Parliamentary Committees

Mental Health Bill 2015
and
Mental Health (Recovery Model) Bill 2015

Report No. 9, 55th Parliament
Health and Ambulance Services Committee
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Abbreviations

AHD	advanced health directive
AMHS	authorised mental health service
DBS	deep brain stimulation
EA	Examination authority
ECT	electroconvulsive therapy
EO	Examination order
EPOA	enduring power of attorney
Explanatory Note, Government Bill	Explanatory Note, Mental Health Bill 2015
Explanatory Note, Private Member's Bill	Explanatory Note, Mental Health (Recovery Model) Bill 2015
HHS	Hospital and Health Service
ITO	Involuntary treatment order
JEO	Justice's Examination Order
GPS	Global positioning system
OCD	Obsessive compulsive disorder
TA	Treatment authority
the Committee	Health and Ambulance Services Committee
the current Act	the *Mental Health Act 2000*
the Department	Department of Health
the Director	The Director of Mental Health (under the *Mental Health Act 2000*)
the 2014 Bill	Mental Health Bill 2014
the Government Bill	Mental Health Bill 2015
the Minister	Hon. Cameron Dick MP, Minister for Health and Minister for Ambulance Services
the Private Member's Bill	Mental Health (Recovery Model) Bill 2015
the Tribunal	the Mental Health Review Tribunal

Chair's foreword

On behalf of the Health and Ambulance Services Committee (the Committee) of the 55th Parliament of Queensland, I present this report on two Bills – the Mental Health (Recovery Model) Bill 2015 and the Mental Health Bill 2015.

In considering the Bills, the Committee's task was to consider the policy to be given effect by the Bills, and whether the Bills have sufficient regard to the rights and liberties of individuals and to the institution of Parliament.

Both Bills propose to repeal and replace the *Mental Health Act 2000.*

The genesis of both Bills stems from a Department of Health review of the *Mental Health Act 2000,* commenced in 2013.

In his explanatory speech on the Mental Health Bill 2015, the current Minister for Health, Hon. Cameron Dick MP, commended the former Health Minister for commencing the review into the *Mental Health Act* and supporting the reforms. He noted that whilst there are some important differences between the 2014 Bill and the current Government Bill, the Bills have many reform directions in common.

The Committee undertook its consideration of the Bills in a similarly bipartisan manner.

The Private Member's Bill introduced by the Member for Caloundra, Mark McArdle MP, in May 2015 is similar to the Bill introduced in 2014 which lapsed upon the dissolution of the House.

In 2015, the Department undertook significant further consultation and review of the Bill.

This further consultation and review resulted in the introduction of the Mental Health Bill 2015 in September 2015. The Mental Health Bill 2015 provides for comprehensive significant additional safeguards, absent from the 2014 Bill.

While the Committee could not reach an agreement on whether either of the Bills, should be passed, we were able to reach informed agreement on and include commentary around the majority of the provisions in the Bills.

We have also clearly identified those issues where the Committee differs.

I thank my fellow Committee members for their diligent approach to considering the Bills and the often confronting and emotive evidence presented to the Committee during its inquiry.

On behalf of the Committee, I thank those who made written submissions on these Bills. Thank you also to officials from the Department of Health who briefed the Committee, the witnesses who provided evidence at the public hearings, the Committee secretariat and the Technical Scrutiny Secretariat.

I commend the report to the House.

Leanne Linard MP

Chair

Recommendations

Recommendation 1 43

The Committee recommends that the Minister for Health and Minister for Ambulance Services advise the House of the benefits of not having separate assessment criteria and treatment criteria in the Mental Health Bill 2015.

Recommendation 2 43

The Committee recommends that the Member for Caloundra advise the House of the benefits of not having separate assessment criteria and treatment criteria in the Mental Health (Recovery Model) Bill 2015.

Recommendation 3 44

The Committee recommends that the Minister for Health and Minister for Ambulance Services advise the House of the safeguards under the Mental Health Bill 2015 for patients in regional/rural and remote areas, particularly regarding the making an assessment of a person subject to a recommendation for assessment, and reviewing a treatment authority if not made by a psychiatrist.

Recommendation 4 45

The Committee recommends that the Member for Caloundra advise the House of the safeguards under the Mental Health (Recovery Model) Bill 2015 for patients in regional/rural and remote areas, particularly regarding the making an assessment of a person subject to a recommendation for assessment, and reviewing a treatment authority if not made by a psychiatrist.

Recommendation 5 48

That the Minister for Health and Minister for Ambulance Services advise the House how the Government intends to address the concerns expressed by the Office of the Public Advocate and the Office of the Public Guardian regarding the 'less restrictive way'.

Recommendation 6 49

That the Member for Caloundra advises the House how the concerns expressed by the Office of the Public Advocate and the Office of the Public Guardian regarding the 'less restrictive way' could be addressed.

Recommendation 7 64

The Committee recommends that, in the event that either of the Bills pass, the following provisions in the Mental Health Bill 2015 relating to nominated support persons be retained:

- to allow the appointment of up to two nominated support persons ;
- relating to appointment and revocation of nominated support persons; and
- to allow a nominated support person to request a psychiatrist report where the patient is charged with a serious offence and was subject to a treatment authority, forensic order or treatment support order.
- The development of a policy on the appointment and functions of independent patient rights advisers by the Chief Psychiatrist, which will include minimum competencies and standards for service delivery, and require compliance with a monitoring framework.
- The establishment of a state-wide adviser network and the appointment of a state-wide co-ordinator, to oversee and support the network and to report to the Chief Psychiatrist on activity.

- Plans to review the operations of patient rights advisers, in conjunction with the Queensland Mental Health Commissioner and consumers, in 12 to 18 months' time once arrangements had been bedded down.

1. Introduction

1.1 Role of the Committee

The Health and Ambulance Services Committee (the Committee) is a portfolio Committee of the Legislative Assembly, which commenced on 27 March 2015 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.[1]

The Committee's primary areas of responsibility include health and ambulance services.[2]

Under section 93(1) of the *Parliament of Queensland Act 2001* a portfolio Committee is responsible for examining each Bill and item of subordinate legislation within its portfolio areas to consider:

- the policy to be given effect by the legislation,
- the application of fundamental legislative principles, and
- for subordinate legislation – it's lawfulness.

1.2 Referral

1.2.1 Private Member's Bill

On 5 May 2015, the Member for Caloundra, Mr Mark McArdle MP, introduced the Mental Health (Recovery Model) Bill 2015 into the Queensland Parliament as a Private Member's Bill. The Member for Caloundra stated the Bill is substantially the same as the Mental Health Bill 2014 (the 2014 Bill), introduced in the previous session. As, no time was fixed by the House or the Committee of the Legislative Assembly, the Standing Orders required the Committee to report to the House on or before 5 November 2015.[3]

1.2.2 Government Bill

On 5 May 2015, the Minister for Health and Minister for Ambulance Services, the Hon. Cameron Dick MP (the Minister) informed the Legislative Assembly of the Government's intentions in relation to Mental Health reform.
The Minister described the *Mental Health Act 2000* (the current Act) as '…a very complex and powerful act and has serious implications for the rights, liberties and obligations of Queenslanders who may have a mental illness.' An exposure draft of the Government's Bill was released for consultation, to allow '… all Queenslanders to see the bill in its entirety and give feedback on the provisions.' [4]

On 6 May 2015 the Minister wrote to the Committee to provide further information, advised he expected to introduce a mental health bill in the September parliamentary sitting, and requested the Committee defer taking submissions and conducting hearings on the Private Member's Bill until after this time.[5]

On 17 September 2015, the Minister introduced the Mental Health Bill 2015 into the Queensland Parliament. The Bill was referred to the Committee for consideration and the Committee was required, by resolution of the Legislative Assembly, to report to the Parliament on both Bills by 24 November 2015. The Minister commended the former Health Minister for commencing the review into the current Act and supporting the reforms. He noted that whilst there are some important differences

1 *Parliament of Queensland Act 2001*, section 88 and Standing Order 194.
2 Standing rules and Orders of the Legislative Assembly, Schedule 6.
3 Standing rules and Orders of the Legislative Assembly, Standing Order 136 (1).
4 Hansard, 5 May 2015, page 282.
5 Correspondence, 6 May 2015.

between the 2014 Bill and the current Government Bill, the Bills have many reform directions in common.[6]

1.3 Departmental review of the current Act

The Department commenced a review of the current Act in June 2013. The review 'identified a range of opportunities to improve the mental health legislative scheme in Queensland to ensure its currency with clinical practice, human rights principles and legislative drafting practices'.[7] The review resulted in the introduction of the Mental Health Bill 2014 in November 2014.

1.4 Mental Health Bill 2014 – referred to predecessor Committee

The former Minister for Health, the Hon. Lawrence Springborg MP, introduced the Mental Health Bill 2014 (the 2014 Bill), into the 54th Parliament on 27 November 2014. The Bill was referred to the Committee's predecessor, the Health and Community Services Committee (HCSC) for consideration, with a reporting date of 23 February 2015.

The HCSC commenced work on the 2014 Bill. The 2014 Bill and the HCSC inquiry lapsed upon the dissolution on the 54th Parliament on 6 January 2015.

As with the two Bills now under consideration, the 2014 Bill proposed to repeal the current Act and replace it with a new Act. The Explanatory Notes described the purposes of the Bill as follows–

> *… the primary purpose of the Bill is to improve and maintain the health and wellbeing of persons with a mental illness who do not have the capacity to consent to treatment or care.*
>
> *The Bill also enables persons to be diverted from the criminal justice system if found to have been of unsound mind at the time of an alleged offence or to be unfit for trial Where necessary, the Bill aims to protect the community if persons diverted from the criminal justice system may be at risk of harming others.*[8]

The Explanatory Notes also describe an extensive consultation process between June 2013 and July 2014, which included inviting the public to identify key areas for improvement in the current Act, releasing a Discussion Paper on the review and widespread public consultation, which included conducting meetings and workshops.[9]

The Department of Health (the Department) briefed the predecessor Committee on the Bill on 11 December 2014, and the Committee wrote to stakeholders and subscribers to inform them of the inquiry and invite written submissions. The Committee received and published eleven submissions on the Bill, before dissolution of the Parliament. Submissions had not closed at that time.

Material relating to the inquiry is available on the former Committee's webpage.[10]

1.5 2015 Inquiry process

The Committee agreed to consider both 2015 Bills together and present a combined report on the proposed mental health reforms. This report also contains reference to submissions made to the former Committee on the 2014 Bill.

6 Queensland Parliament, Record of Proceedings, 17 September 2015, pp. 2005-2008.
7 http://health.qld.gov.au/system-governance/legislation/reviews/mental-health/default.asp
8 Explanatory Notes, Mental Health Bill 2014, page 1.
9 Explanatory Notes, Mental Health Bill 2014, pages 13-14.
10 http://www.parliament.qld.gov.au/work-of-Committees/former-Committees/HCSC/inquiries/past-inquiries/MentalHealthB14

On 1 October 2015, the Committee wrote to the Department and the Member for Caloundra, seeking advice on the Bills, and to stakeholders and subscribers, to inform them of the inquiry and invite written submissions.

The Committee received seventy-seven submissions, 38 of which are published on the Committee's webpage.[11] The remaining 39 were form submissions, which directly reference material published by the Citizens Commission on Human Rights (CCHR). A list of submitters, including those referencing the CCHR material, is at **Appendix A** to this report.

On 14 October, 9 November and 23 November 2015 the Committee held public briefings on the Bills, to hear from officers from the Department, the Member for Caloundra and prominent clinicians.

On 28 October 2015 the Committee held a public hearing, to take further evidence from invited witnesses.

During the inquiry the Committee received the following additional written advice:

- Correspondence from the Minister for Health and Minister for Ambulance Services, the Hon. Cameron Dick MP, dated 28 September 2015, outlining the policy differences between the Bills.
- Correspondence from the Member for Caloundra, dated 13 October 2015, proposing a harmonisation process and seeking an extension on the inquiry reporting time.
- Correspondence from the Department, dated 5 November 2015, in response to matters raised during the 28 October public hearing.
- Correspondence from the Member for Caloundra, dated 10 November 2015, regarding the key differences between the two Bills.
- Correspondence from the Department, dated 13 November 2015, providing further information on potential fundamental legislative principle issues.
- Correspondence from the Department, dated 18 November 2015, in response to matters raised in the 9 November 2015 public briefing and providing further information on potential fundamental legislative principle issues.
- Correspondence from Associate Professor Stephen Stathis to Dr Bill Kingswell, dated 22 October 2015, regarding the use of electroconvulsive therapy (ECT) in Children and Adolescents, which was referenced during the 9 November 2015 public hearing.

The written advice from the Department and Member of Caloundra and transcripts of the public briefing and hearing are available on the Committee's webpage.[12]

1.6 Policy objectives of the Bills

Both 2015 Bills propose to repeal and replace the current Act with a new Act.

The primary purpose of both Bills is to improve and maintain the health and wellbeing of persons with a mental illness who do not have the capacity to consent to treatment.[13]

The Bills also enable people to be diverted from the criminal justice system if found to have been of unsound mind at the time of an alleged offence, or to be unfit for trial, and aim to protect the community if people diverted from the criminal justice system may be at risk of harming others.

The Explanatory Notes for both Bills also state the objects are to be, achieved in a way that:

11 http://www.parliament.qld.gov.au/work-of-committees/committees/HASC/inquiries/current-inquiries/B1-MH-RM-B2015

12 http://www.parliament.qld.gov.au/work-of-committees/committees/HASC/inquiries/current-inquiries/B1-MH-RM-B2015

13 Explanatory Notes, Government Bill, page 1; Explanatory Note, Private Member's Bill, page 1.

- safeguards the rights of persons,
- is least restrictive of a person's rights and liberties, and
- promotes the recovery of a person with a mental illness, and their ability to live in the community, without the need for involuntary treatment or care.[14]

1.7 Consultation on the Bills

The Explanatory Notes for both 2015 Bills include reasonably detailed information on the consultation process.

The Department commenced a review of the Mental Health Act 2000 in 2013.

The review commenced by inviting the public to identify key areas for improvement to the Act, and was, followed by an initial round of public consultation in July-August 2013, which included meetings and workshops with the following key stakeholders:

- the Queensland Mental Health Commission
- peak bodies for mental health consumers
- users of mental health services, their families and carers
- legal agencies
- authorised mental health services
- individual victims
- government agencies, including the Public Guardian and the Public Advocate
- the Mental Health Court and other courts
- the Mental Health Review Tribunal.

A Discussion Paper was, subsequently released for public consultation from May to July 2014, with further meetings and workshops also convened during this period. The Explanatory Notes state over 120 submissions were, received in response to the Discussion Paper, and that an analysis of this feedback formed the basis for the 2014 Bill and the subsequent Private Member's Bill.[15]

1.7.1 Government Bill

The Queensland Mental Health Commissioner was, consulted throughout the development of the 2015 Government Bill. The Government released a draft Bill for public comment for a two-month period, to 26 June 2015, and continued its 'extensive range of consultation workshops and meetings' during this time. The following organisations were involved in this round of consultation:

- authorised mental health services
- interested consumers and organisations representing mental health consumers
- peak health representative bodies
- legal advocacy groups
- government agencies, including the Public Guardian and the Public Advocate
- the Mental Health Court
- magistrates, and
- the Mental Health Review Tribunal.

The Government received 97 submissions on the draft Bill.[16]

1.7.2 Private Member's Bill

The Committee received no advice regarding consultation on the Private Member's Bill after July 2014, as it was, advised that the Bill was substantially the same as the Bill introduced in 2014.

14 Explanatory Notes, Government Bill, page 1.
15 Private Member's Bill, page 11.
16 Government Bill, Explanatory Notes, page 11.

