

Office of the Public Advocate
Systems Advocacy

**Submission to the
Department of Health**

Mental Health Bill 2015

June 2015

Introduction

Interest of the Public Advocate

The Public Advocate was established by the *Guardianship and Administration Act 2000* (Qld) 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 for a matter;
- promoting the protection of the adults from neglect, exploitation or abuse;
- encouraging the development of programs to help the adults reach the 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 2015, the Office of the Public Advocate estimates that there are approximately 115,745 Queensland adults with impaired decision-making capacity (or 1 in 42 adults).² Of these vulnerable people, most have a mental illness (54 per cent) or intellectual disability (26 per cent). In addition to these factors, other conditions that can impact decision-making capacity include (but are not limited to) acquired brain injuries arising from catastrophic accidents, ageing conditions such as dementia, and conditions associated with problematic alcohol and drug use.

While not all people with these conditions will have impaired decision-making capacity, it is likely that many people with these conditions may, at some point in their lives if not on a regular and ongoing basis, experience impaired decision-making capacity in respect of a matter.

Engagement of the Public Advocate in the review

Since the review of the *Mental Health Act 2000* (the Act) commenced in 2013, the Public Advocate has been closely engaged in the review process.

The regulation of mental health treatment falls squarely within the Public Advocate's purview, particularly from the perspectives of promoting and protecting the rights of adults with impaired decision-making capacity, and monitoring and reviewing services to adults with impaired decision-making capacity.

More importantly, the Act, both currently and in respect of its future directions, is a significant piece of 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 future 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 QC to give a public lecture on a human rights approach to mental health regulation due to his extensive expertise in relation to this field³ and as part of a general strategy undertaken by the Public Advocate to become informed, and inform others in the course of engaging with the review of the Act.

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

² Office of the Public Advocate, *The potential population for systems advocacy* (Fact Sheet, Office of the Public Advocate (Queensland), April 2015).

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 & 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 [Office of the Public Advocate](#) | [Mental Health Bill 2015](#)

As part of this strategy, the Public Advocate also held a Roundtable with legal professionals and relevant statutory officers who work with the Act to consider the proposed changes in the Discussion Paper that was developed by the Queensland Government for the purpose of consulting on the review of the Act in 2014.⁴ The Public Advocate also 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 informed the Public Advocate's consideration of the previous review, and has influenced this submission.

Principles

The following principles underpin the Public Advocate's position in this submission:

- 1. Mental health legislation should have an ethical foundation that includes both a rights-based and recovery-oriented approach to treatment:** A strong ethical framework, inclusive of clear guiding principles, enables a cohesive regulatory framework for mental health treatment that promotes integrity and a sense of underlying purpose, and provides guidance for those interpreting and exercising legislative powers. Consistent with contemporary understandings of mental health treatment and Australia's human rights obligations under the *United Nations Convention on the Rights of Persons with Disabilities*, this framework should be both rights-based and reflective of a recovery-oriented approach.
- 2. A reduction in stigma and discrimination against people with mental illness should be a key objective of mental health legislation:** One of the key aims of any mental health legislation should be to reduce stigma in relation to mental illness, which if not adequately addressed can lead to prejudice and discrimination against people with mental illness.
- 3. Mental health legislation should balance respect for autonomy and self-determination of people with mental illness with the need to protect the person and community from harm:** While mental health legislation needs to balance a number of competing principles, respect for autonomy means providing people with mental illness with adequate support and information to actively participate in their own treatment decisions and, where they have capacity, enable them to make these decisions themselves.
- 4. Consultation, advocacy and patient involvement is not a substitute for safeguards in mental health legislation:** While strategies to engage patients and their families are important, they are not a substitute for automatic safeguards such as independent monitoring and reviews that provide a crucial safety net in any mental health system.
- 5. The criminal justice system should not be discriminatory in the way it responds to offenders and alleged offenders:** The involuntary treatment of people with mental illness who have been charged with criminal offences should resist a punitive approach that is inconsistent with the principles that underpin our system of criminal justice for people who are found unsound of mind or unfit for trial.
- 6. Mental health legislation should be workable and practicable for those practitioners who work in the system:** Mental health legislation must enable the provision of effective care and treatment for people with mental illness, without the unnecessary bureaucracy that often arises through legalistic processes and that limits people receiving the treatment and care they need in a timely and responsive manner.
- 7. An empirical approach to the monitoring, review and evaluation of legislative schemes as they apply to vulnerable people with mental illness and intellectual disability is crucial:** There should be clear and continuing emphasis on collecting data and transparent reporting to ensure that the efficacy of current approaches can be monitored, measured and assessed.

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*.

⁴ 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; Department of Health; Queensland Advocacy Incorporated and Queensland Public Interest Law Clearing House Incorporated (QPILCH).

Mental Health Bill 2015

The *Mental Health Bill 2015* (the Bill) provides a legislative framework for both the treatment and care of people with mental illness (mental health treatment provisions) as well as the detention and involuntary treatment and care of people who have been found unfit to plead or unsound of mind in relation to an alleged criminal offence due to a mental illness or intellectual disability (forensic provisions).

There are aspects of the Bill that the Public Advocate considers to be consistent with a rights-based and recovery-oriented approach to the treatment of mental illness. These include:

- a capacity-based approach to the involuntary treatment of mental illness;
- the explicit recognition of advanced health directives (with some reservations noted below); and
- a focus on the reduction and elimination of restraint and seclusion.

The Public Advocate also retains significant concerns about various aspects of the Bill that she believes are inconsistent with the principles outlined at the beginning of this submission, in particular:

- not having taken the opportunity to embrace a stronger recovery-orientation in respect of the treatment of mental illness, which would bring the Bill into line with other contemporary legislative approaches (such as the new Victorian *Mental Health Act 2014*);
- the implementation of the proposed new approach (the 'less restrictive way') in terms of its reliance on guardians and attorneys to consent to mental health treatment for patients without appropriate safeguards and the radical policy shift that this will represent for Queensland's guardianship system;
- the lack of either an appropriate legislative or systemic response to people with intellectual disability who, by virtue of their contact with the criminal justice system, will come under the ambit of the forensic provisions of the Bill and thus the failure to adequately address the issues highlighted in *R v AAM ex parte A-G (Qld) QCA*,⁵
- the need for clarification of certain aspects of the new jurisdiction of the Magistrates Court and what supporting systems will be in place; and
- the introduction of non-revokable forensic orders that, for the first time, introduce a 'punitive' approach to the mental health legislative framework.

Strengthening the recovery-oriented approach

The Public Advocate agrees that the ethical framework for the Bill should incorporate both a rights-based and recovery-oriented approach to mental health treatment, but believes there are significant opportunities to strengthen this approach in the Bill.

A recovery-oriented framework for mental health treatment and legislation emphasises the value of the lived experience of people with mental illness alongside the expertise, knowledge and skills of clinicians. Such a 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.⁶

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.⁷

⁵ *R v AAM; ex parte A-G (Qld) QCA 305*.

⁶ Dr Ian Freckleton QC, Public Lecture: *Mental Health Law Reform and Human Rights*, (Queensland University of Technology, 5 May 2014).

⁷ *Ibid*.

The way in which contemporary mental health legislation is beginning to incorporate this approach is by facilitating the making of advance statements that set out the person's treatment preferences in case they become unwell and need mental health treatment. Their treating psychiatrist is then under an obligation to make a treatment decision in accordance with the advance statement unless satisfied that the treatment specified is not clinically appropriate.

This approach has been incorporated in the new Victorian *Mental Health Act 2014*, for example, and is accompanied by many supporting strategies (underpinned by supported decision-making principles) to encourage people to participate in their treatment decisions in partnership with their treating teams.

Advance health directives

The Bill explicitly recognises that a person may make an advance health directive, as provided for under the *Powers of Attorney Act 1998*, to provide direction about their future care and treatment for a mental illness.⁸ A person who is not subject to a treatment authority may be treated under an advance health directive (or with the consent of a personal guardian or attorney).⁹ Furthermore, the Chief Psychiatrist will be charged with the responsibility to maintain a records system for advance health directives.¹⁰

While the Public Advocate believes that the recognition of advance health directives under the *Powers of Attorney Act 1998* is a step in the right direction, of itself and without further direction, such recognition is not consistent with a recovery-oriented approach.

For example, when a doctor is deciding on the treatment and care to be provided to an involuntary patient (other than a patient subject to a treatment authority), the doctor must 'have regard to' the views, wishes and preferences of the patient, including those expressed in an advance health directive.¹¹ However, once a person is subject to a treatment authority, there is no such obligation.

