomes an involuntary patient for the purposes of assessment¹⁹¹ or becomes a classified patient.¹⁹² An attorney or guardian must also be provided with notices of hearings for reviews,¹⁹³ treatment applications¹⁹⁴ and classified patient information orders.¹⁹⁵ It is also recognised that, where information could be given to a victim, information may be given to the victim's guardian.¹⁹⁶ Informal decision-makers are also given some very limited recognition.¹⁹⁷

Where a guardian has been appointed to make decisions for an adult, their decision-making authority will be overridden to the extent that it overlaps with any mental health orders. This is not explicitly stated in the *Mental Health Act 2000*; however, it is commonly understood to be the case.

Although a guardian's decision-making authority is eclipsed by overlapping mental health orders (to the extent of the overlap), a guardian appointed for health matters will still have authority for health matters not related to mental illness (and this ongoing role will be further emphasised if a more restrictive definition of treatment is adopted, as recommended above). Therefore, if a person subject to an order under the *Mental Health Act 2000* becomes ill, unless the illness is a mental illness and the criteria for an involuntary treatment order are met, the person may consent to their own treatment. If the person has impaired capacity for that health matter, then a guardian for health matters may consent to treatment on their behalf. Similarly, if there was no appointed guardian, a statutory health attorney could provide consent.

The Review considers how the *Guardianship and Administration Act 2000* and the *Mental Health Act 2000* interact with regard to urgent health care (section 63, *Guardianship and Administration Act 2000*) and electro-convulsive therapy.¹⁹⁸ The Review concludes that the two Acts do not conflict with regard to the provision of electro-convulsive therapy. The Review also proposes to clarify that the emergency transport and operation provisions in the proposed *Mental Health Act 2014* do not affect the operation of the *Guardianship and Administration Act 2000*, particularly the provisions regarding urgent health care.¹⁹⁹

Specific recognition of personal guardians and attorneys

The Review has considered the role of a guardian or an attorney in relation to the operation of the mental health system. For the purposes of this discussion, the following definitions are relevant:

- Attorney: an attorney under a power of attorney, enduring power of attorney or advance health directive, under the *Powers of Attorney Act 1998*. For the purposes of the Discussion Paper, an attorney would need to be authorised to make the relevant decision for the person.²⁰⁰
- Personal guardian: a guardian appointed under the *Guardianship and Administration Act 2000*. For the purposes of the Discussion paper, a guardian would need to be authorised to make the relevant decision for the person.²⁰¹

The Review has given some specific recognition to guardians and attorneys. For example, a personal guardian or attorney may:

- request that a psychiatric report be prepared and that they be provided with a copy of the report;²⁰²

¹⁹¹ *Mental Health Act 2000* (Qld) ss 45(d)-(e).

¹⁹² *Mental Health Act 2000* (Qld) ss 70(1)(b)(iv)-(v).

¹⁹³ *Mental Health Act 2000* (Qld) ss 189(1)(f)-(g).

¹⁹⁴ *Mental Health Act 2000* (Qld) s 232(2)(d)-(e).

¹⁹⁵ *Mental Health Act 2000* (Qld) s 318G(1)(e)-(f).

¹⁹⁶ *Mental Health Act 2000* (Qld) ss 318C(6)(b).

¹⁹⁷ For example, *Mental Health Act 2000* (Qld) s 169K(2)(n) (Information that may be given about a patient to facilitate the patient's transfer to and care at the Forensic Disability Service includes whether the patient has a guardian or an informal decision-maker).

¹⁹⁸ Review of the *Mental Health Act 2000*, Background Paper 12, 1-2; Review of the *Mental Health Act 2000* Discussion Paper, recommendation 12.1.

¹⁹⁹ Review of the *Mental Health Act 2000*, Background Paper 12, 2; Review of the *Mental Health Act 2000* Discussion Paper, recommendation 12.1.

²⁰⁰ Review of the *Mental Health Act 2000*, Background Paper - Glossary.

²⁰¹ *Ibid.*

- where a person does not have capacity, attend an interview for a psychiatric assessment and receive a copy of the resulting psychiatric report;²⁰³ and
- work co-operatively with an independent patient companion to further the patient's interests.²⁰⁴

The Review also refers to 'substitute decision-makers'. This term is not defined by the Review, but it is understood to include a personal guardian or an attorney. A substitute decision-maker is referred to in the following contexts:

- a person who is fit for trial can instruct their lawyer to explore mental health defences if they wish to; and if a person is not fit, a substitute decision-maker could make decisions on the person's behalf;²⁰⁵
- the options proposed for assessing persons charged with offences refers to a patient or a substitute decision-maker;²⁰⁶
- the proposal for special hearings states that a lawyer will act in the best interests of the person in consultation with both the person and a substitute decision-maker, if one has been appointed;²⁰⁷ and
- a health provider may provide health care in urgent circumstances if the provider believes the health care should be carried out urgently to prevent significant pain or distress and it is not reasonably practical to get consent from a substitute decision-maker, such as a personal guardian.²⁰⁸