1.8 Should the Bills be passed?

Standing Order 132(1)(a) requires the Committee after examining a Bill to determine whether to recommend that that Bill be passed.

The Committee considered whether it should make a recommendation for either Bill to be passed. Two votes on motions to that effect were both tied and, in accordance with section 91C(7) of the *Parliament of Queensland Act 2001*, the questions on the motions failed. The Committee was unable to make a recommendation on whether either Bill should be passed.

Committee comment

While the Committee could not reach agreement on whether either Bill should, be passed, the Committee supports the common purposes of the Bills and acknowledges the considerable contribution the Department of Health and stakeholders have made in reviewing the Mental Health Act 2000 and the development of both Bills to build on and improve the current Act.

Government members of the Committee support the passage of the Government Bill. The additional measures and safeguards in the Government Bill go further to protect the interests of patients, staff and the community.

Opposition members of the Committee support the passage of the Private Member's Bill. The Opposition members of the Committee agree that both Bills are very similar in intent, that expert evidence supports elements of both and in that circumstance the Opposition believes that it is a matter for the House to determine to support with or without amendments.

2. The Mental Health Act and the Bills

2.1 Current Act

This chapter provides an overview of the main differences between the current Act and the two Bills.

The current Act was, developed after a detailed review, to replace a 1974 Act. The current Act substantially modernised Queensland's mental health legislation, and incorporated international principles to reflect the rights of people with a mental illness. Broadly, the current Act provides for the involuntary assessment, treatment and protection of people who have a mental illness, while at the same time safeguarding their rights and freedoms, and balancing their rights and freedoms with the rights and freedoms of other people.

2.2 How will the *Mental Health Act 2000* be amended?

Table 1

	Mental Health Act 2000	2015 Mental Health Bills
Principles for the administration of the Act	Prescribes one set of principles - principles for persons with a mental illness.	Prescribe two sets of principles - principles for persons with a mental illness and principles for victims. Principles for people with a mental illness: • Two new principles – recognising, protecting and promoting the best interests of minors and recognising the import ace of recovery-oriented services and the reduction of stigma. • Expanded to apply to persons who do and may have a mental illness.
Examinations, assessment and treatment authorities	Provides for a request for assessment, recommendation for assessment, justice's examination order and involuntary treatment order.	Provide for an examination authority, treatment criteria and treatment authority.
Emergency examination authorities	Provides for emergency examination authorities, under which ambulance and police officers may take a person who appears to have a serious mental impairment or mental illness for treatment or care.	Relocate emergency examination authorities to the *Public Health Act 2005*.
Support persons	Provides for patients to choose an 'allied person' to help them understand their rights, speak with their treating team and provide support at the Mental Health Review Tribunal.	Provide for patients to appoint a nominated support person, by written notice. Expanded provisions around their appointment, revocation, roles and responsibilities.
Patient rights	Patients have a right to be treated with dignity and respect, to have their religion and culture respected, to have their privacy respected, to have their personal	Patient rights are expanded to include right to receive visits at any reasonable time, to communicate by post or phone and to request a second opinion from

	Mental Health Act 2000	2015 Mental Health Bills
	information dealt with confidentially, to receive information in a language and form they understand and to receive assistance to communicate effectively.	another health practitioner where a complaint about their care or treatment cannot be resolved. Authorised mental health services must engage a patient rights adviser to advise patients and support people about rights and responsibilities. Provide for a patient's information to be given to specified people or agencies.
Mechanical restraint and seclusion	Provides that mechanical restraint may be approved by an authorised doctor.	Provide that mechanical restraint must be approved by the Chief Psychiatrist. Provide for the Chief Psychiatrist to issue directions on the use of seclusion. Provide explicit criteria for the use of mechanical restraint and seclusion and sets clear time limits on their use. Introduces provisions for reduction and elimination plans, to be developed by an authorised doctor to provide for the reduction and elimination of either or both mechanical restraint and seclusion. Require the Chief Psychiatrist to prepare a policy about mechanical restraint and seclusion, including minimising their use and impact.
Psychosurgery	Is a regulated treatment under the Act.	Is a prohibited treatment under the Bills.
Non-ablative neurosurgical procedures, including ECT	Provides that ECT can be performed on a minor if the minor consents, or it has been approved by the Mental Health Review Tribunal.	Provide that non-ablative neurosurgical procedures and ECT are regulated treatments. The use of regulated treatments require the informed consent of the person, or approval by the Mental Health Review Tribunal where the person is unable to consent or is a minor.
Less restrictive way		Place a greater emphasis on a 'less restrictive way' to treat the person (rather than involuntary treatment) as a means of reducing the adverse effects on the rights and liberties of the person.
Capacity to consent		Define when a person has capacity to consent to be treated. Provide that a person may have the capacity to consent, even though they decide not to receive treatment, and may

	Mental Health Act 2000	2015 Mental Health Bills
		be supported by another person when making a decision about the treatment.
Advanced health directives		Make provisions for advanced health directives, including that any views about treatment and care in an AHD must be taken into account in deciding the nature and extent of treatment and care to be provided under a treatment authority.
Mental Health Review Tribunal		Provide for free legal representation for patients for specific types of hearings, such as where the Attorney-General is represented, for minors and for electroconvulsive therapy application.
Psychiatrist reports		Provide that psychiatrist reports will no longer be required for all involuntary patients who are charged with an offence, instead a psychiatrist's report can be requested.
Magistrates Court		Provide that the Court will be able to discharge a person if satisfied they were of unsound mind at the time of the alleged offence or are unfit for trial.

2.3 Main differences between the Bills

On 28 September 2015, the Minister provided the Committee with a document summarising the key differences between the Bills.[17] The following table includes information from this document, highlighting the additional measures included in the Government Bill.

Table 2

	Information provided by the Minister on the Government Bill	Comment
Principles for persons with a mental illness	Includes a principle about recognising and taking into account a person's hearing, visual or speech impairment. Amends principle relating to Aboriginal and Torres Strait Islander people to align with the principle in the *Queensland Mental Health Commission Act 2013.*	There are no comparable provisions in the Private Member's Bill.
Principles for victims	Applies to victims of an unlawful act and others, including a close relative of the victim and another individual who has suffered harm because of the unlawful act.	The principles in the Private Member's Bills apply only to victims of an unlawful Act.
Examinations, assessment and treatment authorities	Re-drafts the criteria for placing a person on an emergency examination authority to place emphasis on high-risk individuals who need urgent treatment.	

17 Correspondence, Minister for Health and Minister for Ambulance Services, 28 September 2015

	Information provided by the Minister on the Government Bill	Comment
	Enables a person to be, detained in an authorised mental health service or public sector health service facility on the oral instructions of an authorised doctor to enable the doctor to prepare a recommendation for assessment. Requires an authorised doctor to explain to a patient why an advance health directive has not been followed and document the reasons in the patient's records Includes examples of where an advance health directive, or guardian or attorney consent, may not be adequate, for example, where the matters stated in an advance health directive are not clinically relevant or appropriate for the person's treatment and care. States that the requirement to treat a person in a 'less restrictive way' is to be read subject to chief psychiatrist policies, for example, where force may be required, where the person objects to the treatment, or where the person's treatment occurs over a certain period of time. Modifies the definition of capacity so that a person only needs to understand they have an illness, or symptoms of an illness, that affects the person's mental health and well-being. Clarifies that a recommendation for assessment may be, made if the treatment criteria 'may' apply to the person. Enables an authorised doctor in a designated 'rural and remote' area to do both a recommendation for assessment, and do the assessment, only if another authorised doctor is not reasonably available to do the assessment. Enables the review of the making of a treatment authority by an authorised psychiatrist in a designated 'rural and remote' area to be extended from 3 days to 7 days only if there is no other reasonably practicable way to do the review within 3 days. Enables a person already in an authorised mental health service on an examination order made by a magistrate or a court treatment order made by the Mental Health Court to become a classified patient. Clarifies the arrangements for the suspension of proceedings where a person becomes a classified patient, where a psychiatrist report is prepared, and when a reference is made to the Mental Health Court.	
Psychiatrist Report	Clarifies the circumstances in which support persons can request a report.	

	Information provided by the Minister on the Government Bill	Comment
Mental Health Court	Enables the Mental Health Court to impose a non-revoke period of up to 10 years (increased from 7 years) on a forensic order for the most serious violent offences, such as murder and rape. Omits clause 123 (Where an expert's opinion is affected by a dispute of facts), as the provision is not necessary, and to avoid confusion with clause 124 (Where matters may be returned to the criminal courts). Amends clause 124 (see clause 117 Mental Health Bill 2015) to clarify the basis for the Court's decision to refer a matter to the criminal courts, namely, if the court is satisfied there is a substantial dispute about whether the person committed the offence as charged by the Crown. Explicitly states how the confidentiality of victim impact statements is to be treated in the Mental Health Court, in the same way that applies in the Mental Health Review Tribunal. Clarifies that non-revocation periods for certain forensic orders do not apply for a determination of temporary unfitness for trial. Clarifies that a condition on an order cannot include a requirement in relation to a particular medication or dosage of a medication. Clarifies that, for a court treatment order, the Court may order a minimum amount of treatment in the community for the person, consistent with its 'least restrictive' role. Enables the Mental Health Court to have hearings with one assisting clinician where appropriate; a practice direction is to be issued to ensure this only occurs with the agreement of the parties. Removes the two-term limit on the appointment of assisting clinicians. Extends legal protections and immunities to assisting clinicians. Clarifies that the advice of an assisting clinician need not be disclosed to the parties if the advice only relates to court administrative and procedural matters. Enables the Court to dismiss frivolous or vexatious appeals. Enables information held by the Mental Health Court and the Tribunal to be disclosed for genuine research purposes, subject to confidentiality obligations.	

	Information provided by the Minister on the Government Bill	Comment
	Amends the terminology 'forensic order (mental condition)' to 'forensic order (mental health)' for consistency in the Bill. Makes other procedural improvements to the provisions related to the Mental Health Court.	
Magistrates Courts	Provides that a magistrate may only dismiss a charge for a proceeding that can be determined by a magistrate. Removes the ability of magistrates to set conditions on the dismissal of a charge, noting that there is an express power for a magistrate to refer a person for an examination.	
Restrictive practices	Clarifies that the offence of using mechanical restraint, seclusion or physical restraint applies to any patient, including patients being treated under an advance health directive, or with the consent of an attorney or guardian. Enables an authorised doctor, with the approval of the senior medical administrator, to extend seclusion beyond the mandated 9-hour period, for up to further 2 hours, to enable a reduction and elimination plan to be prepared.	
Medication	Defines medication, makes it an offence to administer medication to a patient unless it is clinically necessary and makes a number of related provisions.	There are no comparable provisions in the Private Member's Bill.
Physical restraint	Defines physical restraint, specifies circumstances in which physical restraint may be used and makes it an offence to use physical restraint on a patient, other than under the Act.	There are no comparable provisions in the Private Member's Bill.
Nominated support persons	Enables a person to appoint up to two nominated support persons. Provides for a nominated support person to withdraw from the role.	The Private Member's Bill provides that a person may appoint 'a nominated support person' and makes no provision for the nominated person to resign.
Rights of patients and others	Enables the administrator of an authorised mental health service to restrict the use of phones or electronic communication devices only on an individual basis, if its use would be detrimental to the health and well-being of the patient or others. Standardises the provisions where matters are to be told, explained or discussed with a nominated support person, family, carer or other support person.	

	Information provided by the Minister on the Government Bill	Comment
	Makes explicit the circumstances where an obligation to communicate with a patient's support persons is not required, namely, where: • the patient, who has capacity for the matter at the relevant time, requests the communication does not take place • the support person is not readily available and willing for the communication to take place, or • the communication is likely to be detrimental to the patient's health and well-being. Clarifies that the requirements to communicate with a nominated support person, family, carer or other support person do not limit the ability to disclose information under the confidentiality provisions of the *Hospital and Health Boards Act 2011.*	
Patient rights advisers	Provides that an adviser may be an employee of an entity that the Hospital and Health Service has engaged to provide services, or an employee of the Hospital and Health Service but not employed with in the mental health service. Provides additional functions for advisers, namely: • to work cooperatively with community visitors in performing their functions under the *Public Guardian Act 2014* • to consult with authorised mental health practitioners, authorised doctors, administrators and the chief psychiatrist on the rights of patients under this Act, guardianship legislation or other laws. Clarifies the ability to disclose patient records, and notices given to a patient under the Act, to an adviser to enable the adviser to perform functions under the Act. Renames 'patient rights adviser' to 'independent patient rights adviser' to emphasise the independence of the role.	
Electronic tracking devices	Remove the ability of the Chief Psychiatrist to require a forensic patient to wear a GPS tracking device. This authority is limited to the Mental Health Court and the Mental Health Review Tribunal, where the issues can be considered in a transparent way, rather than by the Chief Psychiatrist exercising an administrative power.	The Private Member's Bill allows the Chief Psychiatrist to amend a forensic order to impose a monitoring condition which requires a patient to wear an electronic tracking device.
Chief Psychiatrist	Includes provisions for the Chief Psychiatrist to resign, and to establish grounds for removal from office.	

	Information provided by the Minister on the Government Bill	Comment
	Includes a requirement for the Chief Psychiatrist to prepare a policy for forensic patients charged with 'prescribed offences' (e.g. manslaughter, murder) while in the community (similar to the current requirement for 'special notification forensic patients').	
Authorised mental health services	Amends the search provisions to require two persons to be present during a search that requires the removal of clothing. Amends the provisions related to the use of reasonable force, so that reasonable force for an examination, assessment or treatment can only occur in an authorised mental health service or public sector health service; this limitation will not apply under an examination authority.	
Mental Health Review Tribunal	Clarifies that, for a treatment authority or court treatment order, the Tribunal may order a minimum amount of treatment in the community for the person, consistent with its 'least restrictive' role. Clarifies that a condition on an authority or order cannot include a requirement in relation to a particular medication or dosage of a medication. Requires that, if a forensic patient with a non-revocation period on the forensic order is transferred interstate, the order continues for the length of the non-revocation period and is reinstated if the person returns to the State during the non-revocation period. Enables the Tribunal to amend the category of a treatment authority or treatment support order to inpatient for the purpose of an authorised doctor reviewing the patient's treatment and care. Provides that a person representing someone at a hearing must represent the person's views, wishes and preferences to the extent the person is able to express them, and represent the person's best interests if the person is unable to express them. Includes a regulation-making power to prescribe other types of hearings where legal representation must be provided. Enables the Tribunal President to refer questions of law to the Mental Health Court. Makes other procedural improvements to the provisions related to the Mental Health Review Tribunal. Amends the terminology ‘court treatment order' to 'treatment support order'.	

3. Objects and principles, key concepts and functions

This chapter describes the objects and principles of the legislation, as well as some of the important definitions, decision makers, concepts and functions in the mental health system that are set out in the Bills, and in many instances, the current Act.

3.1 Objects

Section 4. of the current Act states:

> *The purpose of this Act is to provide for the involuntary assessment and treatment, and the protection, of persons (whether adults or minors) who have mental illnesses while at the same time—*
>
> *(a) safeguarding their rights and freedoms; and*
>
> *(b) balancing their rights and freedoms with the rights and freedoms of other persons.*

Clause 3 of the Bills replace the purpose of the Act with main objects for the proposed new Acts, and prescribe the way in which the objects are to be, achieved.

The objects are the same in both Bills:

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

While there are some drafting differences, both Bills provide that the objects are to be achieved in a way that:

- safeguards the rights of persons,
- promotes the recovery of a person who has a mental illness, and the person's ability to live in the community, without the need for involuntary treatment and care, and
- ensures the rights and liberties of a person who has a mental illness are adversely affected only to the extent required to protect the person's health and safety or to protect others.