Further, it is unclear in the Bill as to when it would be sufficient to treat a person under their advance health directive and when their views, wishes and preferences (as expressed in the directive) would be ignored and a treatment authority made, or care and treatment provided under a treatment authority in a manner inconsistent with the advance health directive.

This requires further clarification particularly in circumstances such as the following:

- when an authorised doctor is considering whether a treatment authority should be made for a person, or whether there is a less restrictive way of providing treatment and care (for example through an advance health directive);¹² and
- when an authorised doctor is determining the nature and extent of the treatment to be provided to a person under a treatment authority (and must have regard to the person's views, wishes and preferences as outlined in an advance health directive).¹³

In the first scenario there are no criteria for the authorised doctor to consider in deciding that a person should not be treated under an advance health directive. In the second scenario, there are also no criteria for the authorised doctor to consider when deciding on the nature and extent of the treatment under a treatment authority and the extent to which this must align with a person's advance health directive.

The Victorian *Mental Health Act 2014* provides that a person may outline their preferences in relation to treatment in an 'advance statement' in the event that a person becomes a patient. An authorised doctor is then obliged to make treatment decisions that are congruent with this statement unless satisfied that the

⁸ *Mental Health Bill 2015* (Qld) Part 10.

⁹ *Ibid* cl 13, 202.

¹⁰ *Ibid* cl 233.

¹¹ *Ibid* cl 202.

¹² *Ibid* cl 45.

¹³ *Ibid* cl 50.

preferred treatment in the advance statement is not clinically appropriate; and is not a treatment ordinarily provided by the designated mental health service.¹⁴

The doctor must then inform the patient of the decision and the reasons for the decision, and advise the patient that he or she has a right to request written reasons for the decision.¹⁵ This provides for a more transparent mechanism for incorporating the person's advance statement into their treatment program and by which to override a person's advance health directive when it is not clinically appropriate.

In the Bill proposed for Queensland, this decision is left to the discretion of the authorised doctor, without any criteria to follow, or any obligation to inform the person why they have decided to override the advance health directive. This is not consistent with a recovery-oriented approach.

Without such provisions (nor provisions that obligate the patient's views in an advance health directive to be taken into account in the treatment provided under a treatment authority), there is little substance to the provisions around advance health directives (and the expressed recovery-based principle) in the Bill.

An advance health directive can currently be made by a person under the *Powers of Attorney Act 1998* and may be overridden by an involuntary treatment order under the current *Mental Health Act 2000*. The proposed approach in the Bill adds little to this except an obligation for an authorised doctor to have regard to a person's views, wishes and preferences when deciding on care and treatment for certain categories of involuntary patients, including those views that may be expressed in an advance health directive.

The Public Advocate would suggest strengthening the provisions relating to the use of advance health directives by obligating the treating doctor/team to make decisions that align with the expressed wishes of the person, except to the extent that, when objectively assessed against specific criteria, the treating doctor decides otherwise. These provisions should be expressly stated within the legislation.

Such provisions should include the criteria that must be applied by an authorised doctor in deciding that a person cannot be treated under an advance health directive. These should include that:

- the preferred treatment in the advance health directive is not clinically appropriate; and/or
- the preferred treatment in the advance health directive would mean that the person or others would be at imminent risk of serious harm; and/or
- the person is consistently objecting to the treatment outlined in the person's advance health directive; and/or
- the preferred treatment in a person's advance health directive would involve the administration of physical restraint or detention of the person.

Where an authorised doctor decides not to treat a person under an advance health directive (i.e. to make a treatment authority) or decides that the nature and extent of treatment under a treatment authority will be applied in a manner that is not congruent with the advance health directive, the authorised doctor must:

- inform the person of the decision and the reason for the decision; and
- provide written reasons to the person for the decision on request.

While the Public Advocate supports the inclusion of provisions as outlined above should the Bill's current reliance on advance health directives be the course of action decided by Government, ideally the Bill would include separate provisions for advance statements to limit any potential ramifications that may arise as a result of challenges in implementing an effective interface between the two legislative instruments. Further to this, it should be noted that without a thorough analysis of the way in which the advance health directive provisions in the *Powers of Attorney Act 1998* will interact with the proposed provisions in the Bill, there may be potential legislative and systemic consequences that are unable to be identified on the basis of the information presently available.

¹⁴ *Mental Health Act 2014* (Vic) s 73(1).

¹⁵ *Ibid* s 73(2).

Treatment plans

The Bill does not include the concept of a 'treatment plan'. Rather an authorised doctor has to decide on the nature and extent of treatment to be provided and record it in the patient's health records.¹⁶

In applying a recovery-oriented approach, the treatment plan is a valuable concept. It enables a solid infrastructure around which conversations can be held, negotiations made and outcomes recorded and agreed to (sometimes signed by both doctor and patient). It can be a collaborative document, reflecting not only the discussions of the doctor and patient but also the patient's family, carers, guardians, attorneys and other support persons.

Treatment plans can empower the patient as they are presented with a specific 'plan' in relation to their treatment, which sets out what they can expect, facilitates discussions regarding their treatment with the doctor, and encourages reflection upon their own health. If a person has an advance statement setting out what treatment they would prefer, they can see this incorporated into their treatment plan. A treatment plan can take a holistic approach to a person's treatment, incorporating consideration for not only traditional treatment but also social, cultural, environmental and other issues integral to a person's treatment and recovery.

The justifications given for the removal of treatment plans from legislation are that the plans presented practical issues in their implementation,¹⁷ including the fact that they created confusion in relation to the relationship between the plan and regular records that are required to be kept by doctors, as well as the fact that in many cases of mental illness, a person's condition can change rapidly and therefore treatment plans can become obsolete in a short period of time.

While treatment planning can and should be a continuous process, there are alternative ways to resolve these practical issues that should be explored before resorting to the elimination of the concept of treatment plans. For example if there is confusion between a treatment plan and a person's health records, it could be legislated that any treatment plan be part of, or be copied into, the person's records, which is already contemplated by the transitional provision in the Bill regarding existing treatment plans.¹⁸

The complete removal of the treatment plan from legislation should be avoided. The Bill should incorporate the concept of a treatment plan that:

- is consistent with a person's advance health directive (unless otherwise provided);
- is developed in partnership with the person, and their family, carers, guardians, attorneys and support people;
- is developed in accordance with the principles in clause 5;¹⁹ and
- where possible, is signed by the doctor and the person.

To support this, the Bill should include provisions to overcome difficulties in the practical implementation of treatment plans by requiring that such plans be copied or reflected in the patient's records.

Such changes would provide Queensland with a more contemporary Act that is consistent with a recovery-oriented approach while also maintaining safeguards for patients, health professionals and the community.

¹⁶ *Mental Health Bill 2015* (Qld) cl 203.

¹⁷ Background Papers, *Mental Health Bill 2015* (Qld) p 10.

¹⁸ *Mental Health Bill 2015* (Qld) cl 773.

¹⁹ *Ibid* cl 5.

Strengthened recovery-orientation – Summary of comments and recommendations

The Mental Health Bill 2015 should include provisions that support the principle of a recovery-based approach (or ‘recovery-orientated services’ as listed in the principles in clause 5 of the Bill).²⁰

This should include provisions that enable and support patients to either make or participate in decision-making about their treatment.

In addition to the capacity-based treatment criteria that the Public Advocate supports, the legal mechanisms to support this approach should include stronger obligations to recognise and uphold the provisions made in advance care directives and specific requirements in relation to treatment plans.

Rather than relying solely on the provisions for advance health directives that are articulated in the *Powers of Attorney Act 1998*, the Mental Health Bill 2015 should follow the example of other contemporary mental health legislation and incorporate clear provisions and criteria to support the use of advance care directives.

There should be a positive onus on authorised doctors to treat a person in accordance with their advance health directive unless certain criteria are met. If an authorised doctor decides not to treat a person in accordance with their advance health directive, they should inform the person of this decision and the reason for this decision, and provide written reasons upon request.

The concept of the treatment plan should also be reinstated as it provides a valuable tool to empower the patient and facilitate their participation in treatment planning.

²⁰ Ibid.

‘Less restrictive way’

The Bill includes the concept of a ‘less restrictive way’.²¹ This predominately relates to the making and review of treatment authorities with the requirement that, where there exists a less restrictive way for a person to receive treatment and care for their mental illness, that way should generally be implemented in lieu of resorting to involuntary treatment.²²

The approach of adopting a less restrictive way (where one exists) is to be commended in that it could have the result that instances of involuntary treatment are reduced and people with mental illness are better able to direct their own treatment or to have their appointed and trusted representatives provide direction. However, the way in which this approach is currently presented in the Bill is at best somewhat nebulous and in some areas unclear. Conversely, at worst, it has the potential to leave many vulnerable people subject to treatment for mental illness against their will without appropriate safeguards.