The Review also gives some acknowledgement to the role of guardians or other decision-makers in relation to health matters that fall outside of a mental health order. For example, it acknowledges that where a person is subject to a forensic order (disability) and has a mental illness, that person retains the right to consent to his or her own treatment. If consent is not possible, the person has the right to be treated as an involuntary patient or in accordance with the regime established by the *Guardianship and Administration Act 2000*. Specifically, the review states:

"limiting the authority under a forensic order (disability) to the provision of care, ensures that individuals who have a finding of unsoundness or unfitness relating to an intellectual disability have the same rights as other members of the community to give consent to treatment for mental illness or, if consent is not possible, to have the treatment provided under the involuntary treatment provisions of the Mental Health Act, or the *Guardianship and Administration Act 2000*".²⁰⁹

This greater and more explicit recognition of the role of personal guardians and attorneys is to be commended. Whilst this arguably represents an improvement upon the current *Mental Health Act 2000*, it may not sufficiently acknowledge the specificity with which appointments for guardians or attorneys are made or the nuances of the system in which those appointees operate. It arguably also gives insufficient acknowledgement to informal decision-makers, particularly statutory health attorneys, who should often be recognised as having the same decision-making powers as an appointed guardian or attorney.

Recommendation 38: The proposed *Mental Health Act 2014* must clarify the overlap between guardianship orders and orders authorising involuntary treatment.

²⁰² Review of the *Mental Health Act 2000* Discussion Paper, recommendation 3.4.

²⁰³ Ibid 3.7.

²⁰⁴ Ibid 7.7.

²⁰⁵ Review of the *Mental Health Act 2000*, Background Paper 3, 7.

²⁰⁶ Ibid, addendum.

²⁰⁷ Review of the *Mental Health Act 2000*, Background Paper 4, 10.

²⁰⁸ Review of the *Mental Health Act 2000*, Background Paper 12, 1.

²⁰⁹ Review of the *Mental Health Act 2000*, Background Paper 11, 2.

Special hearings

It is noted that substitute decision-makers have a role to play in special hearings. In drafting these provisions, the Tribunal must ensure that the phrase ‘substitute decision-maker’ is adequately defined. Given the seriousness of the role, a person formally appointed as guardian or attorney for legal matters should be required.

Assuming that the substitute decision-maker will be appointed under the *Guardianship and Administration Act 2000* or the *Powers of Attorney Act 1998*, regard must also be had to their duties and obligations under that legislation. In particular, guardians and attorneys must comply with a series of general principles, and this includes an obligation to “act in a way that is consistent with the adult’s proper care and protection,” which has been interpreted to mean the adult’s best interests.²¹⁰

Therefore, there is likely to be a situation where both a lawyer representing a person at a special hearing and a person appointed as guardian or attorney for the purpose of decision-making regarding the special hearing must both act in the person’s best interests. Their views on ‘best interests’ will likely be informed by different considerations and therefore may not align, potentially resulting in differing opinions regarding how a matter should proceed. In that instance, there must be guidance regarding where and how that dispute is to be resolved.

Recommendation 39: The proposed *Mental Health Act 2014* must clarify the role of a substitute decision-maker and a lawyer during a special hearing, particularly with regard to decisions about the running of the hearings and determinations of what is in the patient’s best interests.

Involvement of supporters

Treatment and consultation

The Review proposes to strengthen the principles of patient support in the legislation, including by acknowledging in the proposed *Mental Health Act 2014* that “family, carers and other support persons have an important role in supporting decision-making, particularly regarding treatment, care, rehabilitation and recovery”.²¹¹ The involvement of family, carers and other supports can enhance treatment, strengthen support networks, encourage rehabilitation, and strengthen patient participation and involvement.²¹²

To facilitate this involvement, the Review proposes to include a statement of principles detailing the rights and responsibilities of family, carers and other support people. These people have the right to:

- contact the patient during treatment;
- participate in decisions regarding treatment and ongoing care;
- obtain additional information about a patient’s support, care, treatment, rehabilitation and recovery
- be consulted by the treating team about treatment options being considered for the patient;
- arrange other support services for the patient (such as respite care, counselling and community care); and
- obtain any information that the patient requests they should receive.²¹³

In order to ensure that family, carers and other supporters use these rights constructively, they will have the responsibility to:

²¹⁰ *Guardianship and Administration Act 2000* (Qld) sch 1 and *Powers of Attorney Act 1998* (Qld) sch 1; *Re JD* [2003] QGAAT 14 (19 September 2003) [35]; *Re SD* [2005] QGAAT 71 (29 November 2005) [39].