3.2 Overview of principles

Principles for the administration of the legislation are set out in the current Act and both Bills. A person performing a function or exercising a power under the current or proposed Acts is to have regard to the principles.[18]

The Act contains one set of principles, which apply to persons with a mental illness. The Bills add an additional set of principles, which apply to victims.[19]

The principles relating to persons with a mental illness are broader than the current Act as they apply to both persons with a mental illness, and persons who may have a mental illness.[20] The Bills also provide that a reference to a person who has a mental illness in the principles, and the objects of the proposed new Acts, includes a person with an intellectual disability.[21]

18 Government Bill, cl.7; Private Member's Bill, cl.7

19 *Mental Health Act 2000*, s.8; Government Bill, cl.5 and cl.6; Private Member's Bill, cl.5 and cl.6

20 Government Bill, cl.5; Private Member's Bill, cl.5; *Mental Health Act 2000*, s.8

21 Government Bill, cl.8; Private Member's Bill, cl.8(a). The application of the proposed Act to a person with an intellectual disability is wider in the Government Bill than in the Private Member's Bill as it also includes references in the proposed Act to recovery of a person meaning a reference to the rehabilitation, and development of living skills, of the person: Government Bill, cl.8(c)

3.3 Principles for person with a mental illness

Clause 5 of the Bills prescribe the principles that apply in relation to a person who has or may have a mental illness. While most of the principles are comparable with the current Act, both Bills propose some new and amended principles.
In summary, the principles included in clause 5 of both Bills are:

- The same basic human rights must be recognised and taken into account, including the right to respect and dignity as an individual.
- A person is presumed to have capacity to make decisions about their life, treatment and care, and to the greatest extent practicable a person is to be encouraged to take part in decisions and to have their views, wishes and preferences taken into account.
- Family, carers and other support persons are to be involved in decisions about a person's treatment and care to the greatest extent practicable, subject to the person's right to privacy.
- A person is to be provided with the necessary support and information to enable them to exercise their rights under the Act.
- A person is to be helped to achieve their maximum physical, social, psychological and emotional potential, quality of life and self-reliance.
- Recognising and taking account of a person's age-related, gender-related, religious, communication and other special needs.
- Recognising and taking account of the unique cultural, communication and other needs of Aboriginal people and Torres Strait Islanders and persons from culturally and linguistically diverse backgrounds. This includes providing culturally appropriate services and interpreters. This is an amended principle, which aligns with the principle in the *Queensland Mental Health Commission Act 2013*.[22] The comparable principle in the current Act focuses on maintaining a person's cultural and linguistic environment and values.[23]
- Recognising, protecting and promoting the best interests of minors receiving treatment and care, including, for example, by receiving treatment and care separately from adults. This is a new principle.
- Taking into account the importance of a person's continued participation in community life and the maintenance of existing supportive relationships, for example, by providing treatment in the community in which the person lives.
- Recognising the importance of recovery-oriented services and the reduction of stigma associated with mental illness. This is a new principle.
- Providing treatment and care to a person with a mental illness only if it is appropriate to promote and maintain the person's health and wellbeing.
- Recognising and taking into account a person's right to confidentiality.[24]

3.3.1 Additional measures in the Government Bill

The Government Bill also includes a person's right to privacy,[25] as well as a new principle to recognise and take into account a person's hearing, visual or speech impairment.[26]

3.4 Principles for victims

Both Bills provide for new principles which are to apply to a victim of an unlawful act.

22 Hon Cameron Dick MP, Minister for Health and Minster for Ambulance Services, correspondence dated 28 September 2015, attachment.
23 *Mental Health Act 2000*, s.8(g).
24 Government Bill, cl. 5; Private Member's Bill, cl.5.
25 Government Bill, cl.5(m).
26 Government Bill, cl.5(f).

The principles common to both Bills are:

- The physical, psychological and emotional harm caused to a victim by the unlawful act must be recognised with compassion.
- The benefits to the victim of the timely completion of proceedings against a person for the unlawful act must be recognised.
- The benefits to the victim of being advised in a timely way of decisions to allow a person alleged to have committed the unlawful act to be treated in the community must be recognised.
- The benefits of counselling, advice on the nature of proceedings under this Act and other support services to the recovery of the victim from the harm caused by the unlawful act must be recognised.
- The benefits to the victim of being given the opportunity to express his or her views on the impact of the unlawful act to decision-making entities under the Act must be recognised.

3.4.1 Differences between the Bills

Additional measures in the Government Bill

The principles in clause 6 of the Government Bill will apply to a victim and to 'others'. The application of those principles is expanded, in addition to the victim as outlined in 3.4 above, to also cover a close relative of a victim of an unlawful act and another individual who has suffered harm because of an unlawful act committed against a victim of an unlawful act.

The Government Bill also includes a principle to recognise the benefits to the victim of being advised in a timely way of a decision to allow a person to be treated in the community must be recognised.[27]

Additional measures in the Private Member's bill

The Private Member's Bill also includes a principle to recognise the benefits to the victim of being advised in a timely way of proceedings under the Act against a person for the unlawful act.

3.5 Key definitions, decision makers and functions

3.5.1 Definition of mental illness

The meaning of mental illness in clause 10 of the Bills is substantially the same as the definition in section 12 of the current Act. Both the Act and the Bills provide that:

> *(1) Mental illness is a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.*
>
> *(2) However, a person must not be considered to have a mental illness merely because—*
>
> *(a) the person holds or refuses to hold a particular religious, cultural, philosophical or political belief or opinion; or*
>
> *(b) the person is a member of a particular racial group; or*
>
> *(c) the person has a particular economic or social status; or*
>
> *(d) the person has a particular sexual preference or sexual orientation; or*
>
> *(e) the person engages in sexual promiscuity; or*
>
> *(f) the person engages in immoral or indecent conduct; or*
>
> *(g) the person takes drugs or alcohol; or*
>
> *(h) the person has an intellectual disability; or*
>
> *(i) the person engages in antisocial behaviour or illegal behaviour; or*

27 Private Member's Bill, cl.6(2)(e); Government Bill 2015, cl 6(2)(e).

(j) the person is or has been involved in family conflict; or

(k) the person has previously been treated for mental illness or been subject to involuntary assessment or treatment.

(3) Subsection (2) does not prevent a person mentioned in the subsection having a mental illness.

Examples for subsection (3)—

1 A person may have a mental illness caused by taking drugs or alcohol.

2 A person may have a mental illness as well as an intellectual disability.

The only variation is a minor drafting change to subsection (4) which continues to provide, as in the Act, that a decision that a person has a mental illness must be made in accordance with internationally accepted medical standards.

3.5.2 Involuntary patient

Clause 11 of the Bills provide that an involuntary patient means:

- a person who is subject to an examination authority, a recommendation for assessment, a treatment authority, a forensic order, a court treatment order (in the Private Member's Bill) or a treatment support order (in the Government Bill), a judicial order, or
- a person from another State detained in an authorised mental health service (AMHS).

In addition, the Government Bill provides that a person detained in an AMHS under clause 36, for the purposes of making a recommendation for assessment, is also an involuntary patient.
Chapter 4 discusses examination authorities, recommendations for assessment and treatment authorities.

3.5.3 Treatment criteria

Treatment criteria form the basis for a person being paced on a treatment authority.[28] Clause 12 of the Bills define treatment criteria as including all of the following:

- The person has a mental illness.
- The person does not have capacity to consent to be treated for the illness. With regard to not having capacity to consent, both Bills state the person's own consent only is relevant and that this applies, despite the *Guardianship and Administration Act 2000*, the *Powers of Attorney Act 1998* or any other law.[29]
- Because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in imminent serious harm to the person or others, or the person suffering serious mental or physical deterioration.

The application of the treatment criteria is discussed in Chapter 4.

3.5.4 Less restrictive way

Clause 13 of the Bills provide that there is a less restrictive way for a person to receive treatment and care for their mental illness if, instead of receiving involuntary treatment and care, the person is able to receive the necessary treatment and care in one of the following ways—

- if the person is a minor, with the consent of the minor's parent,
- if the person has an advance health directive (AHD), under the AHD,
- if a personal guardian has been appointed for the person, with the consent of the personal guardian,
- if an attorney has been appointed by the person, with the consent of the attorney,

28 Government Bill, Explanatory Notes, page 13.
29 Government Bill cl. 12(2) and 12(3); Private Member's Bill, cl12(2) and 12(3).

- with the consent of the person's statutory health attorney.

When deciding whether there is a less restrictive way for a person to receive the necessary treatment and care for their mental illness, a person performing a function or exercising a power under the proposed new Acts must consider the ways mentioned above, in the order they are listed.

Additional measures in the Government Bill

Clause 13 of the Government Bill also provides that a person acting under the Act must also comply with the policy made by the Chief Psychiatrist under section 303(1)(a). The policy will outline when it may not be appropriate for a person to receive treatment and care for the person's mental illness under an AHD or with the consent of a personal guardian, attorney or statutory health attorney for the person.[30]

The Government Bill also:

- includes examples of when there may not be a less restrictive way for a person to receive the treatment and care that is reasonably necessary for the person's mental illness,[31]
- declares that it does not limit the power of the public guardian to act as a statutory health attorney for a person under the *Powers of Attorney Act 1998,*[32]
- clarifies that public guardian means the public guardian under the *Public Guardian Act 2014* and statutory health attorney means the person's statutory health attorney under section 63(1) of the *Powers of Attorney Act 1998*.[33]

The application of the less restrictive way is discussed in Chapter 4.

3.5.5 Capacity to consent to treatment

Clause 14 of the Bills define when a person has capacity to consent to be treated. While the definitions differ slightly, both Bills provide that a person has the capacity to consent to be treated if the following apply:

- The person is capable of understanding, in general terms:
    - the nature and purpose of the treatment for the mental illness,
    - the benefits and risks of the treatment, and alternatives to the treatment,
    - the consequences of not receiving the treatment,
    - that they have an illness, or symptoms of an illness, that affects their mental health and wellbeing (Government Bill), or that they recognise they have a mental illness (Private Member's Bill).
- The person is capable of making a decision about the treatment and communicating the decision in some way.

Clause 14 of the Bills also provide that a person may have the capacity to consent, even though they decide not to receive treatment, and may be supported by another person when making a decision about the treatment. It also states that the common law about the capacity of a minor to consent or a parent to consent on the minor's behalf is not affected by clause 14.

30 Government Bill, cl. 13(2)(b).
31 Government Bill, cl. 13(1).
32 Government Bill, cl. 13(3).
33 Government Bill, cl. 13(4).

3.5.6 Limited community treatment

The Bills define limited community treatment as treatment and care of a person in the community, including in the grounds and buildings (other than an inpatient unit) of an AMHS, for a period of not more than seven consecutive days, that is authorised under the proposed Act.[34]

In addition, the Government Bill provides that an authorised doctor may decide to authorise limited community treatment only if satisfied that it is appropriate having regard to the relevant circumstances of the person and the purpose of limited community treatment.[35] If limited community treatment is authorised, the person's treatment authority must state the nature and conditions of the limited community treatment, the period of not more than seven consecutive days of the limited community treatment and the duration for which the authorisation is in force. Chapter 7, Part 6 provides for authorisation of limited community treatment for classified patients.

3.5.7 Authorised mental health service

The term authorised mental health service (AMHS) is used throughout the Bills and is defined in the dictionary schedule of the Bills to mean:

- a health service or part of a health service declared to be an AMHS under the relevant section, or
- an AMHS (regional) in the Private Member's Bill, or AMHS (rural and remote) in the Government Bill, or
- a high security unit.

The Chief Psychiatrist may declare an AMHS by gazette notice, and the declaration may include conditions.[36]

3.6 Roles and functions

3.6.1 Chief Psychiatrist

The Bills replace the position of Director of Mental Health (the Director) in the current Act with the Chief Psychiatrist. The Chief Psychiatrist is appointed by the Governor in Council and must be a psychiatrist.[37]

The Chief Psychiatrist has significant functions and powers under the Bills, many of which are consistent with those of the Director of Mental Health. While there are slight differences in drafting, both Bills provide:

> *(1) The Chief Psychiatrist has the following functions—*
>
> *(a) to the extent practicable, ensuring the protection of the rights of patients under this Act while balancing their rights with the rights of others;*
>
> *(b) to the extent practicable, ensuring the involuntary examination, assessment, treatment, care and detention of persons under this Act complies with this Act;*
>
> *(c) facilitating the proper and efficient administration of this Act;*
>
> *(d) monitoring and auditing compliance with this Act;*
>
> *(e) promoting community awareness and understanding of this Act;*
>
> *(f) advising and reporting to the Minister on any matter relating to the administration of this Act—*

34 Government Bill, Schedule 3; Private members Bill, Schedule 3
35 Government Bill, cl. 52.
36 Government Bill, cl.327; Private Member's Bill, cl.318.
37 Government Bill, cl. 296; Private Member's Bill, cl. 289.

(i) on the Chief Psychiatrist's own initiative; or

(ii) on the written request of the Minister;

(g) preparing and giving to the Minister a report on the competencies the Chief Psychiatrist considers necessary for a health practitioner to perform a function or exercise a power of an authorised doctor.[38]

(2) Also, the Chief Psychiatrist has the functions and powers given to the Chief Psychiatrist under this or another Act.

The Government Bill specifies that the Chief Psychiatrist may do all things necessary or convenient to perform the Chief Psychiatrist's functions.[39]

3.6.2 Administrator of authorised mental health service

The Bills provide for the Chief Psychiatrist to appoint an administrator of an AMHS.[40] While there are slight differences in drafting, both Bills provide that administrators have the following functions:

- to the extent practicable, ensuring the operations of the AMHS are complaint with the Act,
- taking reasonable steps to ensure patients of the AMHS receive appropriate treatment and care,
- notifying patients of the AMHS, the Chief Psychiatrist, the Tribunal and others of decisions and other matters as required under the Act, and
- appointing authorised doctors and authorised mental health practitioners.[41]

3.6.3 Authorised doctor

The Bills provide for the administrator of an AMHS to appoint an authorised doctor if satisfied that the person has the competencies required by a policy made by the Chief Psychiatrist.[42]
The definition of authorised doctor is wider in the Bills than in the current Act. In both Bills it means a doctor appointed under the relevant section or a health practitioner, other than a doctor, appointed to perform the functions of an authorised doctor. The Government Bill also provides that authorised doctors can be a specified administrator of an AMHS.[43]

A health practitioner is a person registered under the Health Practitioner Regulation National Law, or another person who provides health services, including, for example, a social worker.[44]
Authorised doctors have a wide range of functions under the Bills.

3.6.4 Authorised psychiatrist

An authorised psychiatrist is an authorised doctor who is a psychiatrist.[45]

3.6.5 Authorised mental health practitioner

The Bills provide for the administrator of an AMHS to appoint a health practitioner as an authorised mental health practitioner if satisfied the person has the competencies required by a policy made by the Chief Psychiatrist.[46]

38 Government Bill, cl. 299.
39 See also, Government Bill, cl.26; Private Member's Bill, cl.26.
40 Government Bill, cl. 300; Private Member's Bill, cl. 321.
41 Government Bill, cl. 331; Private Member's Bill, cl.322.
42 Government Bill 303(1)(i) and cl.336; Private Member's Bill, cl. 327.
43 Government Bill, Schedule 3; Private Member's Bill, Schedule 3.
44 Government Bill, Schedule 3; Private Member's Bill, Schedule 3.
45 Government Bill, Schedule 3; Private Member's Bill, Schedule 3.
46 Government Bill 303(1)(i) and cl.338; Private Member's Bill, cl.294(1)(i) and cl. 327.