Although this new approach is described as ‘less restrictive’, the Public Advocate has some serious concerns that primarily relate to the proposed new reliance on Queensland’s guardianship system for the treatment of people with mental illness, in particular:

- the lack of safeguards for many patients who will be treated for mental illness without their consent (but with the consent of guardians or attorneys);
- the ability of the guardianship system to manage the risk associated with the involuntary treatment of people with mental illness;
- the lawfulness of guardians and attorneys consenting to treatment for mental illness specifically in the case of:
 - ongoing treatment for mental illness where the person is objecting;
 - circumstances where guardians are called on to enforce, or authorise others to enforce, their treatment decisions; and
 - circumstances where guardians are called on to consent to a person remaining in an authorised mental health service where they are prevented from leaving (i.e. detention); and
- the impact on Queensland’s guardianship (which is already overstretched and under-resourced).

Reliance on the guardianship system

The implementation of the ‘less restrictive way’ concept will rely significantly on the guardianship system. With the exception of parental consent, all of the available less restrictive ways to receive treatment and care are created by either the *Guardianship and Administration Act 2000* or the *Powers of Attorney Act 1998*. This reliance on the guardianship system is concerning for a number of reasons.

First and foremost, if the Bill (as currently drafted) is passed by Parliament, it will implement a significant policy change to the guardianship system in Queensland. To date, consistent with the *parens patriae* jurisdiction, this system has been primarily a protective one focused on making decisions in the best interests of adults who lack capacity to make decisions about certain matters for themselves. It has not been designed to restrict the rights and liberties of people with mental illness who are consistently objecting to treatment or require treatment or detention against their will to protect the community. The Bill will change this by providing a means by which essentially *involuntary* treatment for mental illness (including detention in mental health services) could be pursued under the authority of guardians and attorneys.

Such a shift in the nature of Queensland’s guardianship system should only occur following a fulsome and holistic review. The Public Advocate respectfully suggests that such a review may find that this approach is

²¹ Ibid cl 13.

²² Ibid cl 18; Chapter 2.

not consistent with the United Nations *Convention on the Rights of Persons with Disabilities*, and certainly not consistent with the move towards supported decision-making being advocated for by the Australian Law Reform Commission in relation to guardianship law.²³

The Public Advocate does not support such a policy shift in the absence of a fulsome and holistic review.

Secondly such a policy shift is not currently supported by the legislative framework for guardianship in Queensland. As will be outlined below, it is not clear that Queensland's current guardianship legislation allows for guardians or attorneys to make decisions that can be enforced by them or by others, particularly in relation to people who are objecting to treatment. This will lead to uncertainty, a lack of clarity about what guardians and attorneys can and cannot authorise, a lack of safeguards for patients, and potential civil and criminal liability for doctors and other health professionals.

Safeguards

Reliance on guardians and attorneys to consent to treatment for mental illness does not bring with it the same safeguards as treatment authorised under a treatment authority.

Safeguards under a treatment authority

Consistent with most other mental health legislation in other Australian jurisdictions and internationally, there are some important safeguards that will exist for those patients who are subject to a treatment authority. For example, prior to a treatment authority being made for a person (which authorises involuntary treatment), there must be:²⁴

- either a voluntary examination by an authorised doctor or an examination undertaken following an examination authority made under the Bill; and
- an assessment by an authorised doctor to determine if the person meets the treatment criteria under the Act (which includes that the person lacks capacity).

If, following these processes, the doctor determines that the person meets the treatment criteria, then a treatment authority can be made, which can authorise the person's care and treatment including their detention in an authorised mental health service if required.

Once a treatment authority is made then:

- An authorised doctor must assess a patient of an authorised mental health service subject to a treatment order within 3 months of the last assessment to determine whether the treatment criteria still apply to the patient or whether there may be a less restrictive way to administer treatment.²⁵
- The Mental Health Review Tribunal must also review treatment authorities:²⁶
 - within 28 days after the authority is made;
 - within 6 months after the above assessment, and within 6 months after this;
 - then at intervals of not more than 12 months.
- The treatment authority can also be reviewed at any time upon application by the patient or another person.²⁷

A person who is subject to a treatment authority may appeal a decision of the Mental Health Review Tribunal to the Mental Health Court.²⁸ Decisions made by the Mental Health Court can be further appealed to the Court of Appeal.²⁹

²³ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Report 124).

²⁴ *Mental Health Bill 2015* (Qld) Chapter 2.

²⁵ *Ibid* cl 206.

²⁶ *Ibid* cl 403(1).

²⁷ *Ibid* cl 403(2).

Limited safeguards under the ‘less restrictive way’

Patients who lack capacity to make decisions for themselves about their treatment because of the extent of their mental illness, and for whom treatment is authorised using the proposed ‘less restrictive way’ provisions will not have these same protections.

Under the proposed regime, guardians (which may include the Public Guardian but will more likely be family members appointed by QCAT) or statutory health attorneys (who are not appointed by QCAT and are usually the person’s next of kin) will decide a person’s treatment for mental illness. It would appear possible, and in fact likely, that this could include the ongoing administration of a range of psychotropic medication and/or placement in an authorised mental health service.

However, contrary to the protections provided under the mental health system, aside from seeking a review of an appointment itself, the guardianship system does not provide a system by which decision-making by guardians and attorneys can be challenged or reviewed.

Arguably, the guardianship system was not designed for the imposition of treatment that is potentially highly restrictive of a person’s liberties. Furthermore, and of particular concern given the limited oversight and review mechanisms, there is a significant risk that people with mental illness will be highly vulnerable to abuses of power.

Comparison of safeguards

The table below outlines the different safeguards available to patients who may potentially be receiving similar treatment under the two regimes.

Table: Different safeguards under the *Mental Health Bill 2015* for patients under a treatment authority and patients treated on the authority of a guardian under the *Guardianship and Administration Act 2000*

Safeguards	Patient subject to a treatment authority	Person subject to guardianship
How is treatment and care for a mental illness authorised?	A treatment authority authorises treatment and care for a mental illness both in the community and as an involuntary inpatient in an authorised mental health service.	A guardian appointed by QCAT for personal matters (including health care) can consent to health care for the person.
What are the criteria/steps that must be met prior to authorisation for the treatment and care of mental illness being provided?	First, either a voluntary examination (undertaken by an authorised doctor), OR an examination undertaken on the basis of an examination authority made by the Mental Health Review Tribunal , must occur to determine if a recommendation for assessment should be made.	QCAT can appoint a guardian for personal matters (including health care) if satisfied of certain criteria.
	Second, an assessment must be undertaken by an authorised doctor to determine if the person meets the treatment criteria .	Criteria for appointment of guardian <ul style="list-style-type: none"> ▪ the person lacks capacity for health care; and ▪ a decision about health care needs to be made; and ▪ without an appointment the adult’s needs will not be adequately met OR the adult’s interests will not be adequately protected.
Treatment criteria <ul style="list-style-type: none"> ▪ the person has a mental illness; and ▪ the person lacks capacity; and ▪ without involuntary treatment imminent serious harm may likely be suffered by the person or others; OR the person may likely suffer serious mental or physical deterioration. 		

²⁸ Ibid cl 505.

²⁹ Ibid cl 514.

<p>Can the order/authorisation for treatment and care of mental illness be reviewed?</p>	<p>A person subject to a treatment authority (or another person) may seek a review at any time from the Mental Health Review Tribunal.</p> <p>An authorised doctor must assess a patient of an authorised mental health service within three months to determine if the treatment criteria still apply.</p> <p>The Mental Health Review Tribunal must automatically review the treatment authority:</p> <ul style="list-style-type: none"> ▪ within 28 days of the authority being made; ▪ within 6 months of the above assessment, then within 6 months again; ▪ then further reviews at not more than 12 months. 	<p>A decision of a guardian to consent to health care that includes treatment for mental illness cannot be reviewed.</p> <p>A person subject to a guardianship order can seek a review of the appointment of a guardian at any time from QCAT.</p> <p>QCAT must review the appointment of a guardian at least every 5 years.</p>
<p>Is there an appeal about the decision to authorise treatment and care for a mental illness?</p>	<p>A person subject to a treatment authority may appeal a decision of the Mental Health Review Tribunal to the Supreme Court, and then to the Court of Appeal.</p>	<p>A person may appeal a decision of the tribunal to appoint a guardian to the QCAT Appeal Tribunal, and then to the Court of Appeal.</p>

The Public Advocate is particularly concerned about safeguards where a person is in receipt of inpatient treatment in an authorised mental health service. In other states, where either Mental Health or Guardianship legislation specifically provides for a guardian to authorise admission to a mental health facility, there is both explicit provision for this and numerous safeguards.