²¹¹ Review of the *Mental Health Act 2000*, Background Paper 7, 3.

²¹² *Ibid.*

²¹³ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 7.1.

- respect the patient’s humanity and dignity;
- consider the opinions and skills of professional and other staff who provide patients with assessment, individualised care planning, support, care, treatment, recovery and rehabilitation services;
- cooperate, as far as is possible, with reasonable programs of assessment, individualised care planning, support, care, treatment, recovery and rehabilitation services.²¹⁴

To support these rights and responsibilities, the proposed *Mental Health Act 2014* will also note that, under the *Hospital and Health Boards Act 2011*, family carers and other support persons may be provided with information about a patient’s treatment and care, if the information is for the purpose of treatment and care or if the person has sufficient personal interest in the patient’s health and welfare.²¹⁵

The Review also proposes that patients in an authorised mental health service have a right to be visited by family carers and support persons at reasonable times, and to correspond with individuals, unless that is excluded by the proposed *Mental Health Act 2014*.²¹⁶

The increased involvement of family, carers and supporters is vital for patients, and as such, these recommendations are supported. The inclusion of both rights and responsibilities in the proposed *Mental Health Act 2014* are also supported. However, the Review must ensure that the responsibility of supporters to ‘cooperate’ does not preclude supporters from questioning and ultimately disagreeing with decisions made regarding the patient’s treatment including assisting a person to seek a review of their treatment or seek a second psychiatric opinion. Without the ability to seek a review and/ or question and disagree with decisions, the positive effect that a support person may have will be severely curtailed.

Recommendation 40: The proposed *Mental Health Act 2014* must not curtail the ability of family, carers or supporters to legitimately question or disagree with treatment decisions. The ability of a support person to assist the person to seek a review of the treatment and a second psychiatric opinion should be explicitly recognised.

Tribunal hearings

The Review has also addressed the involvement of family, carers or other supporters whilst a patient is undergoing involuntary treatment.

The Review also discusses the people who may attend a Tribunal hearing. The review notes that some people, such as family members or supporters, can be granted leave to attend a hearing but may only represent the views or wishes of the patient. They are not able to present a view about the patient, or other information or evidence that would assist the Tribunal in its decision-making. Presently, evidence of that nature can only be presented by the treating team.²¹⁷

This is problematic because other people, particularly those who are appointed or act as a decision-maker for the patient, could have significant and valuable information. Stakeholders at the Roundtable agreed that information from supporters would be valuable to the Tribunal in making decisions.

The Review acknowledges that patients should have a right to enable information about themselves, separate from any views formed by the treating team, to be presented to the Tribunal. To facilitate this, it is proposed that other people be able to give evidence at a Tribunal hearing at the patient’s request, with the Tribunal then making a determination as to how much weight should be placed

²¹⁴ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 7.1.

²¹⁵ Ibid 7.5.

²¹⁶ Ibid 7.4.

²¹⁷ Review of the *Mental Health Act 2000*, Background Paper 9, 4.

upon that evidence.²¹⁸ We support this recommendation.

Other issues

Support for victims

The Review makes a number of recommendations regarding support for victims. These include developing a statement of principles, requiring that those administering the proposed *Mental Health Act 2014* recognise:

- the harm caused to the victim by the unlawful act;
- the benefits of the victim receiving timely advice regarding proceedings and timely completion of those proceedings;
- the benefits of victims being able to express their views to decision-making entities;
- the benefits of the victim receiving timely advice regarding a patient's release into the community; and
- the benefits of victims receiving counselling, advice regarding legal procedures and support.²¹⁹

The importance of these principles is acknowledged. In particular, we believe that these principles are important because it will often be therapeutic for a victim to understand and have a role in the legal process intended to address an unlawful act committed against them.

It should be acknowledged that some victims would themselves have a mental illness or intellectual disability. In those instances, the application of these principles should be adapted to accommodate these people. For example, a person should be provided with any additional support they require because of their person's illness or disability. Further, the process by which a victim can express their views or otherwise be involved in the process must be sufficiently flexible to accommodate the person's illness or disability; such as by allowing victim submission to be made in any suitable format or with the assistance of another person. It is recommended that the Review include the need to accommodate victims with mental illness or intellectual disability in these proposed principles.

Recommendation 41: The needs of victims who may be particularly vulnerable or have difficulty communicating due to mental illness or intellectual disability should be incorporated into the new proposed principles.