3.6.6 Mental Health Review Tribunal

Both Bills provide for the Mental Health Review Tribunal to continue under the Bills. The Tribunal has responsibility for reviewing treatment authorities, forensic orders, certain orders, the fitness for trial of particular persons and the detention of minors in high security units (see Chapter 4.3). The Tribunal also hears applications for examination authorities, the approval of regulated treatments (see Chapters 12.6 and 13.3) and the transfer of certain patients into and out of Queensland.[47]
Under the Private Member's Bill, the Tribunal also has the power to review the imposition of monitoring conditions requiring particular persons to wear tracking devices (see Chapter 15.5).[48]

Some of these responsibilities are new to the Tribunal, including the review of court treatment orders, the hearing of applications for examination authorities and the hearing of applications for the transfer of particular patients into and out of Queensland.[49]

The Minister also advised the Committee that, in relation to the Mental Health Review Tribunal (MHRT) the Government Bill also includes the following additional measures:

- Clarifies that, for a treatment authority, or treatment order, the tribunal may order a minimum amount of treatment in the community for the person, consistent with its least restrictive role,
- Clarifies that a condition on an authority or order cannot include a requirement in relation to a particular medication or dosage of a medication,
- Requires that, if a forensic patient with a non-revocation period on the forensic order is transferred interstate, the order continues for the length of the non-revocation period and is reinstated if the person returns to the State during the non-revocation period,
- Enables the Tribunal to amend the category of a treatment authority or treatment support order to inpatient for the purpose of an authorised doctor reviewing the patient's treatment and care,
- Provides that a person representing someone at a hearing must represent the person's views, wishes and preferences to the extent the person is able to express them, and represent the person's best interests if the person is unable to express them,
- Includes a regulation-making power to prescribe other types of hearings where legal representation must be provided,
- Enables the Tribunal President to refer questions of law to the Mental Health Court,
- Makes other procedural improvements to the provisions related to the Mental Health Review Tribunal,
- Amends the terminology 'court treatment order' to 'treatment support order'.[50]

3.6.7 Mental Health Court

The Mental Health Court established under the current Act would continue under both Bills.[51] It is constituted by a member (a Supreme Court judge[52]) sitting alone, generally assisted by one or two clinicians.[53] The clinicians may be psychiatrists, or for a hearing relating to a person with an intellectual

47 Government Bill, Chapter 12; Private Member's Bill, Chapter 12. See also: government Bill, Explanatory Notes, page 6; Private Member's Bill, Explanatory Notes, pages 3-4.
48 Private Member's Bill, cl.395.
49 Department of Health, *Comparison of Key Provisions – Mental Health Bill 2014 and Mental Health Act 2000*, http://www.parliament.qld.gov.au/documents/Committees/HCSC/2014/MentalHealthB14/tp-11Dec2014-mhb1rev.pdf, pages 9-10.
50 Correspondence, Minister for Health and Minister for Ambulance Services, 28 September 2015.
51 Government Bill, cl. 635; Private Member's bill, cl. 666.
52 Government Bill, cl.639; Private Member's Bill, cl.670.
53 Government Bill, cl.636(2) provides for either one or two clinicians to assist; Private Member's Bill, cl.667(2) requires that there be two clinicians.

disability, a clinician may be a person with expertise in the care of people with an intellectual disability.[54] The jurisdiction of the Mental Health Court remains largely unchanged by the Bills.[55]

3.7 Application of the Bills to private health care providers

The Bill applies to private providers to the extent that they wish to be an AMHS. A private hospital that is an AMHS may exercise the various powers under the Bill. The relevant protections under the Bill also apply.

Currently, there are four private AMHS in Queensland - Belmont Private Hospital, Greenslopes Private Hospital, New Farm Clinic and Toowong Private Hospital.[56]

54 Government Bill, cl.636; Private Member's Bill, cl.667.

55 See Government Bill, cl.637; Private Member's Bill, cl.668; Mental Health Act 2000, s 383.

56 See the Schedule of Authorised Mental Health Services as at 9 October 2015, https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/clinical-staff/mental-health/amhs_schedule.pdf

4. Examinations, assessments and treatment authorities

4.1 Introduction

Involuntary treatment under the *Mental Health Act 2000* is for persons with a mental illness who, because of illness at a particular time, cannot make decisions about their own treatment and care, and therefore do not have the capacity to consent to mental health treatment.[57] The Bills regulate providing treatment and care to such people without their consent, but with a greater focus than the Act on protecting the patient's rights by providing 'that treatment without a person's consent can only occur if the person is unable to consent and if there is a serious risk of harm to the person or others'.[58] A greater focus is also placed on whether there is a 'less restrictive way', than involuntary treatment, to treat and care for the person with a mental illness.[59]

4.2 Overview – steps leading to involuntary treatment

There are two basic steps that lead to involuntary treatment– examination and assessment.[60] Under the current Act and the Bills, an examination of a person who may have a mental illness must occur to establish whether a person should be assessed. The doctor who performs the examination may make a recommendation for assessment. The assessment then informs a determination on whether the person requires involuntary treatment.

The current provisions in the Act are complex and the statutory documents required for involuntary treatment complicate the aforementioned three steps. Issues identified in the Review of the Act included:

- there are too many documents leading to the involuntary treatment,
- there are insufficient checks and balances on the making of justices examination orders,
- the majority of individuals placed on emergency examination orders have no underlying mental illness,
- the treatment criteria is not unequivocally based on a person's lack of consent to treatment, and
- the treatment criteria do not take a longitudinal approach to diagnosis.[61]

Substantial changes have been proposed in both Bills to address these concerns, particularly the process of obtaining an order to examine a person to determine whether they need to be assessed for involuntary treatment. A number of changes are also made to the legislation regarding an order for involuntary treatment.

Table 3, below, outlines the current and proposed provisions, including the statutory documents required, who can instigate proceedings for an examination, assessment and treatment, and the criteria to be used by the decision-maker regarding the making of an order.

57 Transcript of proceedings, 11 December 2014, page 2.
58 Queensland Parliament, Record of Proceedings, 27 November 2014, page 4085.
59 Explanatory Notes, page 1.
60 Queensland Health, Review of the Mental Health Act 2000: Discussion Paper (May 2014), available at http://www.qmhc.qld.gov.au/wp-content/uploads/2014/02/Mental-Heath-Act-Discussion-Paper.pdf (accessed 15 November 2015)
61 Queensland Health, Review of the Mental Health Act 2000: Discussion Paper (May 2014), page 8.

Table 3

	Order	Statutory documents	Instigating persons	Criteria
Examination	**Current Act**	Justices examination order	Any person may apply to a magistrate or a justice of the peace (JP) for a justices examination order	Decision made by magistrate or JP using criteria specific to a justices examination order
		Emergency examination order	Ambulance or police officer, or a private psychiatrist	Decision is made by police or ambulance officer or private psychiatrist using criteria specific to emergency circumstances
	Mental Health Bill and Mental Health (Recovery Model) Bill	Examination authority	The administrator, or person authorised by the administrator, of an authorised mental health service (AMHS), or a person who has received clinical advice about the person who is the subject of the application	Decision is made by the Mental Health Review Tribunal, based on treatment criteria, efforts to engage the person in voluntary treatment and clinical input
Assessment	**Current Act**	Request for assessment*	Any person may complete a Request for Assessment	Form may be completed by an adult who believes that a person has a mental illness and requires involuntary assessment, and has observed the person within three days before making the request
		Recommendation for assessment*	The authorised doctor who undertakes the examination	Decision is made by authorised doctor using criteria specific to assessment
	Mental Health Bill and Mental Health (Recovery Model) Bill	Recommendation for assessment	The authorised doctor who undertakes the examination	Decision is made by the examining doctor who forms the view that the treatment criteria apply to the person and there is no less restrictive way for the person to receive treatment and care
Treatment	**Current Act**	Involuntary treatment order	The authorised doctor who undertakes the assessment	Decision is made by authorised doctor using criteria specific to treatment order
	Mental Health Bill and Mental Health (Recovery Model) Bill	Treatment authority	The authorised doctor who undertakes the assessment	Decision is made by the authorised doctor using the treatment criteria and considers whether there is a less restrictive way for the person to receive treatment and care

4.3 Examination

The Bills remove the provisions for a request for assessment, justices' examination order (JEO) and emergency examination orders (EEO), and instead make provision for one statutory document in the form of an examination authority (EA).[62]

Consistent with the Act, under an EA a doctor or authorised mental health practitioner may examine a person to decide whether to make a recommendation for assessment. An EA continues to provide the power to enter premises and detain a person for an examination to determine whether a recommendation for assessment should be made, or to transfer a person to an AMHS if necessary for the examination to occur.[63] However, the process to apply for an EA in the Bill is different to that of obtaining the assessment documents under the current Act.[64]

4.3.1 What happens now?

Request for assessment

The request for assessment has been replaced in the Bills. Queensland Health, in the Background Paper to the Review in 2014, stated that requests for assessment are primarily made by another staff member of the AMHS after the recommendation for assessment is made, to ensure compliance with the Act. Hence, the current process is not seen to create additional safeguards for the person with a mental illness.[65]

Justices examination order

The review of the Act identified concerns with how JEOs operate. Under the JEO process a magistrate or justice of the peace is required to form a reasonable belief that a person has a mental illness, however it is not clear how they manage this without clinical advice. Furthermore, the magistrate or justice of the peace does not see the person who is alleged to have a mental illness, and is therefore reliant on the information provided in the application.[66]

The Committee was advised that, in most Australian jurisdictions, the assessment and entry into the mental health system relies upon clinical expertise. Queensland is the only Australian jurisdiction where justices of the peace are used in such a way. This arrangement was introduced to enable people in rural and remote communities access to the services of the Mental Health system.

There are valid concerns in the community that JEOs may be sought for vexatious or malicious reasons, e.g. in family disputes, and also used as a way of gaining guardianship control over elderly persons. Data obtained during the review of the Act and considered by the HCSC during its inquiry into the 2014 Bill, supported these concerns; in the majority of cases there was no basis on which the person subject to a JEO was assessed as meeting the criteria for involuntary assessment.[67]

The criteria to be used by a magistrate or justice of the peace when deciding whether to make a JEO have also been identified as broad and do not reflect the treatment criteria.[68] The Act provides that the magistrate or justice of the peace may make the JEO if they reasonably believe:

- the person has a mental illness
- the person should be examined to decide whether a recommendation for assessment should be made

62 Government Bill, cl.31; Private Member's Bill, cl.31.
63 Government Bill, cl.31; Private Member's Bill, cl.32.
64 See Government Bill, cl. 500; Private Members' Bill, cl. 466.
65 Queensland Health, Review of the Mental Health Act 2000 – Background Paper 1 (May 2014)
66 Queensland Health, Review of the Mental Health Act 2000 – Background Paper 1 (May 2014)
67 Queensland Health, Review of the Mental Health Act 2000 – Background Paper 1 (May 2014)
68 Queensland Health, Review of the Mental Health Act 2000 – Background Paper 1 (May 2014)

- an examination cannot properly be carried out unless the order is made. [69]

The above criteria do not require the magistrate or justice of the peace to consider evidence that the person may lack the capacity to consent to treatment, a fundamental part of the Act.

4.3.2 An examination authority under the Bills

As noted above, the Bills replace the JEOs with an 'Examination Authority'. The purpose of an involuntary examination is to determine whether an involuntary assessment and, subsequently, involuntary treatment, is required.

Who can apply for an examination authority?

Under the Bills, if a person believes someone has a mental illness and may require involuntary treatment, they must seek clinical advice, such as from a doctor or authorised mental health practitioner, before considering an application. All applications for an EA are to be made to the MHRT, which has expertise in dealing with mental illness.
The following persons may apply to the Tribunal for an examination authority for another person:

- the administrator of an AMHS,
- a person authorised in writing by the administrator of an AMHS to make an application,
- a person who has received advice, from a doctor or authorised mental health practitioner, about the clinical matters for the person who is the subject of the application.[70]

The application must include a statement by a doctor or authorised mental health practitioner about whether the behaviour of the person, or other relevant factors, could reasonably be considered to satisfy the requirements for making an examination authority for the person.[71]

In contrast to the Act, which allows anyone to apply for a JEO,[72] the limitation in the Bills on who may apply for an EA, will address the concerns around vexatious use of the JEO applications and potentially reduce the number of incidences where inappropriate or unnecessary examinations can be undertaken.

Committee comment

While there is general support for the proposed removal of the JEO's for the reasons above, concerns have been raised in relation to the requirement for a person to seek clinical advice before making an application to the Tribunal. The purpose for the applications for a JEO, currently, or an EA under the Bills, is to provide necessary medical intervention to treat or prevent a person from deteriorating.

Should either of the Bills pass, clear information and advice on how to access the Tribunal should be made available as part of the implementation of the new Act. This should provide clear and easily accessible advice to people who may have a loved one suffering from a mental illness who requires immediate care and attention. The justices of the peace provided a link, particularly in rural and remote areas for people to seek and receive the medical assistance. It is important that the proposed amendments do not unduly delay necessary medical intervention for a person suffering from an acute mental illness.

The Committee seeks clarification from the Minister and the Member for Caloundra that the changes to the requirements around applications to the Tribunal for an examination authority will not prevent access to necessary medical intervention to prevent the deterioration of persons in need of an Examination Authority, particularly in rural and remote areas.

69 *Mental Health Act 2000*, s. 28.
70 Government Bill 5, cl.500(1); Private Member's Bill, cl.466(1).
71 Government Bill, cl.500(2); Private Member's Bill, cl.466(2).
72 *Mental Health Act 2000*, s. 27.

What must the Tribunal consider?

Under the Bills, the Tribunal must hear the application and issue, or refuse to issue, an examination authority for the person.[73]

The Tribunal may issue an examination authority for the person only if the Tribunal considers:

- the person has, or may have, a mental illness
- the person does not, or may not, have capacity to consent to be treated for the mental illness and either:
  - reasonable attempts have been made to encourage the person to be treated voluntarily for the person's mental illness, or
  - it is not practicable to attempt to encourage the person to be treated voluntarily for the person's mental illness, and
- there is, or may be, an imminent risk, because of the person's mental illness, of:
  - serious harm to the person or someone else, or
  - the person suffering serious mental or physical deterioration.[74]

Powers under an examination authority

An examination authority allows a doctor or an authorised mental health practitioner to examine a person to determine whether to make a recommendation for assessment of the person.

The examination authority must state the AMHS responsible for the examination of the person under the authority,[75] and remains in force for 7 days after it is issued.[76]

If a person is subject to an examination authority, a doctor or authorised mental health practitioner may, under clause 32:

- enter certain places to find the person,
- examine the person without the person's consent,
- detain the person at the place at which the person is examined for the period reasonably necessary for the examination.

If it is clinically appropriate, an authorised person may transport the person to an AMHS or public sector health service facility for the examination.[77]

A doctor or authorised mental health practitioner may exercise a power under clause 32 with help, and using the force, that is necessary and reasonable in the circumstances.[78]

Before performing a function or exercising a power under clause 32 in relation to a person, a doctor or authorised mental health practitioner must do or make a reasonable attempt to do the following:

- identify himself or herself to the person,
- tell the person an examination authority has been made,
- explain to the person, in general terms, the nature and effect of the authority,
- if requested, give the person a copy of the authority,

73 Government Bill, cl.501, cl 502; Private Member's Bill, cl.467, cl. 468.
74 Government Bill, cl.502(2); Private Member's Bill, cl.468(2).
75 Government Bill, cl.502(3)(b); Private Member's Bill, cl.468(3)(b).
76 Government Bill, cl.503; Private Member's Bill, cl.469.
77 Government Bill, cl.32; Private Member's Bill, cl.32.
78 Government Bill, cl.33; Private Member's Bill, cl.33. For performing a function or exercising a power under clause 32 in relation to a person, a doctor or authorised mental health practitioner is a public official for the Police Powers and *Responsibilities Act 2000*: Government Bill, cl.34; Private Member's Bill, cl.34.