For example, in New South Wales, the *Mental Health Act 2007* (NSW) allows for a guardian to consent to a person being admitted as a voluntary patient.³⁰ Further to explicit provision for guardians to consent to such admission, safeguards exist to the extent that all voluntary patients must also have regular reviews (every 12 months) by the Mental Health Review Tribunal.³¹ Upon such a review, the person can be discharged from the mental health facility despite the views of the guardian.³²

The Public Advocate considers that similar reviews of voluntary inpatients should also occur in Queensland, tapered in the same manner as for the proposed schedule for involuntary patients subject to a treatment authority. A recent NSW Supreme Court case *Sarah White v The Local Health Authority*³³ is testament to the importance of such safeguards. In this case, a woman was an inpatient in a mental health facility under the authorisation of her guardian. The NSW Supreme Court ordered her release from the facility when, following a 12 month review by the Mental Health Review Tribunal that ordered her to be discharged, the guardian continued to request her detention in the facility.

Risk and the guardianship system

The application of clause 13 is written in broad terms, stating simply that “there is a less restrictive way for a person to receive treatment and care for the person’s mental illness if, instead of receiving involuntary treatment and care, the person is able to receive treatment and care” in one of the ways listed in that clause.³⁴ It appears that the intent of this clause is to implement the ‘step-down approach’ referred to in policy documents. Whilst a step-down approach could be a positive development for people subject to involuntary treatment, the use of the guardianship system to facilitate this approach should be undertaken

³⁰ Mental Health Act 2007 (NSW) s 7.

³¹ Ibid s 9.

³² *Sarah White v The Local Health Authority* [2015] NSWSC 417.

³³ Ibid.

³⁴ *Mental Health Bill 2015* (Qld) cl 13(1).

with caution. It appears that clause 13 could apply to any person who is subject to a treatment authority and therefore that any person could be 'moved' from a treatment authority to a guardianship order. Consideration should be given to whether this broad application is suitable.

A person subject to a treatment authority must meet the treatment criteria, meaning that they: have a mental illness; do not have capacity to consent to treatment for that illness; and, because of their illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in either imminent serious harm to the person or someone else, or in the person suffering serious mental or physical deterioration.³⁵

Decision-making by attorneys or guardians for people with mental illness may be appropriate where the person is relatively stable and relatively compliant with treatment, but where they lack the capacity to consent to treatment themselves. However, where a person meets all of the criteria for a treatment authority, there is arguably a high likelihood that the use of a power of attorney or guardianship order would be unsuitable for that person. This is primarily due to the fact that they meet the third criterion, that of presenting a risk of harm or deterioration.

The guardianship system, in its current form, is not equipped to provide an appropriate response to people who present a risk of imminent serious harm or serious mental or physical deterioration. If a person was a guardian or attorney for a person with mental illness for whom such a risk existed, the appropriate response would likely be to return that person to an appropriate part of the mental health system for the requisite treatment and care. If that is indeed the appropriate response, the question must be asked as to why the person's treatment and care would be removed outside of that system in the first place. Further, attorneys and guardians presently possess insufficient powers to consent to the administration of treatment on an ongoing basis where the person is objecting and/or has to be physically restrained or detained on a regular basis to administer such treatment. These issues are discussed further below.

Currently, the draft Bill does not make any distinction between when a person should be treated under a treatment authority and when it would be appropriate to have an attorney or guardian consent to treatment for mental illness. Clause 13 simply states that a less restrictive way exists if "the person is able to receive treatment and care" in one of the listed ways. There is no clarification or explanation of what is meant by the phrase 'able to'.³⁶

The Public Advocate respectfully suggests that an attorney or guardian for health matters should only be enabled to make decisions where the person has a mental illness and does not have capacity to make decisions with respect to their treatment (that is, the first two limbs of the treatment criteria). They should not be able to make decisions where it can be demonstrated that because of a person's illness, the absence of involuntary treatment or continued involuntary treatment is likely to result in imminent serious harm to the person or someone else, or in the person suffering serious mental or physical deterioration (that is, the third limb of the treatment criteria).

If this distinction is made, then a 'step-down' approach could be safely implemented. Without such a distinction, there is a serious danger that the guardianship system will be utilised in lieu of appropriate treatment under a treatment authority. This not only presents significant risk to the person and community, but also means that there is a lack of important safeguards, oversight and monitoring for those people with mental illness who are seriously unwell and receiving treatment. This creates an inequitable situation for people with mental illness, and does not seem to be implemented in any other common law jurisdiction.

³⁵ Ibid cl 12(1).

³⁶ Ibid cl 13(1).

The lawfulness of certain treatment decisions consented to by guardians and attorneys

If a guardian or an attorney was to make decisions regarding treatment and care for a person with a mental illness, then the operation of the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* must be clarified in respect of the following key areas:

- ongoing treatment for mental illness where the person is objecting;
- circumstances where guardians are called on to enforce, or authorise others to enforce, their treatment decisions; and
- circumstances where guardians are called on to consent to a person remaining in an authorised mental health service where they are prevented from leaving (i.e. detention).

Objections to treatment

In some instances, a person with mental illness may object to treatment that has been consented to by their guardian or attorney. The *Guardianship and Administration Act 2000* provides that “generally, the exercise of power for a health matter or special health matter is ineffective to give consent to health care of an adult if the health provider knows, or ought reasonably to know, the adult objects to the health care”.³⁷ There are some exceptions, for example if the health care is urgent;³⁸ or if the adult has little to no understanding of what the healthcare involves or why it is required, and the health care is likely to cause no distress or temporary distress that would be outweighed by the benefit of the proposed healthcare.³⁹

If a person with mental illness objects to treatment (and no exception applies), then that objection should have the result that the person’s guardian or attorney cannot use their power to consent to treatment.⁴⁰ It would potentially constitute an offence for healthcare to be carried out in those circumstances.⁴¹

The application of the *Guardianship and Administration Act 2000* when a person is objecting could therefore be a barrier to having a guardian or attorney consent to treatment for a mental illness. Additionally, and as discussed immediately below, even if treatment was able to occur without consent, there would be difficulties associated with enforcing that decision and providing the treatment. Consideration should be given to the potential difficulties arising from those provisions concerned with objections to treatment, and the impacts that this may have on consent to treatment for a mental illness by guardians or attorneys.

Enforceability of decision-making

Where a guardian or attorney consents to treatment on behalf of a person with mental illness, they have little power to enforce that decision. The *Guardianship and Administration Act 2000* states that “a health provider and a person acting under the health provider’s direction or supervision may use the minimum force necessary and reasonable to carry out health care authorised under this Act”.⁴²

In circumstances where a person’s treatment for mental illness is initially authorised under the *Guardianship and Administration Act 2000*, this provision arguably cannot, and should not, be used to forcibly treat a person with mental illness on an ongoing basis. The objective of guardianship legislation is not to enable the involuntary treatment of people with mental illness or other conditions, but rather to “establish a comprehensive regime for the appointment of guardians and administrators to manage the personal and financial affairs of adults with impaired capacity in Queensland.”⁴³

³⁷ *Guardianship and Administration Act 2000* (Qld) s 67(1).

³⁸ *Ibid* s 63(1).

³⁹ *Ibid* s 67(2).

⁴⁰ *Ibid* s 67(1).

⁴¹ *Ibid* s 79(1).

⁴² *Ibid* s 75.

⁴³ Explanatory Memorandum, *Guardianship and Administration Bill 1999* (Qld) p 1.

It can be further argued that, in drafting that provision, it was not contemplated as being used for the level of force that may be required in order to provide some people with treatment. For example, a person may require physical restraint in order to administer each dose of medication, and it is unlikely that this provision was intended to authorise such significant and ongoing levels of force. Further, the provision should not be interpreted as enabling such levels of force because there are insufficient safeguards within the *Guardianship and Administration Act 2000* to protect those people against whom force could be used.