Patients' right to privacy and confidentiality

Under the *Mental Health Act 2000*, a person may obtain a forensic information order, which entitles them to information about a forensic patient. The information includes the when ordered will be reviewed; revocation or confirmation of orders; the fact that limited community treatment has been approved, granted or revoked and any relevant conditions; and the fact that a patient has ceased to be a forensic patient.²²⁰ The Tribunal does not approve application for these orders in a timely fashion and, under the information order, a person is only notified of 'the fact' that an event has occurred and not of the reasons for that occurrence. It is believed that victims would benefit from receiving more information about the reasons for particular decisions, particularly a decision to grant community-based treatment or to revoke a forensic order.²²¹

To address these concerns, the Review proposes that the Director of Mental Health be charged with approving forensic information orders. Further, when an order is in place, the Tribunal should

²¹⁸ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 9.5; Review of the *Mental Health Act 2000*, Background Paper 9, 5.

²¹⁹ Review of the *Mental Health Act 2000* Discussion Paper, recommendation 8.1.

²²⁰ *Mental Health Act 2000* (Qld) s 318O(1).

²²¹ Review of the *Mental Health Act 2000*, Background Paper 8, 6.

provide a victim who has a forensic information order with a statement of reasons and a summary of the risk assessment that led to the decision for the patient to be granted community-based treatment or for the forensic order to be revoked.²²²

The review also addresses classified patient information orders, which enable a victim who has obtained an order to be provided with similar ‘facts’ when a person is a classified patient. The Review proposes to replace these orders with the ability for the Department of Health and the Queensland Health Victim Support Service to disclose relevant information to a victim.

Feedback regarding these proposals

These proposals represent a significant breach of the right of patients to privacy of their personal information. A statement of reasons and a summary of a risk assessment will include a significant amount of highly personal information. In particular, a risk assessment may include information about the patient’s mental state, psychological history, social circumstances and treatment.

Stakeholders at the Roundtable were not supportive of victims being provided with this type of information. At a practical level, stakeholders felt that any summary document could ultimately be different to the statement of reasons that must be given to a party if requested, which could cause confusion and difficulties within the legal process.

Stakeholders also felt it was important that the Review acknowledge the true status of a person subject to a forensic order. Firstly, stakeholders emphasised that we must never lose sight of the fact that when a person is made subject to a forensic order, the legal system has given them a defence and they are not guilty of a crime. Secondly, although a person has a mental illness or disability this does not necessarily make them more prone to violence or criminality, and any violence or criminality in which they may engage may not necessarily be a result of their illness or disability.

Stakeholders recognised that we must strike a delicate balance between the needs of victims to access information and have confidence in the system, and the right of patients to have their privacy respected. Stakeholders also recognised that information of this nature is highly confidential and any relaxation of this confidentiality should be done with the highest degree of caution. Stakeholders acknowledged that, although confidentiality requirements do ‘hamstring’ people in terms of what they can tell victims, the need to balance this with patients’ right to privacy and confidentiality exists regardless.

The overarching message given by stakeholders was that the privacy of patients should not be intruded upon by requiring the provision of additional information to victims. It was stated that victims presently have sufficient information to inform their movements and decisions. Stakeholders felt that the provision of a statement of reasons and a summary of the risk assessment would be far too great an intrusion on patients’ right to privacy.

The importance of victims being informed about important events is acknowledged and we support the provision of such information as is already provided under a forensic information order. However, we do not support the expansion of these orders to enable the provision of such highly personal information as would be contained in a statement of reasons and summary of the risk assessment. To do so would represent a gross breach of the patient’s rights to privacy and of confidentiality.

²²² Review of the *Mental Health Act 2000* Discussion Paper, recommendation 8.8.

With regard to classified patient information orders, we do not support the replacement of these orders with the ability of nominated organisations to disclose relevant information. Firstly, this represents a significant relaxation of the control that currently exists over the private and confidential information to which these orders relate. Further, the phrase 'relevant information' is not defined and there are no indications of who will decide what information is relevant for the purpose of disclosure to victims. As discussed, the patient's right to privacy must be respected and maintained, and this proposal carries a significant risk that privacy and confidentiality will be breached. It is therefore recommended that the Review does not proceed with this proposal, and instead maintains the use of classified patient information orders.

Recommendation 42: A statement of reasons and a summary of a risk assessment should not be incorporated into the information made available pursuant to forensic information orders and classified patient information orders.

Concluding comments

Thank you for the opportunity to provide comment and feedback on the proposed *Mental Health Act 2014*.

The Public Advocate would also like to thank those colleagues who took the time to attend the Roundtable and participate in such a constructive and informative discussion of the proposals in the Discussion Paper. The Mental Health Act Review Team was particularly helpful in ensuring that participants were cognisant of all the relevant information and background to the proposals.

This submission was also informed by the valuable and insightful public lecture provided by Dr Ian Freckleton QC and the forum facilitated by Dr Penny Weller on behalf of the Queensland Mental Health Commission.

The Public Advocate would be pleased to provide further explanation or discuss any of these comments in further detail to assist the Review Team in their determinations.

Yours sincerely,



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