- if the doctor or authorised mental health practitioner is entering a place – give the person an opportunity to allow the doctor or health practitioner immediate entry to the place without using force.

However, the doctor or mental health practitioner need not comply with the listed requirements if the doctor or health practitioner believes on reasonable grounds that it would frustrate execution of the authority.[79]

The Government Bill provides additional safeguards requiring the doctor or authorised mental health practitioner must give a copy of the authority to the person's nominated support persons, personal guardian or attorney, if requested.[80]

4.4 Amendment of the *Public Health Act 2005*

What happens now?

Under the current Act, an involuntary emergency examination order (EEO) may be made if a police officer or an ambulance officer takes a person to an AMHS in emergency circumstances because they believe:

- *the person has a mental illness,*
- *there is an imminent risk of physical harm to the person or someone else,*
- *the person should be taken to an AMHS for examination to decide whether assessment documents should be made for the person*.[81]

Once the person is taken to the AMHS, the police officer or ambulance officer must make an EEO and provide it to a health service employee at the health service.[82]

The Bills do not provide for EEOs because the review of the Act found that the majority of people taken to an AMHS under the emergency provisions, in the belief they have a mental illness, are instead suffering from drug or alcohol abuse, and have no underlying mental illness that warrants action under the Act.[83] Of the 11,182 EEOs made in 2013-14, 3,012 (27%) resulted in assessment documents being made and 8,170 (73%) did not result in assessment documents being made.[84]

It is alarming that 73% of the EEOs made by ambulance officers and police officers under the Act in 2013-14 did not meet the assessment criteria. It is not appropriate to continue to use involuntary mental health powers under the *Mental Health Act* to deal with the issues around people affected by, or suffering from drug and alcohol abuse.

Emergency examination authorities

Both Bills propose to amend the *Public Health Act 2005* to insert a new Chapter 4A.[85] Chapter 4A would empower ambulance officers or police officers to detain and transport, using the force that is necessary,[86] a person to a treatment or care place[87] who, amongst other things, is at immediate risk of harm.[88]

79 Government Bill, cl.35; Private Member's Bill, cl.35.
80 Government Bill, cl.35(3).
81 *Mental Health Act 2000*, ss. 33-35.
82 *Mental Health Act 2000*, s. 40.
83 Review of the Mental Health Act 2000 – Background Paper 1.
84 Director of Mental Health, Annual Report 2013–2014, page 17, available at: http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2014/5414T6701.pdf
85 Government Bill, cl.917-920; Private Member's Bill, cl.870-874.
86 Government Bill, cl. 919; Private Member's Bill, cl.872 (proposed new section 157G).
87 A public sector health service facility, AMHS or another place, other than a watch house, where a person may receive treatment and care appropriate to the person's needs.
88 For example, threatening to commit suicide, see Government Bill, Explanatory Notes, page 2.

The proposed emergency transport powers under the amended *Public Health Act* would apply 'in emergency situations for persons who appear to have a mental illness, as well as persons who are significantly affected by drugs or alcohol.'[89]

The Government Bill redrafts the criteria for placing a person on an emergency examination authority (EEA) to place emphasis on high-risk individuals who need urgent treatment.[90]

Similar to the current Act, where an ambulance officer or police officer takes a person to a public sector health service facility or an AMHS, the officer must immediately make an EEA for the person.[91] Also, as with the current Act, a person who is subject to an EEA may be detained for a period (examination period) of up to six hours. However, the Bills propose to extend the period up to 12 hours if a doctor or health practitioner considers it necessary to carry out or finish the examination.[92]

As with the current Act, an examination of a person subject to an EEA may be made without the consent of the person or anyone else. A person lawfully examining the person, or lawfully helping to examine the person, may use the force that is necessary and reasonable in the circumstances to examine, or help examine, the person. [93] An examination may be carried out using an audiovisual link if the doctor or health practitioner believes it is clinically appropriate.[94]
If a recommendation for assessment is not made for the person, the person in charge of the facility or the administrator of the service must take reasonable steps to ensure the person is returned to a place reasonably requested by the person.[95]

The powers that can be exercised under an EEA are similar to those under an EEO under the current Act. The review provisions are also comparable to those that currently apply for involuntary treatment orders.[96]

The Bills also discontinue the powers for psychiatrists to issue EEOs under the new provisions in the *Public Health Act 2005*. This appears reasonable as these powers were rarely used. In 2013-2014 financial year, psychiatrist made only 25 of the 11,182 EEOs, this is less that 1% and is comparable to 2012–2013 results.[97]

4.4.1 Return of persons who abscond

The Government Bill provides for the situation in which a person absconds from a public sector health service facility or AMHS while being detained under proposed new Chapter 4A of the *Public Health Act 2005*. A person in charge of a public sector health service facility or the administrator of an AMHS may authorise persons (that is, certain appropriately qualified health service employees or security officers) to transport the person to a public sector health service facility or an AMHS or ask a police officer to transport the person. Before giving the authorisation or request, the person in charge or administrator must make reasonable efforts to contact the person and encourage the person to come, or return, to

89 Department of Health, *Comparison of Key Provisions – Mental Health Bill 2014 and Mental Health Act 2000*, http://www.parliament.qld.gov.au/documents/Committees/HCSC/2014/MentalHealthB14/tp-11Dec2014-mhb1rev.pdf, page 2.
90 Correspondence, Minister for Health and Minister for Ambulance Services, 28 September 2015
91 Government Bill, cl. 919; Private Member's Bill, cl.872 (proposed new section 157D).
92 Government Bill, cl. 919; Private Member's Bill, cl.872 (Proposed new section 157E).
93 Government Bill, cl. 919; Private Member's Bill, cl.872 (proposed new section 157J).
94 Government Bill, cl. 919; Private Member's Bill, cl.872 (proposed new section 157F).
95 Government Bill 2015, cl.919; Private Member's Bill, cl.872.
96 Department of Health, *Comparison of Key Provisions – Mental Health Bill 2014 and Mental Health Act 2000*, http://www.parliament.qld.gov.au/documents/Committees/HCSC/2014/MentalHealthB14/tp-11Dec2014-mhb1rev.pdf, page 2.
97 Director of Mental Health, Annual Report 2013–2014, page 18.

the public sector health service facility or AMHS. The authorisation is in force for three days after the person absconds.[98]

4.4.2 Warrant for apprehension of person to transport

Under the Government Bill, an authorised person may apply to a magistrate for a warrant for apprehension of the person, where necessary, to enable an authorised person to transport the person to a public sector health service facility or AMHS for examination.[99] A warrant may be issued if the magistrate is satisfied it is necessary. The warrant authorises an authorised person to:

- enter any one or more places the authorised person reasonably believes the person is,
- search the places to find the person,
- remain in the places for as long as the authorised person considers it reasonably necessary to find the person, and
- transport the person to a stated public sector health service facility or stated AMHS.[100]

An authorised person may exercise the powers under the warrant with the help, and using the force, that is reasonable in the circumstances. Before entering a place under the warrant the authorised person must do or make a reasonable attempt to do the following things unless immediate entry is required to ensure the effective execution of the warrant is not frustrated:

- identify himself or herself to a person present at the place,
- give the person a copy of the warrant,
- tell the person the authorised person is permitted by the warrant to enter and search the place to find the person named in the warrant,
- give the person an opportunity to allow the authorised person immediate entry to the place without using force.

The warrant ends within seven days of its issue.

An application for a warrant may be made electronically in urgent circumstances or other special circumstances, such as the authorised person's remote location, where the magistrate is satisfied that it was necessary to make the application in that way.[101]

4.4.3 Searches of persons in treatment or care place – Government Bill

The Government Bill provides an additional safeguard for staff and patients of a public health service facility or an AMHS by allowing a doctor or health practitioner to conduct a search of a person who is detained for an examination to be searched in limited circumstances.[102]

Where a doctor or health practitioner believes a person, under examination may have possession of a harmful thing,[103] the doctor or health practitioner may, without the person's consent:

- carry out a general search, scanning search or personal search of the person,
- if the person in charge of the public sector health service facility or the administrator of the AMHS gives approval for a search requiring the removal of clothing – carry out a search requiring the removal of clothing, and
- carry out a search of the person's possessions.

A 'harmful thing' is defined in the Government Bill as:

> ***harmful thing*** *means anything—*

98 Government Bill, cl. 919; Private Member's Bill, cl.872 (proposed new sections 157G to 157K).
99 Government Bill, cl. 919; Private Member's Bill, cl.872 (proposed new sections 157Q to 157V).
100 Government Bill, cl. 919; Private Member's Bill, cl.872 (proposed new sections 157Q to 157V)
101 Government Bill, cl. 919; Private Member's Bill, cl.872 (proposed new sections 157Q to 157V)
102 Government Bill, cl. 919 (see proposed new sections 157W to 157ZF).
103 Government Bill, cl. 919; (see proposed new sections 157W to 157ZF).

(a) that may be used to—

(i) threaten the security or good order of a public sector health service facility or authorised mental health service; or

(ii) threaten a person's health or safety; or

(b) that, if used by a patient in a public sector health service facility or authorised mental health service, is likely to adversely affect the patient's treatment or care.

Examples of harmful things—

• a dangerous drug

• alcohol

• medication

• provocative or offensive documents.[104]

A doctor or health practitioner may carry out a search with the help, using the force that is necessary and reasonable in the circumstances.

The searcher may seize anything found during the search that the searcher reasonably suspects is connected with, or is evidence of, the commission or intended commission of an offence against an Act, or a harmful thing.

Certain protections apply to the searches, including that only a person of the same gender can touch clothing worn by a person and searches must be carried out in a part of a building that ensures the person's privacy.[105]

There is no comparable clause in the Private Member's Bill.

Committee comment

The Committee is satisfied that the searches in the Government Bill provide a necessary protection for our medical professionals and the person under examination who may have in their possession harmful things that could harm themselves or others. The safeguards around such searches are sufficient in relation to the searches.

4.5 Recommendation for assessment

Once the examination has taken place, the current Act outlines assessment criteria as the basis for a doctor or authorised mental health practitioner to decide if a recommendation for assessment should be made. These criteria are different to those used for examinations, and the review of the *Mental Health Act 2000* described them as a 'backward modification' of the treatment criteria, which adds to the complexity of the current Act.[106]

Under the Bills, there are no longer separate assessment criteria and treatment criteria. The Bills propose that an authorised doctor or authorised mental health practitioner use 'treatment criteria' to inform their decision in making a recommendation for assessment. The doctor or authorised mental health practitioner may make a recommendation for assessment if satisfied that, on an assessment of the person:

- an authorised doctor may form the view that the treatment criteria (may[107]) apply to the person and,

104 Government Bill, cl. 919; (proposed new sections 157X)
105 Government Bill, cl. 919; (proposed new sections 157W to 157ZF).
106 Review of the Mental Health Act – Background Paper 1, page 12.
107 Government Bill, cl.39(1)(a).

- there is,[108] or appears to be,[109] no less restrictive way for the person to receive treatment and care for the person's mental illness.

The recommendation for assessment must be made within seven days after the examination.[110]

Both Bills provide that a recommendation for assessment is in force for seven days.[111]

A recommendation for assessment may be revoked at any time before the start of the assessment period by the doctor or authorised mental health practitioner if it subsequently appears that the treatment criteria would not be met or there is a less restrictive way to treat the person. [112] These actions are not provided for under the current Act.

Additional measures in the Government Bill

Once the recommendation for assessment is made, the Government Bill provides for communication with the person regarding the decision and its effects, unless it is not in the person's best interests to do so,[113] or may adversely affect the health and wellbeing of the person.[114]

Clause 40(3) of the Government Bill requires the doctor or authorised mental health practitioner to give a copy of the recommendation to the person's nominated support persons, personal guardian or attorney, if requested.

Clauses 36 to 38 of the Government Bill would allow a doctor or authorised mental health practitioner to detain a person for up to one hour to make the assessment recommendation. Reasonable force may be used to detain the person under these clauses. The doctor or authorised mental health practitioner must make a reasonable attempt to explain the situation to the person being detained. The reasons for, and duration of, the detention must be recorded in the person's health records.

4.4.4 Stakeholder views

The Queensland Section of the Australian Psychological Society's College of Forensic Psychologists (the College) was of the view that the assessment criteria should be retained. The College considers that, otherwise it will be likely that individuals, especially those in custody, who require an assessment will not receive it. This would not be in keeping with the forensic mental health principle that prisoners and detainees have the same rights to availability, access and quality of mental health care as the general population.[115]

The Queensland Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) advocated amending the Government Bill so that the assessment criteria focus on whether the person 'appears to have mental illness' rather than 'has a mental illness'. This, it contended, would help clarify whether the treatment criteria apply. [The Private Member's Bill treatment criteria includes this distinction.[116]]

Committee comment

The Committee notes that the review of the *Mental Health Act 2000* showed the current assessment criteria added to the complexity of the Act. When the complexity relates to the assessment, possible detention and treatment of a person, it is important that the legislation is clear and unambiguous. However, the Committee seeks clarification from the Minister and from

108 Private Member's Bill, cl.36(1)(b).
109 Government Bill, cl.39(1)(b).
110 Government Bill, cl.39; Private Member's Bill, cl.36.
111 Mental Health Bill 2015, cl.41; Private Member's Bill, cl.38. The Government Bill provides that it is in force for seven days after the day it is made. The Private Member's Bill provides that it is in force for seven days after it is made.
112 Government Bill, cl.42; Private Member's Bill, cl.39.
113 Government Bill, cl.40; Private Member's Bill, cl.37.
114 Government Bill, cl.40(2)
115 Submission 59, page 3.
116 Submission 33, pages 1-2. See also Private Member's' Bill, cl.12.

the Member for Caloundra as to why it is better to remove the assessment criteria and retain, instead, just treatment criteria.

Recommendation 1

The Committee recommends that the Minister for Health and Minister for Ambulance Services advise the House of the benefits of not having separate assessment criteria and treatment criteria in the Mental Health Bill 2015.

Recommendation 2

The Committee recommends that the Member for Caloundra advise the House of the benefits of not having separate assessment criteria and treatment criteria in the Mental Health (Recovery Model) Bill 2015.

4.6 Assessments

The powers proposed in the Bills that can be exercised in assessing a person, including detention of the person, are comparable to the current Act. However, unlike under the current Act, the Bills do not have separate assessment criteria and treatment criteria.[117]

The Bills provide that an authorised doctor may make an assessment of a person subject to a recommendation to decide whether the treatment criteria apply to the person and whether there is a less restrictive way for the person to receive treatment and care for the person's mental illness.[118]

The current Act provides that where an authorised doctor who is a not psychiatrist made a recommendation for assessment and treatment order for the same person, or where a treatment order was made after an audiovisual only assessment, a psychiatrist must confirm or revoke the order within 72 hours.[119] The current situation creates the possibility of involuntary detention and treatment of a person pending the confirmation or revocation of the order by a psychiatrist under s. 112 of the *Mental Health Act 2000*.

The Bills provide that the authorised doctor who undertakes the assessment must not be the doctor who makes the recommendation for assessment. However, the Bills retain the ability for an authorised doctor in a regional, rural or remote area (as designated by the Chief Psychiatrist) to make a recommendation for assessment and treatment authority for the same person so that the provision of mental health services in these areas is not restricted.[120]

The authorised doctor must take reasonable steps to find out whether there is a less restrictive way for the person to receive treatment and care for the person's mental illness, including, for example, by searching the person's health records to find out whether the person has made an AHD or has a personal guardian.[121]

A person may be assessed in an AMHS, a public sector health service facility, or another place considered clinically appropriate by the authorised doctor making the assessment.