Some other states provide explicit provision for guardians to enforce, or authorise others to enforce, their decisions. For example the *Guardianship Act 1987* (NSW) provides for the tribunal to make a guardianship order that explicitly provides for either the guardian, a specified person, or a person authorised by the guardian to take such measures or action to ensure the person under guardianship complies with any decision of the guardian.⁴⁴

Consideration should be given to the difficulties that will be experienced by guardians and attorneys with regard to enforcing decisions about the treatment of a person's mental illness, particularly where a person objects to treatment or where force is required to administer treatment for another reason. Also, section 75 of the *Guardianship and Administration Act 2000*⁴⁵ should be recognised as an inappropriate way of involuntarily treating a person with mental illness.

Detention in an authorised mental health service

Should a guardian or attorney be able to consent to a person receiving treatment for a mental illness on an ongoing basis as an inpatient in an authorised mental health service, it is possible that this might, in some circumstances, constitute a deprivation of the person's liberties (in other words detention). This may particularly be the case where the person expresses an intention to leave but is told that they cannot leave, or is under the impression that if they attempted to leave they would be prevented.⁴⁶

The extent to which guardians and attorneys can consent to such detention under the *Guardianship and Administration Act 2000* is not entirely clear. The general rule is that any statutory authorisation of practices that deprive a person of their rights and liberties must be express and explicit. In *Coco v R*, the High Court discussed the common law principle that general words in a statute are insufficient to authorise interference with basic rights and immunities stating:⁴⁷

*The courts should not impute to the legislature an intention to interfere with fundamental rights. Such an intention must be clearly manifested by unmistakable and unambiguous language. General words will rarely be sufficient for that purpose if they do not specifically deal with the question because, in the context in which they appear, they will often be ambiguous on the aspect of interference with fundamental rights ((8) See *Chu Kheng Lim v. Minister for Immigration* (1992) 176 CLR 1 at 12 per Mason CJ).*

This means that the authorisation of detention in an authorised mental health service generally requires explicit words in statute and cannot be read into legislative provisions, such as general guardianship legislation, that authorise substitute decision-makers to make decisions about accommodation, health care and service provision. As mentioned above, admission to a mental health facility by a guardian has been specifically provided for in other states such as New South Wales.⁴⁸ The New South Wales *Guardianship Act 2007* also contains specific provision for 'coercive powers' for guardians, which empowers guardians to take such measures or authorise others to take such measures to ensure the person under guardianship complies with any decision.⁴⁹

⁴⁴ *Guardianship Act 1987* (NSW) s21A.

⁴⁵ *Guardianship and Administration Act 2000* (Qld) s 75.

⁴⁶ *Antunovic v Dawson* [2010] VSC 377.

⁴⁷ *Coco v R* (1994) 179 CLR 427 [10] (Mason CJ; Brennan, Gaudron, McHugh JJ).

⁴⁸ *Mental Health Act 2007* (NSW) s 7;

⁴⁹ *Guardianship Act 2007* s21A.

While the Public Advocate is not advocating for guardians in Queensland to take on such a coercive function, arguably if the intention of the Bill is to rely on guardians and attorneys to consent to detention in authorised mental health services, then explicit statutory authorisation should be provided as other states have. Anything else imports a discriminatory approach into the law for people with mental illness where, unlike people without mental illness, their liberties and rights can be subject to infringements without proper authorisation or safeguards.

Impact on the guardianship system

As mentioned above, the system that is being created by the Bill relies heavily upon the guardianship system. In addition to the issues discussed above, there are a number of other circumstances that may lead to increased demand on the guardianship system. For example, with regard to psychiatric reports, a personal guardian for legal matters or an attorney for legal matters may be required to effect a request for a psychiatric report. Additionally, as discussed further below, a personal guardian or attorney may need to be appointed for legal matters to make decisions, such as in which court a matter will be elected to be heard.

Further, when a treatment authority is reviewed by the tribunal at the approximate 12-month period,⁵⁰ the tribunal will be required to 'consider whether the appointment of a personal guardian for the person may lead to a less restrictive way for the person to receive treatment and care for the person's mental illness'.⁵¹

This reliance upon guardianship is likely to have a corresponding resourcing impact on the guardianship system. There will likely be an increase in applications to the Queensland Civil and Administrative Tribunal (QCAT) for people to be appointed as guardians or for existing appointments to be extended to other areas, for example health care or legal matters. This would then result in a commensurate increase in the reviews of appointments that QCAT must undertake. There may also be an increase in other guardianship matters coming before QCAT, such as recognition of enduring powers of attorney or applications for directions.

It is also likely that there will be a general increase in the number of people who have enquiries about or are seeking assistance to navigate the guardianship system. This will affect not only QCAT and the Public Guardian, both of which already receive a significant number of enquiries, but also other government departments and community organisations/legal centres that presently provide assistance to those people. There may also be an increase in the reporting of systemic issues, which would need to be investigated and addressed by the Public Advocate or other relevant government entities.

The significant impact that the Bill, and particularly the concept of the 'less restrictive way', will have upon the guardianship system must be urgently recognised, acknowledged and addressed. The guardianship system, which is already under-resourced and over-stretched, is unlikely to be able to sustain this additional role without a commensurate increase in resources. This must be urgently considered and addressed before the Bill (as currently drafted) is put into effect.

Education

The Bill as drafted will radically expand the decision-making role of guardians and attorneys in the mental health system. If it is implemented there will be an urgent need for greater education for those who become involved with the mental health system. Education will be essential for attorneys, guardians and nominated support people to enable them to understand the mental health system in order to assist and support a person subject to treatment or care to the best of their ability. However, education for this purpose is also more generally required for a person's family, carers and other support persons.

The role of the patient rights adviser will go some way toward providing education; however they are likely to be in high demand, and their role will potentially require supplementation with additional resources. Consideration should be given to whether the Bill could include additional requirements for the provision of education; either provided generally by the Queensland government or by individual services.

⁵⁰ *Mental Health Bill 2015* (Qld) cl 403.

⁵¹ *Ibid* cl 409.

Less restrictive way – Summary of comments and recommendations

The Public Advocate does not support the Bill as currently drafted in respect of the new reliance it imposes on the guardianship system in Queensland such that attorneys and guardians will be expected to authorise treatment (which may involve detention) for people with mental illness who may object to their treatment.

This not only imports a policy shift in the philosophical basis and purpose of the current guardianship system in Queensland but is arguably not supported by appropriate legislative provisions (in particular a lack of potentially necessary powers for guardians and attorneys) in the current guardianship legislation.

There are also insufficient safeguards for guardians and attorneys to take on this role. In other states where guardians are authorised to take on this role, the relevant mental health legislation contains extensive regulation for 'voluntary patients' including regular reviews by the relevant mental health review tribunal.

Such a fundamental policy shift in the approach to guardianship should not occur in the absence of a fulsome and holistic review.

While a 'step-down' approach is to be commended, guardians and attorneys should not be authorising treatment where a person meets the third limb of the treatment criteria in the Bill, that is where it can be demonstrated that because of a person's illness, the absence of involuntary treatment or continued involuntary treatment is likely to result in imminent serious harm to the person or someone else, or in the person suffering serious mental or physical deterioration.

Safeguards for voluntary patients should be incorporated into the Bill so that inpatients have tapering reviews that accord with those provided for involuntary patients.

The Public Advocate contends that the impact upon the guardianship system in Queensland of the proposals contained in the Bill have not been fully explored. The current guardianship system is already under-resourced and over-stretched and cannot sustain this additional role without a commensurate increase in resources.

Responses for people with intellectual disability

The history of this issue in Queensland

The Act also provides a legislative framework for the response to people with intellectual disability who come into contact with the criminal justice system and are found of unsound mind or unfit for trial.

In the previous review of the *Mental Health Act 2000* conducted by Brendan Butler AM SC in 2006,⁵² 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. This was primarily because of those provisions of the Act dealing with criminal charges and forensic orders.

In addition to highlighting the inappropriateness of detaining people with intellectual disability and no mental illness in authorised mental health services, Butler AM SC noted the issue of people with an intellectual disability not being accommodated in appropriate facilities when provisions for secure care were made under the Act, unlike for those people with a mental illness.⁵³ The final report, *Forensic Mental Health System: Final Report Review of the Queensland Mental Health Act 2000* (the Butler Report), recommended that a review of the Act properly address the need for secure care for people with an intellectual disability.⁵⁴

In 2006, the late Honourable William Carter QC commenced a review in relation to the “existing provisions for the care, support and accommodation of people with intellectual/cognitive disability who represent a significant risk of harm to themselves or the community”.⁵⁵ 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.⁵⁶

The Carter Report⁵⁷ recommended a legislative framework for restrictive practices inclusive of 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 DSQ and the 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”.*⁵⁸

The fragmented nature of the system

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

- *Mental Health Act 2000* (forensic orders for people 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*.