117 *Mental Health Act 2000*, ss.13, 14.
118 Government Bill, cl.43(3); Private Member's' Bill, cl.40(3).
119 *Mental Health Act 2000*, ss. 108-112
120 Government Bill, cl.43(3); Private Member's' Bill, cl.40(3).
121 Government Bill, cl.43; Private Member's' Bill, cl.40.

An authorised person may transport the person to an AMHS or a public sector health service facility for assessment.[122]

Both Bills mandate that an authorised doctor making an assessment of a person must discuss the assessment with the person.[123] The Private Member's Bill also requires the authorised doctor to discuss the assessment, to the extent practicable, with:

- the person's nominated support person, if any, and
- the person's family, carers and other support persons, and
- the person's personal guardian, if any, and
- the person's attorney, if any.[124]

A person may be detained for assessment at a service or facility for up to 24 hours. Prior to the end of the period, the authorised doctor making the assessment of the person may extend the period to not more than 72 hours after it starts if it is necessary to carry out or finish the assessment. Once the authorised doctor making the assessment makes a decision, the assessment period ends.[125]

If an authorised doctor assesses a person and decides the treatment criteria do not apply to the person or there is a less restrictive way for the person to receive treatment and care for the person's mental illness, the authorised doctor must tell the person of the decision and explain its effect to the person. The Government Bill additionally requires the authorised doctor to make a note on the recommendation for assessment of the decision not to make a treatment authority for the person.[126]

The Queensland Section of the Australian Psychological Society's College of Forensic Psychologists raised concerns around the different standards for regional, rural and remote people regarding assessment and treatment orders. Their concerns focussed on the same authorised doctor who made a recommendation for assessment of a person also making the assessment, and contended that the second assessment or review could be conducted using teleconference/videoconference equipment.[127]

Committee comment

The Committee is cognisant that some regional/rural and remote areas may have limited professional staff and some of the requirements placed on facilities in urban areas may not be feasible in regional / rural and remote areas.

The Committee seeks assurance from the Minister and the Member for Caloundra that the Bills will not compromise patient care for regional/rural and remote areas.

Recommendation 3

The Committee recommends that the Minister for Health and Minister for Ambulance Services advise the House of the safeguards under the Mental Health Bill 2015 for patients in regional/rural and remote areas, particularly regarding the making an assessment of a person subject to a recommendation for assessment, and reviewing a treatment authority if not made by a psychiatrist.

122 Government Bill 2015, cl.44; Private Member's Bill, cl.41.
123 Government Bill 2015, cl.44(3); Private Member's Bill, cl.41(3).
124 Private Member's Bill, cl.41(3).
125 Government Bill 2015, cl.45; Private Member's Bill, cl.42. Records must be made of the time of the commencement of assessment period: Government Bill 2015, cl.46; Private Member's Bill, cl.43.
126 Government Bill 2015, cl.47; Private Member's Bill, cl.44.
127 Submission 59. Similar provisions apply under the Private member's Bill, cls.40, 51.

Recommendation 4

The Committee recommends that the Member for Caloundra advise the House of the safeguards under the Mental Health (Recovery Model) Bill 2015 for patients in regional/rural and remote areas, particularly regarding the making an assessment of a person subject to a recommendation for assessment, and reviewing a treatment authority if not made by a psychiatrist.

4.7 Treatment

Under the current Act, once a person has been assessed, involuntary treatment can be provided to the person if an authorised doctor assessing the person with a mental illness is satisfied the treatment criteria apply to the person. An involuntary treatment order (ITO) is made authorising involuntary treatment for the person's mental illness, and for a patient on an inpatient category, detention in an AMHS.[128]

Under the Bills, a treatment authority would replace ITOs that are available under the current Act. A treatment authority may only be made by an authorised doctor,[129] and provides 'a lawful authority to treat a person with a mental illness who lacks the capacity to consent to treatment.'[130]

Both Bills provide for the making of treatment authorities for persons who have a mental illness if the treatment criteria apply to the person and there is no less restrictive way for the person to receive treatment and care for the person's mental illness.[131]

The name change reflects the refocus of the treatment criteria so that decisions regarding involuntary treatment are based on a person's lack of capacity to consent to treatment and the risk of serious harm to the person or others. The shift in focus has been designed to make the use of involuntary treatment an option of last resort where there is a less restrictive way of treating the person.[132]

The Bills would make minor amendments to the current meaning of 'treatment criteria'. The treatment criteria for a person are all of the following:

- the person has a mental illness,
- the person does not have capacity to consent to be treated for the illness (the person's own consent only is relevant, despite the *Guardianship and Administration Act 2000*, the *Powers of Attorney Act 1998* or any other law),
- because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in imminent serious harm to the person or others, or the person suffering serious mental or physical deterioration.[133]

In addition to strengthening and safeguarding patient rights, the revised treatment criteria have been described as taking a more longitudinal approach to the diagnosis of mental illness, 'enabling clinicians to consider whether a person may deteriorate in the absence of involuntary treatment'. The aim of this approach is to support continuity of care and reduce the incidence of people 'cycling' on and off treatment authorities.[134]

128 *Mental Health Act 2000*, ss. 108-112
129 Government Bill, cl.49; Private Member's Bill, cl.46; Government Bill, Explanatory Notes, p.1; Private Member's Bill, Explanatory Notes, page 1.
130 Government Bill, Explanatory Notes, page 1; Private Member's Bill, Explanatory Notes, page 1.
131 Government Bill, cl.30; Private Member's Bill, cl.30.
132 Government Bill, Explanatory Notes, pp. 13-14;Private Member's Bill, Explanatory Notes, page 1.
133 Government Bill, cl.12; Private Member's Bill, cl.12.
134 Queensland Health, Review of *Mental Health Act 2000* Summary of proposals, page 2.

The Queensland Mental Health Commission (QMHC) supports the provisions relating to the making of treatment authorities based on the treatment criteria. The Commission was strongly supportive of 'consideration of the patient's wishes and views when deciding the nature and extent of treatment and care to be provided under a treatment authority and specifically requiring that the authorised doctor talk to the patient'.[135]

4.7.1 Less restrictive way

Both Bills place a greater emphasis on a 'less restrictive way' to treat the person (rather than involuntary treatment) as a means of reducing the adverse effects on the rights and liberties of the person. 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 the treatment and care that is reasonably necessary for the person's mental illness in one of the following ways:

- if the person is a minor – with the consent of the minor's parent
- if the person has made an AHD – under the AHD
- if a personal guardian has been appointed for the person – with the consent of the personal guardian
- if an attorney has been appointed by the person – with the consent of the attorney
- in certain circumstances – with the consent of the person's statutory health attorney.

The alternatives must be considered in the order they are listed.[136]

The Government Bill provides additional safeguards around AHDs, (discussed in Chapter 7.10).

The Government Bill additionally provides that a person performing a function or exercising a power under the proposed Act must comply with relevant policies made by the Chief Psychiatrist.[137]

The Committee notes the views of the Queensland Mental Health Commission (QMHC) that least restrictive practices 'form an essential foundation to a recovery-oriented approach to mental health service delivery and have been accepted internationally and nationally as best practice.'[138]

Janssen Pharmaceutical Companies expressed support for increased planned use of AHDs, personal guardians and attorneys as less restrictive ways of treatment rather than automatic involuntary treatment. However, it sought greater clarity around the term 'less restrictive care'.[139]

The Public Advocate 'fully'[140] supports the least restrictive principle because it 'means the least interference with a person's rights and liberties when providing treatment and care and as such also enables people with mental illness to better … direct their own treatment.'[141]

The Public Advocate had the following concerns:

- the significant policy change represented by the reliance on Queensland's guardianship system without appropriate consideration of policy, practice and resource impacts
- the unresolved question of the lawfulness of guardians' consent to treatment for mental illness where a person is objecting to enforcement of their decisions (or authorisation of others to enforce them) and authorisation of detention of a person in an AMHS, and

135 Submission 14, page 22.
136 Government Bill, cl.13; Private Member's Bill, cl.13.
137 Government Bill, cl.13(2)(b).
138 Submission 14, page 11.
139 Janssen Pharmaceutical Companies, Submission 75, page 3.
140 Submission 32, page 3.
141 Submission 32, page 3.

- the possibility that guardianship could be used as a way to circumvent the safeguards that currently attach to involuntary treatment, such as satisfying the necessary criteria and independent overview by the Tribunal.[142]

The Office of the Public Guardian (OPG) stated that there are likely to be more guardians and attorneys exercising a decision-making power in relation to mental health treatment and care under the 'less restrictive way'. As a result, there would be an increased risk of the powers being exercised inappropriately, which may require investigation by the OPG. According to OPG, both these things may impact significantly upon the resources of the OPG. [143]

The Committee sought a response from the Department to the issues raised by the OPG. The Department response with regard to the Government Bill is below:[144]

> *The Bill continues the policy under the* Mental Health Act 2000 *for a person to be treated in a 'less restrictive way', instead of making an involuntary treatment order (section 14). The Bill strengthens this by making the express statement that a 'less restrictive way' includes treating a person under an advance health directive, or with the consent of a guardian or attorney. This will be supported by Chief Psychiatrist policies, education and training. This represents a significant strengthening of patient rights.*
>
> *Persons with a mental illness are currently treated under advance health directives, or with the consent of a guardian or attorney under the* Powers of Attorney Act 1998 *and the* Guardianship and Administration Act 2000*. The Bill does not change this. Therefore, to the extent that the Public Guardian has raised issues regarding the operation of these Acts for people with mental illness, these concerns apply irrespective of the passage of the Mental Health Bill 2015.*
>
> *Although it is beyond the scope of the Mental Health Bill to address perceived deficiencies in these other Acts, the Bill provides extensive safeguards for mental health treatment. These will be available to patients being treated under guardianship or an advance health directive.*
>
> *Importantly, restrictive practices such as mechanical restraint and seclusion cannot occur under an advance health directive or with the consent of a guardian or attorney. The only basis on which mechanical restraint or seclusion can be authorised is if the patient is subject to an authority or order under the Bill. Furthermore, the regulation of physical restraint and the appropriate use of medications apply independently of any advance health directive, or the consent of a guardian or attorney, providing additional safeguards.*
>
> *These safeguards are complemented by a range of other protections which are equally available for persons being treated under an advance health directive, or with the consent of a guardian or attorney. For example, the primary role of the Chief Psychiatrist is to protect the rights of patients under the Act. This includes persons being treated under an advance health directive, or with the consent of a guardian or attorney (clause 295). Under this authority, the Chief Psychiatrist may require an administrator to provide information about the treatment and care of these patients, issue binding policies and undertake investigations for this group of patients.*
>
> *Chapter 9 of the Bill (Rights of patients and others) also applies to persons being treated under an advance health directive, or with the consent of a guardian or attorney. This includes:*
>
> - *the preparation of a Statement of Rights*

142 Submission 32, page 3.
143 Submission 73, page 4 and pages 7-8.
144 Correspondence Michael Walsh, Director-General, Queensland Health, dated 5 November 2015.

- *the right to be visited by family, carers and other support persons*
- *the right to be visited by health practitioners*
- *the right to be visited by legal or other advisers*
- *the right to communicate by post, telephone or an electronic communication device*
- *the requirement for an authorised doctor to provide a patient with timely, accurate and appropriate information about the patient's treatment and care, and*
- *the right to seek a second opinion*.

The functions of Independent Patient Rights Advisers include advising these patients on their rights. Independent Patient Rights Advisers are to work cooperatively with community visitors under the Public Guardian Act 2014*, and to consult with authorised doctors, administrators and the Chief Psychiatrist on the rights of patients under the* Powers of Attorney Act 1998 *and the* Guardianship and Administration Act 2000*.*

The responsibility of authorised doctors and administrators of authorised mental health services in providing treatment and care to patients (Chapter 7, part 2) includes persons being treated under an advance health directive, or with the consent of a guardian or attorney.

The above provisions of the Bill represent a major improvement in the rights of patients being treated under an advance health directive, or with the consent of a guardian or attorney.

These protections are in addition to those under the Powers of Attorney Act 1998, the Guardianship and Administration Act 2000 *and the* Public Guardian Act 2014*. The Public Guardian has extensive powers under the* Public Guardian Act 2014*, including investigation powers. The community visitors program (adult and child) is established under this Act. The primary 'visitable site' for community visitors under the adult community visitors program is authorised mental health services.*

The Powers of Attorney Act 1998 *and the* Guardianship and Administration Act 2000 *deal with objections to healthcare and the use of force in treating a person treated under an advance health directive, or with the consent of a guardian or attorney. The submission of the Public Advocate expressed concern about the adequacy of these provisions. However, addressing these concerns is beyond the scope of the Mental Health Bill 2015, and these perceived issues would exist whether the Bill is passed or not.*

Committee comment

These provisions appear to better respect the rights and liberties of the person by ensuring that they have a greater say in their treatment, either by way of prior arrangements such as an AHD, or through the person's parent, guardian or attorney.

The Committee notes the concerns of the Public Advocate and requests that the Minister and the Member for Caloundra address the concerns of the Public Advocate during the second reading debate on the Bills.

Recommendation 5

That the Minister for Health and Minister for Ambulance Services advise the House how the Government intends to address the concerns expressed by the Office of the Public Advocate and the Office of the Public Guardian regarding the 'less restrictive way'.

Recommendation 6

That the Member for Caloundra advises the House how the concerns expressed by the Office of the Public Advocate and the Office of the Public Guardian regarding the 'less restrictive way' could be addressed.

4.8 Treatment authorities

Where an authorised doctor is satisfied the treatment criteria apply to the person and there is no less restrictive way for the person to receive treatment and care for the person's mental illness, the authorised doctor may decide to make a treatment authority for the person.[145]

If a treatment authority is made, the Bills include two categories for the treatment for patients; the inpatient category and community category, which is in keeping with the current Act. However, unlike the current Act, the Bills require that a patient on a treatment authority must be treated in the community unless it is not possible to meet the patient's treatment and care needs in this way.[146] This change is described as supporting a recovery orientation for patients with a mental illness.[147]
The Bills provide that a treatment authority must state the following:

- the grounds on which the authorised doctor is satisfied the treatment criteria apply to the person,
- the AMHS responsible for the person's treatment and care under the authority,
- the category of the authority,
- the nature and extent of the treatment and care to be provided to the person,
- any conditions the authorised doctor considers necessary for the person's treatment and care, and
- under the Government Bill, if the person is categorised as an inpatient, whether limited community treatment is authorised for the person.[148]

4.8.1 Category

Clause 50(2) of the Government Bill provides that if the authorised doctor decides that the category of the authority is inpatient, the AMHS responsible for the person's treatment and care must not be a high security unit without the prior written approval of the Chief Psychiatrist.

Clause 51 of the Government Bill provides that the authorised doctor must have regard to the relevant circumstances of the person in determining the category of the authority. However, the authorised doctor may decide the category of the authority is inpatient only if the authorised doctor considers, after having regard to the relevant circumstances of the person, that one or more of the following cannot reasonably be met if the category of the authority is community:

- the person's treatment and care needs,
- the safety and welfare of the person, and
- the safety of others.

Clause 49 of the Private Member's Bill provides that the authorised doctor may decide the category is inpatient only if satisfied, having regard to the following matters, that the person's treatment and care needs and the safety and welfare of the person and others cannot reasonably be met if the category is community:

145 Government Bill 2015, cl.48, 49; Private Member's Bill, cls.45, 46.
146 Government Bill 2015, cl.50(1); Private Member's Bill, cl.47(1).See also Queensland Parliament, Record of Proceedings, 27 November 2014, page 4086 in relation to similar provisions in the 2014 Bill.
147 Private Member's Bill, Explanatory Notes, page 5
148 Government Bill 2015, cl.50(1); Private Member's Bill, cl.47(1).

- the person's mental state and psychiatric history,
- the person's social circumstances, including, for example, family and social support,
- the person's response to treatment and care and the person's willingness to receive appropriate treatment and care,
- the person's response to any previous treatment in the community.