⁵² Brendan Butler AM SC, *Promoting Balance in the Forensic Mental Health System: Final Report Review of the Queensland Mental Health Act 2000* (2006)

⁵³ Ibid 101.

⁵⁴ Ibid 102.

⁵⁵ William Carter QC, *Challenging Behaviour and Disability: A Targeted Response*, (Report to Warren Pitt MP, Minister for Communities, 2006, 4.

⁵⁶ Ibid 87.

⁵⁷ Ibid 87.

⁵⁸ Ibid 9.

This fragmentation creates confusion, leaves gaps, and often results in less than optimal responses for people with intellectual disability who come into contact with the criminal justice system, as 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 systems response to enable coherent, consistent and integrated care and support options for this cohort, nor is it inclusive of 'step-down' or 'transitional' services to assist people to make the transition back to community living in less restrictive environments.

Furthermore, 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. Further, some people with intellectual disability are subject to approval for containment and seclusion by QCAT, where they are held in detention-like conditions in the 'community' or at the Wacol precinct. Some of these people are also subject to forensic orders, and are receiving limited community treatment whilst subject to containment.

There are also people for whom the nature of their criminal offences does not bring them before the Mental Health Court yet their pattern of escalating behaviours clearly 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.

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.

In view of the National Disability Insurance Scheme (NDIS) commencing in Queensland, with the likelihood that many state governments will withdraw from the provision of disability services and the expressed intention by the Commonwealth Government that the NDIS will not bear responsibility for forensic services for people with disability, there should also be a review of the support system for people with intellectual disability in relation to situations such as those mentioned above.

Some of the inequitable approaches to people with intellectual disability are outlined in more detail below.

Magistrates Court proceedings

This Bill introduces procedures for Magistrates Courts to follow when the court is reasonably satisfied that a person charged with an offence was, or appears to be, of unsound mind or unfit for trial. These provisions will go some way to addressing the issues raised by the Court of Appeal in *R v AAM; ex parte A-G (Qld)*.⁵⁹

From the Public Advocate's point of view, however, these provisions go only part way to addressing issues such as those experienced by the young woman at the centre of this case, who continued to reappear in the Magistrates Court charged with similar offences. There are a number of shortcomings in the provisions regarding Magistrates Court proceedings for people with an intellectual disability being charged with offences, as outlined below.

The first is the question of how such persons with intellectual disability will be identified so that proper submissions can be made to the Magistrate. It has been proposed⁶⁰ that this will be accommodated by an expansion in the Court Liaison Service that is provided by Queensland Health to assist the courts. However,

⁵⁹ *R v AAM; ex parte A-G (Qld)* QCA 305.

⁶⁰ Background Papers, *Mental Health Bill 2015* (Qld) p 29.

the Public Advocate's understanding of this service is that Court Liaison Officers are trained in mental health and only have administrative connections with Queensland Health. It is unclear whether they will have any connection to disability services to enable them to enquire into what support particular persons might already be receiving and what might be available beyond that which may fall within Queensland Health's jurisdiction.

There must be a dedicated intellectual disability focused Court Liaison Service to be able to properly assess and make submissions to the court with close administrative connections to the Department of Communities, Child Safety and Disability Services (DCCSDS) in the coming years, and then subsequently with the National Disability Insurance Scheme (NDIS) once this commences in Queensland. This will require additional and appropriate resourcing to be able to accurately assess people with intellectual disability.

There does not seem to be any clear indication as to who should be funding reports, if required, for a person with intellectual disability where there is not sufficient evidence to support a finding of unfitness or unsoundness in the Magistrates Court for a person with intellectual disability. An examination order could be ordered by a Magistrate⁶¹ but only under certain conditions, including if the Magistrate is satisfied that the person has a mental illness/dual disability or is unable to decide whether the person has a mental illness or another mental condition.⁶² Without a report or other evidence that can be presented to the court, the Magistrate may not reach a point to believe they require an examination order and may simply not accept that the person has an intellectual disability.

Further, how any of the pertinent information that could be presented by a Court Liaison Officer will come before the Magistrate is unclear. Court Liaison Officers are not statutory officers, have no right of appearance before criminal proceedings, nor do they exist in any formal capacity in law. Should a person not accept the contents of a report, and leave to appear is not granted by the court, a Court Liaison Officer may have no means of presenting evidence to the court. If the proposal is to have Court Liaison Officers play a vital role in Magistrates Court proceedings, they should be recognised in law instead of being an ad hoc party that has no existence in law.

Another issue exists whereby, should a Magistrate discharge a person, the Bill presents no enforceable mechanism to ensure that the person is properly supported so that they do not cycle before the courts by repeatedly committing offences as a result of their intellectual disability.

Currently upon discharge, a Magistrates Court may refer a person to the department that administers disability services for appropriate care, or to the health department, or to another entity the court considers appropriate for treatment and care.⁶³ However, this is not intended to be enforceable⁶⁴ and there are no consequences for the person not attending at any service or even for the service to simply refuse treatment or care. There is no recourse available in these situations, or even in the case that the Magistrate has referred a person to the wrong service. The Magistrate could also discharge a person and set any 'conditions the court considers appropriate'⁶⁵ which is once again unenforceable and also unclear in its scope and operation. This issue is covered in more detail below.

It is clear that the Bill in its current form creates an incomplete and highly ambiguous system in relation to people with intellectual disability. Further consideration must be had in relation to the approach for people with intellectual disability and how they are treated by the Magistrates Court, given that such ambiguities will inevitably result in injustice and people with intellectual disability repeatedly returning to the criminal justice system due to a lack of proper identification and support mechanisms.

⁶¹ *Mental Health Bill 2015* (Qld) cl 176

⁶² *Ibid* cl 176(1)(b)

⁶³ *Ibid* cl 175(2).

⁶⁴ Background Papers, *Mental Health Bill 2015* (Qld) p 29.

⁶⁵ *Mental Health Bill 2015* (Qld) cl 171(2)(b).

Court treatment orders

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 a Court Treatment Order, will have no relevance for people with intellectual disability unless they also have a mental illness requiring involuntary treatment. Clause 139 provides that court treatment orders cannot be made if the person has a sole diagnosis of intellectual disability.⁶⁶ The Overview to the Bill explains that:

“The intention of a court treatment order is to provide a less intensive form of order, for example, where a person’s role in an offence is relatively minor. Court treatment orders may be made by the Tribunal when a forensic order is reviewed. In this context, the purpose of the order is to ‘step down’ a person from a forensic order as part of the patient’s recovery.”⁶⁷

It seems inequitable that a court treatment order (or an equivalent less intensive form of order) is not an option for a person with a sole diagnosis of intellectual disability who should also have an opportunity for less stringent and restrictive oversight than a forensic order where appropriate, and the ability to ‘step down’ from such an order.

Psychiatric reports

Under chapter 4 of the Bill, people with intellectual disability are not given sufficient access to medical reports regarding whether they may have been of unsound mind when a serious offence was allegedly committed or whether they may be unfit for trial.

The application of chapter 4, part 2 to people with intellectual disability appears limited. Part 2 would only apply to a person with intellectual disability if they were subject to a forensic order (disability) of the residential category under which the forensic disability service is responsible for their care.⁶⁸ Given the limited capacity of the forensic disability service, this will provide for only a small number of people.

Part 2 does not appear to apply to people subject to a forensic order (disability) of the residential category under which an authorised mental health service is responsible for their care. Additionally, part 2 does not appear to apply to any person subject to a forensic order (disability) that is within the community category.

Conversely, the application of chapter 4, part 2 to people with mental illness is broad. It includes a person subject to a treatment authority, a court order, or a forensic order for which an authorised mental health service is responsible for the person. Notably, the category of forensic orders is not restricted by references to inpatient categories or the place to which the person is detained.

Equal access should be available to medical reports regarding unsoundness of mind or unfitness for trial. In particular, part 2 should apply to any person subject to a forensic order (disability), whether the order is residential or community-based and whether it is the forensic disability service or an authorised mental health service that is responsible for the person’s care. To do otherwise risks importing discriminatory attributes to the legislation.

Authorised mental health services

The chief psychiatrist is required to make policies about a number of matters relating to authorised mental health services and patients of the service, and the administration of the *Mental Health Act 2015*.⁶⁹ Notably, however, there is no requirement for the chief psychiatrist to make a policy about the treatment, care and support of people who have an intellectual disability or are subject to a forensic order (disability) and who reside in authorised mental health services.

⁶⁶ Ibid cl 139(3).

⁶⁷ Overview, *Mental Health Bill 2015* (Qld) p 8.

⁶⁸ *Mental Health Bill 2015* (Qld) cl 86(1) & 105(a)

⁶⁹ Ibid cl 296.

Conversely, the current *Mental Health Act 2000* requires the Director to issues policies and practice guidelines about the care of a patient subject to a forensic order (disability). This is an important provision given that not all forensic order (disability) patients who require inpatient care can be cared for in the forensic disability service, and as such are detained in authorised mental health services. Further, some people who become subject to a forensic order (mental condition) may also have an intellectual disability for which they will require care and support.

Specific policies regarding people with intellectual disability are necessary as the needs and experiences of people with intellectual disability are significantly different to those of people with mental illness. This position is acknowledged by current mental health legislation, which provides that people with intellectual disability must be subject to different orders and accommodated in specialised facilities. It is also acknowledged by section 309A of the current *Mental Health Act 2000*, which requires appropriate care and support to be provided for those people with intellectual disability who are detained in authorised mental health services.

In order to ensure that the different needs and experiences of people with intellectual disability continue to be recognised and accommodated by the mental health system, clause 296 should be expanded to include a requirement that the chief psychiatrist make policies and practice guidelines regarding the treatment, care and support of people with intellectual disability.

Intellectual disability – Summary of comments and recommendations

While the NDIS is expected to commence in Queensland from July 2016, the interface principles have clearly stipulated that forensic disability will remain the responsibility of the states.

Given the current fragmentation of the provisions for involuntary treatment and care for people with intellectual disability across at least four different Acts, and the lack of a supportive systemic response to this issue, there must be a full review of the legislative framework for this cohort, inclusive of the clinical, accommodation and support services available across Queensland. In the meantime, the provisions in this Bill require enhancement to provide an equitable response to people with intellectual disability.

The procedures for Magistrates Courts to follow in the Bill should be complemented by a Court Liaison Service that is skilled in identifying and responding to people with intellectual disability, with administrative links to the Department of Communities, Child Safety and Disability Services (DCCSDS) for the interim period until the NDIS reaches full implementation, and that can conduct quick assessments and make appropriate referrals for supports and services. Where prior assessments have not occurred and there is insufficient evidence in relation to a person's unsoundness or unfitness, DCCSDS should also provide resources for assessments and reports to support the Magistrates Court processes.

There should be an equivalent 'step down' order (that is less restrictive than a forensic order) also available for people with intellectual disability to enable support and care to be provided that will enable habilitation and reduce the risk of their reoffending.

Chapter 4 of the Bill should be amended to allow equal access for people with intellectual disability to medical reports.

Until the review of forensic disability (as recommended above) is conducted, and while people with intellectual disability continue to be detained in Authorised Mental Health Services, clause 296 of the Bill should be amended to continue to require the chief psychiatrist to make policies and practice guidelines regarding the treatment, care and support of people with intellectual disability.

Interaction with the Criminal Code Act 1899 (Qld)

There are a number of issues that are unclear in the Bill to the extent that it relates to certain criminal offences before the courts, including the definition of serious offences, what supporting systems will be in place, as well as the scope of conditions that can be imposed by the Magistrate upon discharge of a person.

Serious offences

The Bill proposes a modest reduction in the scope of the jurisdiction of the Mental Health Court, with the Court dealing mostly with ‘serious offences’. Only serious offences can be referred by the person, their legal representatives, the Office of the Director of Public Prosecutions and the Chief Psychiatrist/Director of Forensic Disability.⁷⁰

However, there is an issue regarding the definition of ‘serious offence’ as it is currently drafted. A serious offence is defined as follows:⁷¹

serious offence means an indictable offence, other than an offence that is a relevant offence within the meaning of the Criminal Code, section 552BA(4).

Note—

A charge of an indictable offence that is a relevant offence within the meaning of the Criminal Code, section 552BA(4) must, subject to the Criminal Code, section 552D, be heard and decided summarily—see the Criminal Code, section 552BA(2).

Therefore, a serious offence cannot be a ‘relevant offence’ under section 552BA(4). A relevant offence is defined as:⁷²

relevant offence means—

- (a) an offence against this Code, if the maximum term of imprisonment for which the defendant is liable is not more than 3 years; or
- (b) an offence against part 6, other than—
 - (i) an offence mentioned in paragraph (a); or
 - (ii) an offence against chapter 42A; or
 - (iii) an offence that, under section 552BB, is an excluded offence.

All offences against Part 6 of the Criminal Code are relevant offences, unless they are an ‘excluded offence’ under section 552BB.

A number of offences are listed as excluded offences when certain circumstances apply under section 552BB. The issue arises because there are a large number of offences listed under section 552BB that are only excluded offences if the person charged chooses not to plead guilty to the offence.⁷³

As some excluded offences are predicated on a plea of guilty, it is difficult to see how this would work in practice, particularly in seeking to obtain the person’s views on how they wish to proceed if they are suspected of being of unsound mind and/or unfit for trial. A solicitor would not ethically or legally be able to

⁷⁰ Ibid cl 99 & 111.

⁷¹ Ibid Schedule 3.

⁷² *Criminal Code Act 1899* (Qld) s 552BA(4).

⁷³ See, for example, the offence of fraud (section 408C) where it becomes an excluded offence when the value of the property is over the prescribed value (\$30,000) and the offender does not plead guilty.

take instructions from their client in such a situation, and therefore whether certain offences are relevant offences cannot be determined.

The Bill will therefore need to be clarified in respect of how these provisions in the Criminal Code will apply in circumstances where the person charged will need to express their plea before an offence can be considered a 'serious offence' as currently defined in the Bill.

Conditional discharge by Magistrate

Currently, if a person charged with an offence before a Magistrates Court is found by the court to have been, or appeared to have been, of unsound mind when the offence was allegedly committed or the person is found unfit for trial, the Magistrate can discharge the person from the charge.⁷⁴ The court may discharge the person either unconditionally or on conditions that the court considers appropriate.⁷⁵

There are a number of issues that arise from the ability for the Magistrate to impose 'conditions' upon discharge of the person. The first is that there is no guidance or restrictions upon the court as to exactly what 'conditions' can be imposed by the Magistrate. As the Bill currently stands, the court could impose any condition for any period of time and it will remain as a valid court order.

There is other legislation that allows courts to impose unspecified conditions on a person such as when granting bail⁷⁶ or when imposing a probation order on an offender.⁷⁷ However, both of these examples have some guidance within the legislation regarding the conditions that can be imposed, such as ensuring that any conditions for bail are necessary to secure that, when released, the person appears back in court or doesn't commit another offence;⁷⁸ and for probation, that conditions must be in relation to the discouragement of offenders to commit further offences.⁷⁹

The ability for the court to impose 'conditions' in the current Bill is much too wide, and there must be some specific factors and goals in relation to the conditions able to be imposed.

The second concern is that of enforcement of any conditions imposed by the court. It is unclear in the current form as to what repercussions a person could face through not complying with conditions imposed. Although criminally penalising a person who was found unsound of mind or unfit for trial is not supported, there should be some clarification regarding what consequences, if any, exist for noncompliance with these conditions.

Supporting systems

The elimination of the automatic 'Chapter 7' referral system for people on Involuntary Treatment Orders and Forensic Orders from the Act requires Magistrates to make a finding of unsoundness of mind or unfitness for trial for all offences proceeding through the Magistrates Courts.

This will clearly have a significant impact on the resourcing required to ensure that relevant staff are present in the courts to identify and advise Magistrates on issues of unsoundness of mind and fitness for trial. As already noted above, it has been proposed⁸⁰ that this will be accommodated by an expansion in the Court Liaison Service within Queensland Health to assist the courts. However, there has been no published plan as to how the Court Liaison Service will identify those with a mental illness or intellectual disability, how they will work not only throughout the vast network of Magistrates Courts across the state, but also within large networks such as Brisbane where dozens of courtrooms could be operating at any one time.

⁷⁴ *Mental Health Bill 2015* cl 171.

⁷⁵ *Ibid* cl 171(2)(a) & (b).

⁷⁶ *Bail Act 1980* (Qld) s 11.

⁷⁷ *Penalties and Sentences Act 1992* (Qld) s 94.

⁷⁸ As well as other factors – see *Bail Act 1980* (Qld) s 11(2) & (3).

⁷⁹ *Penalties and Sentences Act 1992* (Qld) s 94(b).

⁸⁰ Background Papers, *Mental Health Bill 2015* (Qld) p 29.