The category of authority of a classified patient is inpatient.[149]

Both Bills require that in deciding the nature and extent of the treatment and care to be provided to the person under the treatment authority, the authorised doctor must discuss the treatment and care to be provided with the person and have regard to the views, wishes and preferences of the person, to the extent they can be expressed, including, for example, in an AHD.[150] The Private Member's Bill also provides that the authorised doctor must discuss the treatment and care to be provided with the person's nominated support person, if any, and to the extent practicable:

- the person's family, carers and other support persons,
- the person's personal guardian, if any, and
- the person's attorney, if any.[151]

The Bills provide that as soon as practicable after making a treatment authority for a person, the authorised doctor must tell the person of the decision and explain its effect to the person. If the authorised doctor is a psychiatrist, the administrator of the person's treating health service must, within seven days after the treatment authority is made, give the person a copy of the authority and give the Tribunal written notice of its making.[152]

Under the Government Bill, a copy of the authority must be given to the person's nominated support persons, personal guardian or attorney, if requested.[153] If the authorised doctor is not a psychiatrist, the Bills require the administrator of the person's treating health service to give the person a copy of the authority, if requested.[154]

The Queensland Nurses Union (QNU) submitted that additional staffing and resources will be required to accommodate the increased workload due to persons subject to treatment authorities being treated in the community unless an authorised doctor decides that the person's treatment and care needs can only be met by the person being an inpatient.[155]

Committee comment

The Committee recognises the importance of allowing a person to remain in the community and to receive treatment under the less restrictive way wherever possible. While noting resource implications of having to provide care in the community rather than an AMHS, the Committee considers that the better patient outcomes more than justify any increase in resources.

4.8.2 Review process

If a treatment authority is made by an authorised doctor who is not a psychiatrist, an authorised psychiatrist must review the treatment authority and decide to confirm the treatment authority, with

149 Government Bill 2015, cl.51(4); Private Member's Bill, cl.49(3).

150 Government Bill 2015, cl.53; Private Member's Bill, cl.48. If the person has a health directive, and the authorised doctor decides to make a treatment authority despite the directive or the nature and extent of the treatment and care decided by the authorised doctor is inconsistent with the directive, the authorised doctor must explain to the person the reasons why the doctor made the decision and record the reasons in the person's health records: Government Bill, cl.54.

151 Private Member's Bill, cl.48(a).

152 Government Bill 2015, cl.55; Private Member's Bill, cl.50.

153 Government Bill 2015, cl.55(2)(b).

154 Government Bill 2015, cl.55(3)(a); Private Member's Bill, cl.50(3).

155 Submission 27.

or without amendment, or to revoke the treatment authority. The review must happen within three days (*review period*) after the treatment authority is made. However, if the person subject to the treatment authority is the patient of an AMHS (rural and remote[156]) or (regional[157]), the review may be extended period may be extended to a total of seven days if:

- it is not reasonably practicable to complete the review within three days,[158] or
- the authorised psychiatrist is satisfied the extension is necessary to carry out or finish the review.[159]

Both Bills specify that if the treatment authority is not confirmed or revoked within the review period, the treatment authority is revoked.[160]

After a decision is made on a review of a treatment authority for a person, the authorised person must tell the person of the decision and explain its effect. If the decision is to confirm a treatment authority, the administrator of the person's treating health service must give the person a copy of the authority and give the tribunal written notice of the decision.[161]

The authorised doctor must decide and record in the person's health records a date for the first regular assessment of the patient.[162]

The Government Bill

The Government Bill provides that an authorised doctor may give the person subject to the treatment authority a written notice directing the person to attend for the review at a stated AMHS or public sector health service facility on a stated day within the review period.[163] The person subject to the treatment authority may be detained for the review in the stated service or facility for a period of not more than six hours starting when the person is admitted to the service or facility for the review.[164]

Under the Government Bill, the authorised psychiatrist may decide to confirm the treatment authority only if satisfied the treatment criteria apply to the person and there is no less restrictive way for the person to receive treatment and care for the person's mental illness. If the authorised psychiatrist decides to confirm the authority, the psychiatrist must decide whether to amend the treatment authority in any of the ways set out in clause 57(2). The authorised psychiatrist must revoke the authority if not satisfied that the treatment criteria apply to the person and there is a less restrictive way for the person to receive treatment and care for the person's mental illness.[165]

Private Member's Bill

Under the Private Member's' Bill, the authorised psychiatrist must consider whether the treatment criteria apply to the person and there is a less restrictive way for the person to receive treatment and care for the person's mental illness. If satisfied the treatment criteria apply to the person and there is no less restrictive way for the person to receive treatment and care for the person's mental illness, review the matters in clause 51(4)(b) and discuss the treatment and care to be provided with the

156 Government Bill 2015, cl.56(3)(b).
157 Private Member's Bill, cl.51(3).
158 Government Bill 2015, cl.56(3)(b).
159 Private Member's Bill, cl.51(3).
160 Government Bill 2015, cl.57(6); Private Member's Bill, cl.52(4). However, clause 57(6) does not apply if the person does not attend for the review as directed under clause 56(4): Government Bill 2015, cl.57(7).
161 Government Bill 2015, cl.58; Private Member's Bill, cl.53.
162 Government Bill 2015, cl.59; Private Member's Bill, cl.54.
163 Government Bill 2015, cl.56(4). If a person does not attend at an authorised mental health service as directed under clause 56, see proposed new Chapter 11, Part 6 Division 3 for powers that may be used.
164 Government Bill 2015, cl.56(5).
165 Government Bill 2015, cl.57.

person the subject of the treatment authority. The authorised psychiatrist may confirm the treatment authority with or without amendment or revoke it.[166]

The Queensland Section of the Australian Psychological Society's College of Forensic Psychologists noted concern about the ability to extend a review period from 3 to 7 days under the Bills. [167]

166 Private Member's Bill, cls.51, 52.

167 Submission 59, page 4. The QMHC also expressed concerns about treatment in rural and remote / regional areas, particularly relating to the time period for the review: Submission 14, page 23.

5. Persons in custody

Chapter 3 of the Bills provide for the transport of persons in custody (for example, in a watch house or prison) to an authorised mental health facility for assessment or to receive treatment and care for their mental illness, and for other matters including requirements relating to persons who become classified patients. The provisions are generally comparable to those in the current Act.[168]

The department's background paper, released during review of the Act, described the current provisions as unclear and unnecessarily complex.[169]

5.1 Transport

The Bills provide that transport to an inpatient unit at an AMHS can be provided to certain persons in custody for assessment or treatment and care provided the requisite consents and recommendations are in force. For example, the Chief Psychiatrist's approval must be given before consent can be given for a minor to be transported to a high security unit.

Unlike the current Act, under the Bills the Chief Psychiatrist is to be notified if certain persons are not transported to an AMHS within 72 hours of the recommendation being made.170 The purpose of this notification is for the Chief Psychiatrist to 'consider taking action'.171 under clause 73 of the Government Bill or under clause 66 of the Private Member's Bill. These clauses enable the Chief Psychiatrist to agree to a person in custody being transferred to an AMHS. The provision's purpose is 'to ensure that, as far as practicable, an acutely unwell person in custody receives timely treatment.'[172]

5.2 Classified patients

Classified patients are persons in custody who are subject to a recommendation for assessment, a treatment authority, a forensic order, or a treatment support order. They may be a classified patient (involuntary) or a classified patient (voluntary).[173]

A classified patient (involuntary) is subject to a particular recommendation, authority or order, and is transported from a place of custody to an AMHS and admitted to the inpatient unit.[174]

The Government Bill also provides that a person who is subject to a particular order or authority and remains in an inpatient unit of an AMHS is also a classified patient (involuntary).[175]

A classified patient (voluntary) is transported from a place of custody to an AMHS and admitted to the inpatient unit and consents to receiving treatment or care for the person's mental illness.[176]

The Government Bill also provides that a person who remains in an inpatient unit of an AMHS and consents to receiving treatment and care for the person's mental illness in the inpatient unit of the authorised mental health service is a classified patient (voluntary).

168 Department of Health, *Comparison of Key Provisions – Mental Health Bill 2014 and Mental Health Act 2000*, http://www.parliament.qld.gov.au/documents/Committees/HCSC/2014/MentalHealthB14/tp-11Dec2014-mhb1rev.pdf, page 2.
169 Queensland Health, *Review of the Mental Health Act 2000: Background Paper, 2. Individuals Held in Custody*, May 2014, pages 1-3.
170 Department of Health, *Comparison of Key Provisions – Mental Health Bill 2014 and Mental Health Act 2000*, http://www.parliament.qld.gov.au/documents/Committees/HCSC/2014/MentalHealthB14/tp-11Dec2014-mhb1rev.pdf, pages 2-3.
171 Government Bill, cl. 73 and Explanatory Notes, p.21; Private Member's Bill, cl. 66.
172 Mental Health Bill 2015, Explanatory Notes, p.22.
173 Government Bill 2015, cl.64(1); Private Member's Bill, Schedule 3.
174 Government Bill 2015, cl.64(2); Private Member's Bill, Schedule 3.
175 Government Bill 2015, cl.64(2).
176 Government Bill 2015, cl.64(3); Private Member's Bill, Schedule 3.

When a person in custody becomes a classified patient (involuntary) or (voluntary), an authorised doctor must explain to the person how the proposed Act applies to the person[177] and the administrator of the authorised mental health service must give notice to the Chief Psychiatrist.[178]

A classified patient (involuntary) may become a classified patient (voluntary) if they are able to and consent to treatment for their illness.[179]

5.3 Return to custody

The Chief Psychiatrist must be notified of the happening of certain events, such as a treatment authority being revoked.[180] On receiving such notice, or on the Chief Psychiatrist's own initiative, the Chief Psychiatrist may decide it is not clinically appropriate for the classified patient (involuntary) to receive treatment and care for the patient's mental illness in an inpatient unit of an AMHS and the patient should be returned to a place of custody. The Chief Psychiatrist must give the administrator of the classified patient's treating health service notice of the decision. An authorised doctor for the classified patient's treating health service must tell the classified patient of the decision and explain its effect to the classified patient. [181]

A classified patient will be returned to custody if the patient is no longer an involuntary patient, the patient withdraws consent or where it is no longer clinically necessary for the person to remain in an AMHS for treatment and care.[182]

5.4 Release of classified patient

Notice must be given to the administrator of the person's treating health service and to the Chief Psychiatrist of the release event.[183] A 'release event' is an event that means a classified patient is no longer is required to be in custody if the person were not a classified patient. An example of a release event is where a person would be in lawful custody on a charge of an offence, but the person has been granted bail or the prosecution of the charge is discontinued.

Immediately after the administrator receives the notice, the person can no longer be detained as a classified patient.[184] The person may be detained as a *classified patient (voluntary)* if the person consents and it is clinically appropriate for the person to receive inpatient treatment.[185]

Committee comment

The Committee is satisfied with the provisions relating to persons in custody.

177 Government Bill 2015, cl.75; Private Member's Bill, cl.69(1).
178 Government Bill 2015, cl.76; Private Member's Bill, cl.69(2).
179 Government Bill 2015, cl.79; Private Member's Bill, cl.71. The classified patient (voluntary) may withdraw consent: Government Bill 2015, cl.80; Private Member's Bill, cl.72.
180 Government Bill 2015, cl.81; Private Member's Bill, cl.77.
181 Government Bill 2015, cl.82; Private Member's Bill, cl.78.
182 Government Bill 2015, cl.83; Private Member's Bill, cl.79.
183 The times and sources of notification are slightly different between the Bills.
184 Government Bill 2015, cl.85; Private Member's Bill, cl.81.
185 Government Bill, cl. 79; Private Member's Bill, cl. 71.

6. Psychiatrist reports for serious offences

Chapter 4 of the Bill deals with preparation of psychiatrist reports about persons charged with serious offences. Unlike the current Act, it would not be mandatory to prepare a psychiatrist report for an involuntary patient for any indictable offence.[186]

A 'psychiatrist report' about a person in relation to a charge of serious offence is defined in the Bills to mean a report prepared by an authorised psychiatrist stating whether the authorised psychiatrist considers the person may have been of unsound mind when the serious offence was allegedly committed or may be unfit for trial.

Certain persons may ask the Chief Psychiatrist for a psychiatrist report about a person in relation to the charge of the serious offence.[187] This may occur if the person charged with a serious offence was subject to a treatment authority, a forensic order under which a stated AMHS is responsible for the person, or a treatment support order/court treatment order at the time of the alleged commission of the offence or any time after the alleged commission of the offence, but before a court makes a final decision in the proceedings for the offence.[188]

Both Bills enable the person, the person's lawyer,[189] the person's nominated support person, a personal guardian authorised under the *Guardianship and Administration Act 2000* and an attorney authorised to make certain decisions under the *Powers of Attorney Act 1998* to ask the Chief Psychiatrist for a psychiatrist report about the person in relation to the charge of the serious offence. The Government Bill also enables a parent of the person, if the person is a minor, to make a request.[190]

Within 7 days after receiving a request for a psychiatrist report, the Chief Psychiatrist must direct the administrator of the person's treating health service to arrange for an authorised psychiatrist to prepare a psychiatrist report about the person in relation to the charge of the serious offence.[191]

The Bills also enable the Chief Psychiatrist, on his or her own initiative, to direct that an authorised psychiatrist prepare a psychiatrist report about a person in relation to a charge of a serious offence. The Chief Psychiatrist may only do so if satisfied that certain circumstances exist.[192] The person must attend for an examination.[193]

An authorised psychiatrist who is required to prepare a psychiatrist report must prepare the report within 60 days, although this time period may be extended to 90 days.[194]

In preparing the report, the authorised psychiatrist must:

- examine the person,
- obtain and consider health records for the person relevant to the examination of the person, and

186 Department of Health, *Comparison of Key Provisions – Mental Health Bill 2014 and Mental Health Act 2000*, http://www.parliament.qld.gov.au/documents/Committees/HCSC/2014/MentalHealthB14/tp-11Dec2014-mhb1rev.pdf

187 Other than an offence against a law of the Commonwealth.

188 Government Bill 2015, cls.88, 90; Private Member's Bill, cls.84, 86. The Bills require the administrator of the person's treating health service to advise the person of the ability to make a request: Government Bill 2015, cl.89; Private Member's Bill, cl.85. See also cl.284 of the Government Bill 2015 and cl.279 of the Private Member's Bill regarding the provision of information to the patient's support persons.

189 Under the Government Bill, the lawyer may only request a psychiatrist report if the person has given instructions to the lawyer to make the request.

190 Government Bill 2015, cl.90; Private Member's Bill, cl.86.

191 Government Bill 2015, cl.91; Private Member's Bill, cl.87.

192 Government Bill 2015, cls.92 and cl.93; Private Member's Bill, cl.88.

193 Government Bill 2015, cl.98; Private Member's Bill, cl.95.

194 Government Bill 2015, cl.95; Private Member's Bill, cl.91.

- consider information from the prosecuting authority.195

The authorised psychiatrist may also consider any other relevant information.