There are minor offences where most people appear without legal representation, such as traffic matters, not to mention the very large volume of such matters that are passed through the courts on a regular basis. How and when people with relevant conditions can be identified in such situations has not been articulated in any way.

There are also issues as mentioned above regarding the Court Liaison Service not existing in law. Although the Court Liaison Service will be relied upon for both identification and diagnosis in the courts, they do not appear to be mentioned in the Bill or in any other legislative instrument. As a result, they do not seem to have a right of appearance in court, or any provisions regarding what weight, if any, Magistrates should place on their opinion.

Further clarification is required regarding exactly how the Court Liaison Service will be implemented and what role they will play in the courts. Currently, it appears that these new provisions will be implemented on an ad hoc basis with the significant risk of a large number of people not being identified, much less dealt with appropriately under the Bill.

Criminal Code – Summary of comments and recommendations

The jurisdiction of the Mental Health Court, which relies on the definition of ‘serious offence’ in the Bill, will require clarification. In particular it should be made clear how this new approach proposes to deal with circumstances where the person charged will need to express their plea before an offence can be considered a ‘serious offence’ as currently defined in the Bill.

The ability of a Magistrates Court to discharge a person found unsound of mind or unfit for trial should be further clarified in terms of the specific conditions that may be able to be imposed and the consequences of not complying with such conditions.

Given the new jurisdiction provided to Magistrates Courts and the removal of the automatic ‘Chapter 7’ referral system for people on Involuntary Treatment Orders and Forensic Orders, further clarification is also required regarding exactly how the Court Liaison Service will be implemented across the State and what role they will play in the courts. Without sufficient resources, there will be a risk that many people will not be identified, much less dealt with appropriately under the new Magistrates Courts provisions.

Rights of the patient

There are a number of proposals within the Bill that infringe on the rights of the individual both in terms of orders made and actions that can be taken against the person while under the supervision of mental health services. These proposals should be reconsidered to better reflect a rights-based, recovery-oriented system.

Non-revokable forensic orders

The Bill proposes that the Mental Health Court may impose a forensic order with a non-revocation period of not more than 10 years if the person is charged with a 'prescribed offence'. In deciding the non-revocation period, the Court must have regard to the nature of the offence and the object of the Act in relation to protecting the community.⁸¹

This suggests that psychiatric confinement is being seen in the same way as criminal incarceration, and therefore represents punishment for a person's actions, which psychiatric confinement fundamentally is not. A non-revokable forensic order is simply a gaol term by another name. Arguable, it seems clear that these provisions in the Bill are punitive in nature, affecting only those who are *alleged* to have committed more serious, 'prescribed' offences, and having no effect on lesser offences.

Currently under the Act, when a person is placed on a forensic order, the purpose of such an order is not intended for anything other than the management and treatment of people with a mental illness.⁸² The legislation does not impute any intention for punitive or preventive detention. Further, it has been made clear by the High Court that any such curtailment of the right of personal liberty requires clear, unambiguous language.⁸³

Similarly, the Bill in its current form does not propose any punitive or preventive detention in its objects,⁸⁴ and such non-revokable orders are therefore clearly against both the objects and the principles⁸⁵ of the Bill. In particular, such provisions do not ensure that a person's rights and liberties are affected only to the extent required to protect their own health and safety or to protect others.

Approaching psychiatric confinement in such a way ignores the general safeguards and principles that protect those charged with a criminal offence. In a criminal proceeding, for a person to be sentenced and potentially placed in custody, the prosecution first has to discharge its burden of proof, that of beyond reasonable doubt, over the accused's presumption of innocence. Conversely, in the case of a matter before the Mental Health Court, no party bears the onus of proof, and matters are decided on the balance of probabilities.⁸⁶

The imposition of a non-revocation period is neither person-centred nor consistent with a recovery-oriented approach. It does not require consideration of the person or their individual circumstances, and the period is not intended to reflect or be responsive to the person's anticipated future needs. The imposition of a non-revocation order, particularly insofar as it is informed by the nature of the offence, is punitive. It does not reflect the fact that persons subject to forensic orders have not been found guilty of an offence.

Rather, the imposition of a non-revocation period potentially enables an order to continue for a longer period than is necessary for protection and restricts a person's ability to live without involuntary treatment and care. It would appear that a non-revocation period does little to directly assist in improving and maintaining a person's health and wellbeing and, arguably, if people are not permitted to live independently, may have an adverse effect on their health and well-being.

⁸¹ *Mental Health Bill 2015* (Qld) cl 147.

⁸² *Mental Health Act 2000* (Qld) Chapter 1, Parts 2 and 3; *Re AKB* [2005] QMHC 005.

⁸³ *Coco v The Queen* (1994) 179 CLR 427 at 437-438; *Plaintiff S157/2002 v Commonwealth of Australia* (2003) 211 CLR 476 at para [30] per Gleeson CJ.

⁸⁴ *Mental Health Bill 2015* (Qld) cl 3.

⁸⁵ *Ibid* cl 4.

⁸⁶ *Ibid* cl 642.

The concept of a non-revokable forensic order should be removed from the Bill. A forensic order should not be viewed in the same way as a custodial sentence under criminal law but instead be a means of effecting treatment for a person who has been found not criminally responsible for their actions.

Mechanical restraint and seclusion

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,⁸⁷ it is acknowledged that this may not be achievable in the short-term. However, the circumstances in which seclusion and restraint can be used must be severely restricted and subject to appropriate oversight and significant safeguards. This is particularly important given the impact on a person's human rights, especially their right to bodily security and integrity as well as the acknowledgement that the use of force on a person with mental illness is potentially anti-therapeutic, disempowering and demeaning.⁸⁸

Overall the aim should be to reduce and eliminate the use of restraint and seclusion on people with mental illness. Where restraint and seclusion are used, they must be used for the shortest time possible and with maximum safeguards for the person and transparency in the decision-making process. The Bill strengthens the safeguards for patients, however more can be done to protect their rights such as further safeguards for the use of restraint and seclusion including:

- notification to 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.

These suggestions are based on evidence-based strategies and have been shown to be successful in reducing restraint and seclusion in other jurisdictions.⁸⁹

Patient rights – Summary of comments and recommendations

If the current Bill becomes law then, for the first time, a punitive approach to the treatment of mental illness will be incorporated into Queensland's mental health legislation in the form of a non-revokable forensic order. The non-revokable forensic order treats psychiatric confinement as akin to a gaol sentence which is both inconsistent with the principles underpinning our system of criminal justice and with the objects of the Bill, including a recovery-oriented approach. The Public Advocate does not support the concept of the non-revokable forensic order.

While the Bill has strengthened safeguards for the use of restraint and seclusion in mental health services, further evidence-based safeguards can be included to protect the rights of vulnerable people when their rights and liberties are restricted in this way, including but not limited to notification requirements and compulsory debriefings by the treatment team.

⁸⁷ 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) p15, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf.

⁸⁸ Freckleton, above n6.

⁸⁹ 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=97KkBX5YKZWCgTpKobriYJI39VQmAAAANZiBHA==&bcsi_scan_filename=SecandPPR_KnowRev.pdf>.

Conclusion

This review of Queensland’s legislative framework for mental health treatment and care presents a unique opportunity (one that will arguably not arise for another decade) to ensure Queensland’s mental health legislation represents a contemporary approach and one that is premised upon a foundation of human rights and underpinned by a recovery-oriented approach to the treatment of mental illness.

I commend the Bill to the extent that it takes Queensland some way towards fulfilling this aspiration, including the capacity-based approach to the involuntary treatment of mental illness. However, I believe that more can be done to ensure that we do not miss this important opportunity.

This submission outlines a number of shortcomings in the Bill as currently drafted. The most concerning aspect of the Bill is its lack of detail in relation to how it will interact with other systems that support those people who the Bill will impact the most, notably the guardianship system, the criminal justice system, and the fragmented system for the support and involuntary treatment of people with intellectual disability.

A proper plan for implementation is required, taking into account all of the issues covered in this submission and inclusive of guidelines that are made available to the public. This is a necessary prerequisite to ensuring that the public understands how the new system will work, to educating those whose cooperation is required, and to understanding the potential funding implications in respect of an already strained network of public services.

It is hoped that the Bill can be reconsidered particularly in relation to the reliance placed on the guardianship system for the involuntary treatment of mental illness and the continuing inequitable response to people with intellectual disability who are once again caught by the forensic provisions in the Bill.

In closing, thank you for the opportunity to provide a submission in relation to the proposed Bill. I would be pleased to make myself available to further discuss the issues that I have raised in this submission should additional information be required.

Yours sincerely,



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