The report must include information about the following:

- the person's mental state and, to the extent practicable, the person's mental state when the serious offence was allegedly committed,
- whether the authorised psychiatrist considers the person was of unsound mind when the serious offence was allegedly committed,
- whether the authorised psychiatrist considers the person is fit for trial,
- if the authorised psychiatrist considers the person is unfit for trial – whether the authorised psychiatrist considers the unfitness for trial is permanent.[196]

The person about whom a psychiatrist report is being prepared, and any support person, must participate in an examination for the psychiatrist report in good faith. If the person and any support person do not participate in good faith, it may result in the administrator revoking the direction to prepare the psychiatrist report.[197]

The Chief Psychiatrist may direct that another psychiatrist report be prepared about the person in relation to the charge of the serious offence if the Chief Psychiatrist considers the matters in the original report require further examination.[198]

The Government Bill provides that the Chief Psychiatrist must give a copy of the report to the person who requested it.[199]

The Chief Psychiatrist may refer the matter of the person's mental state in relation to the serious offence to the Mental Health Court if:

- a psychiatrist report has been prepared; and
    - the Chief Psychiatrist is satisfied the person may have been of unsound mind when the serious offence was allegedly committed, or
    - may be unfit for trial and,
- having regard to the report and the protection of the community, there is a compelling reason in the public interest for the person's mental state to be referred to the Mental Health Court.[200]

6.1 Submitter views

The Queensland Law Society (QLS) held the view that Chapter 4 of the Bills do not protect the rights of persons subject to involuntary treatment because psychiatric reports will no longer be mandatory for people subject to involuntary orders who are charged with offences. The QLS stated that the current Act is consistent with the *International Covenant on Civil and Political Rights* and the *United Nations Convention on the Rights of Persons with Disabilities* because the mandatory process 'ensures that the State consistently and fairly applies the law to a citizen subject to involuntary treatment. That process ensures that the State enquires into the question of unsoundness of mind and fitness for trial of persons subject to involuntary treatment charged with criminal offences, thus protecting the person from indiscriminate application of the presumptions of sanity and fitness.'[201]

195 See Government Bill 2015, cl.96; Private Member's Bill, cl.92.
196 Government Bill 2015, cl.95; Private Member's Bill, cl.91.
197 Government Bill 2015, cl.98; Private Member's Bill, cl.94.
198 Government Bill 2015, cl.100; Private Member's Bill, cl.98.
199 Government Bill, cl. 102.
200 Government Bill 2015, cl.101; Private Member's Bill, cl.100.
201 Submission 53, page 5.

The QLS asserted that if the Bills are enacted, 'there is a very real risk that a very significant number of mentally ill persons will unjustly transition from the status of sick persons needing treatment to the status of criminals needing punishment'.

In response to the QLS's submission, the Department advised that the model proposed under the Government Bill 'will substantially increase the number of persons diverted from the criminal justice system due to a mental illness or other mental condition.'[202]

The Department further advised:[203]

> *The model proposed under the* [Government] *Bill will substantially increase the number of persons diverted from the criminal justice system due to a mental illness or other mental condition.*
>
> *The approach to the preparation of psychiatric reports under the current Act applies to persons subject to forensic orders or involuntary treatment orders, and mandates a psychiatric assessment and report for this cohort.*
>
> *The current mandatory approach is inconsistent with natural justice and human rights in that it denies a particular group of people with a mental illness the right to choose how to pursue a legal defence. This perpetuates the State's control over the person's affairs.*
>
> *More importantly, there are many times more persons who come before Courts who do not receive any mental health assessment. These assessments could result in them presenting a mental health defence in court, or otherwise obtaining clinical services that may improve their lives and reduce recidivism. The current arrangement therefore skews clinical resources in manner that in inconsistent with clinical need.*
>
> *The Bill remedies this by giving magistrates the express power to find a person of unsound mind or unfit for trial and refer them to appropriate services. This will be supported by a strengthened Court Liaison Service which will offer assessments and reports to defendants, at no cost. There will be substantial implementation activity supporting this, including education and training for the legal profession.*
>
> *The Bill requires the relevant authorised mental health service administrator to advise the person of the ability to make a request and explain the effect of a request (cl. 89). In practice, this function will be delegated to staff in the Court Liaison Service. The administrator must also tell and explain the matter to the patient's nominated support person or, if the patient does not have a nominated support person, to one or more of the patient's family, carer or other support person, including a guardian or attorney (cl. 284(2)(c)&(d)). For a minor, the Bill expressly requires one or more of the minor's parents to be advised unless it is not in the minor's interests, for example, if there is a dysfunctional family relationship.*
>
> *To ensure the person's rights are protected, a request for a report may also be made by:*
>
> - *the person's nominated support person, if it is in the person's best interests*
> - *a personal guardian who has the authority to make this decision for the person*
> - *an attorney who has the authority to make this decision for the person*
> - *a parent of a minor, or*
> - *the person's lawyer, acting on instructions of the person.*

202 Queensland Health, correspondence received 5 November 2015, page 5.
203 Queensland Health, correspondence received 5 November 2015, page 5.

The QNU considered that persons charged with serious offences who may have a defence of unsound mind or unfitness for trial should automatically be offered a psychiatric report rather than the person or their representative needing to request the report.

Committee comment

The Committee is satisfied with the provisions relating to psychiatrist reports for serious offences.

7. Patients' rights and support

7.1 Current Act and the Bills

Under the current Act, patients have the right to:

- be treated with dignity and respect at all times,
- have their religion and cultural background respected and taken into account,
- be treated in a way that respects their privacy,
- have personal information dealt with confidentially,
- receive information in a form and language that they best understand, and
- receive assistance to communicate effectively, including assistance from an interpreter.

Patients may nominate a support person, known as an 'allied person', to help them understand their rights, speak with their treating team and provide support at the Tribunal.

The Bills include a chapter on the rights of patients of AMHS, which build on the rights of involuntary patients prescribed in Chapter 9 of the current Act. The Bills provide explicit rights for patients and their family, carers and support persons, which are discussed below.

Chapter 8 discusses the new provisions in the 2015 Bills for appointment of patient rights advisers.

7.2 Definition of patient

Definitions of patient are included for the purposes of the chapter. The Private Member's Bill expands the definition of patient in the current Act to include an involuntary patient or a patient receiving treatment and care under an AHD or with the consent of a personal guardian or attorney.[204]

The Government Bill includes a similar, expanded definition, defining patient as:

> (a) an involuntary patient; or
>
> (b) a person receiving treatment and care for a mental illness in an authorised mental health service, other than as an involuntary patient, including a person receiving treatment and care under an advance health directive or with the consent of a personal guardian or attorney.[205]

7.3 Statement of rights

Both Bills require the Chief Psychiatrist to prepare a written *statement of rights*, which contains information about the rights of patients, nominated support persons, family, carers and other support persons under the Act. The statement must include information on how to make a complaint about treatment and care, and may include anything the Chief Psychiatrist considers appropriate.[206]

An administrator of an AMHS must ensure the information in the *statement of rights* is explained to patients on admission, and a copy of the statement is provided to patients if they request it. Where practicable, administrators must do the same for nominated support persons, family, carers and other support persons.[207] Administrators are also required to display signs, which are easily visible, in prominent positions in the service which state that a copy of the statement is available on request.[208] Similar provisions are in the current Act.[209]

204 Private Member's Bill, cl. 269.
205 Government Bill, cl.274.
206 Government Bill, cl. 275; Private Member's Bill, cl.270.
207 Government Bill, cl. 276; Private Member's Bill, cl.271.
208 Government Bill, cl. 277; Private Member's Bill, cl.272.
209 *Mental Health Act 2000*, s.344 to s.346.

7.3.1 Stakeholder views

The QMHC supports provisions relating to a Statement of Rights and recommends:

> *The Bill make it clear that when developing information to support the implementation of the legislation, the Chief Psychiatrist is required to consult with consumers, families and carers.*[210]

Rights in Action supports the provisions and recommends that the statement be 'displayed in prominent positions in the mental health service and a sign stating that these rights are available in accessible formats on request.' Examples of accessible format are provided in the submission i.e. easy English, alternative language, pictorial. [211]

Committee comment

The Committee commends the inclusion, in both Bills, of provisions relating to a written statement of rights, for patients, nominated support persons, family, carers and other support persons.

The Committee agrees with stakeholders that these provisions should be further strengthened by:

- the Chief Psychiatrist consulting with consumers, families and carers when developing this statement, and
- expanding the requirements relating to the display of signs in AMHS, which currently provide that a sign must say that a copy of the statement is available on request, to specify that the statement is available in accessible formats.

7.4 Patient rights

The current Act provides that health practitioners and a legal or other adviser may visit an involuntary patient at any reasonable time.[212] The Bills extend that right by providing patients of an AMHS have the right to receive visits, at any reasonable time, from their nominated support person, family, carers and other support persons, a health practitioner and a legal or other adviser.[213]

The Bills also provide patients of an AMHS with the right to:

- Communicate with another person by post or fixed line telephone and, in the case of the Government Bill, a mobile telephone or other electronic communication device.[214]
- Request that the administrator of an AMHS obtain a second opinion from another health practitioner, including another psychiatrist, where a complaint about the care or treatment of a patient cannot be resolved. The administrator must obtain the opinion in compliance with a policy or practice guideline made by the Chief Psychiatrist and, in the case of the Government Bill, from a health practitioner who is independent of the patient's treating team. Both Bills also require the Chief Psychiatrist to make a policy about requests for an independent second opinion from a psychiatrist or another health practitioner.[215]

7.4.1 Stakeholder views

The QMHC '… is pleased that the Bill includes provisions that support visits by a patient's nominated support person, family, carers and other support persons at 'any reasonable time of the day or night.'

210 Submission 14, page 18.
211 Submission 28, pages 2-4.
212 *Mental Health Act 2000*, s.347.
213 Government Bill, cl.278 to c. 281; Private Member's Bill, cl.273 to cl.276.
214 Government Bill, cl. 282; Private Member's Bill, cl.277.
215 Government Bill, cl.288 and cl. 303; Private Member's Bill, cl.281 and cl.294(1)(d).

The QMHC describes the right to communicate using a mobile phone or electronic device as a 'step forward from the current Act', which is more likely to promote connections with family and friends, and states it:

> *… accepts that these risks should be managed and supports the Bill's provisions which enable the AMHS to prohibit or restrict a person's ability to communicate via a fixed land line, a mobile phone or electronic communication if it is likely to be detrimental to the health or wellbeing of the person or others (clause 288).*[216]

Committee comment

The Committee commends the provisions in the Bills that expressly provide patients of authorised mental health services with additional rights around visitation, communication and complaints about treatment.

The Committee notes that the Bills contain slightly different provisions with regard to a patient's right to communicate. The Private Member's Bill provides that a patient of an AMHS may communicate with another person by post of fixed line telephone. The Government Bill expands this provision to include the use of a mobile phone or other electronic communication device.

The Committee supports the broader provisions included in the Government Bill.

7.5 Service responsibilities

Both Bills require administrators of an AMHS and/or authorised persons involved in a patient's treatment and care to:

- Provide timely, accurate and appropriate information to a patient about their treatment and care.[217]
- Ensure the patient, and where practicable their nominated support persons, family, carers and other support persons, understand any information provided about the patient's treatment or care. In the Government Bill, this requirement extends to a person who may become a patient and an authorised person transporting a person to an AMHS, or public sector health service.[218]
- Give a copy of a written notice about a significant event (such as admission as a classified patient or transfer to another entity) which has been provided to a patient, to the patient's nominated support person, personal guardian or attorney, family, carers or other support persons.[219]

The Private Member's Bill provides that the obligation to communicate with a patient's family member, carer or support person does not apply if the patient requests the communication does not take place.[220]

The Government Bill expands this provision to specify that the obligation to communicate with a patient's family member, carer or support person does not apply if:

- the patient's request is made at a time when the patient has capacity to make the request,
- the person is not readily available or willing for the communication to take place, or
- the communication is likely to be detrimental to the patient's health and wellbeing.

216 Submission 14, page 19.
217 Government Bill c. 283; Private Member's Bill, cl.278.
218 Government Bill, cl. 284; Private Member's Bill, cl.279.
219 Government Bill, cl. 285; Private Member's Bill, cl.280.
220 Private Member's Bill, cl.282.

The Government Bill defines capacity, for the purposes of this section, as the patient having the ability to understand the nature and effect of the request, and to make and communicate the request, and again provides that a patient includes a person who may become a patient.[221]

Committee comment

The Bills provide that an AMHS and authorised persons involved in a patient's treatment have particular responsibilities with regard to communicating with patients, their nominated support persons, family, carers and other support persons.

The Committee notes the Government Bill includes additional provisions, which expand the requirements to cover a person who may become a patient and an authorised person transporting a person to an AMHS, or public sector health service.

The Government Bill also provides greater detail about when the obligation to communicate with a patient's family member, carer or support person does not apply.

The Committee supports the expanded provisions in the Government Bill.

7.6 Role and responsibilities of family, carers and support persons

Both Bills set out rights and responsibilities for a patient's nominated support person, family, carers and other support persons.

Support persons have the right to:

- contact the patient while they are receiving treatment and care,
- participate in discussions about treatment and to be consulted about treatment options,
- receive timely, accurate and appropriate information about the patient's treatment, care, support, rehabilitation and recovery, and
- arrange support services for the patient, for example, counselling, community care or respite.[222]

Similarly, support persons have a responsibility to:

- respect the patient's dignity and humanity,
- consider the opinion and skills of health practitioners whose provide treatment, care and services to the patient, and
- cooperate, to the extent practicable, with reasonable programs of assessment, care, treatment, support, recovery and rehabilitation.[223]

7.7 Nominated support persons

7.7.1 Current Act

The current Act provides for an involuntary patient to choose their parent, guardian, attorney, an adult relative or friend, an adult carer or another adult to be their allied person.[224] The role of an allied person is '…to help the patient to represent the patient's views, wishes and interests relating to the patient's assessment, detention, treatment and care under this Act.' [225] If a patient does not have the capacity to choose an allied person and there is an AHD for the patient under the *Powers of Attorney Act 1998* which identifies an allied person, the person stated in the directive is the patient's allied person. If there is no AHD, the administrator of the treating health service must choose the patient's allied person, or the public guardian becomes the patient's allied person.[226]

221 Government Bill, cl. 286 (3).
222 Government Bill, cl. 289; Private Member's Bill, cl.283.
223 Government Bill, cl. 290; Private Member's Bill, cl.284.
224 *Mental Health Act 2000*, s.341.
225 *Mental Health Act 2000*, s.340.
226 *Mental Health Act 2000*, s.342.

7.7.2 2015 Bills

Both Bills replace the role of allied persons with more comprehensive provisions about nominated support persons and AHDs.

The Bills provide that a person may appoint a nominated support person, by written notice (an appointing person). A record of the notice is kept. The appointing person may also revoke the appointment, again by written notice.[227]

The Bills also provide that if the appointing person becomes an involuntary patient, the nominated support person may:

- receive notices for the patient under this Bill,
- receive confidential information, under the *Hospital and Health Boards Act 2011,* about the patient, and
- represent the patient, or act as the patient's support person, in the Tribunal, to the extent permitted under chapters 12 and 16.[228]

Additional measures in Government Bill

The Government Bill includes expanded provisions, which also specify that:

- Appointment and revocation occur only if the appointing person has capacity at the time of making the appointment or revocation. Capacity is defined as the appointing person having the ability to understand the nature and effect of the appointment or revocation, and to make and communicate the appointment or revocation.
- No more than two nominated support persons may be appointed.
- A nominated support person may resign, by giving written notice to appointing person.[229]

The Government Bill also provides for a nominated support person to request a psychiatrist report where the patient is charged with a serious offence and was subject to a treatment authority, forensic order or treatment support order (see Chapter 6).[230]

7.7.3 Stakeholder views

The QMHC supports the nominated support person provisions:

> *The Commission supports the new nominated support person's role as a role which complements the role played by family, carers and next of kin. Consistent with the Commission's review recommendation, the nominated support person is appointed by the patient and is a person of their choice and has wide ranging powers including representing the patient in the Tribunal. The Commission is also pleased to see that there is recognition that nominated persons need to be advised of their rights and responsibilities.231*

Rights in Action also supports the provisions, and states they should be broadened to enable more than one person to be a nominated support person. The Government Bill provides for this already.

Rights In Action believe the provisions should be supported by community education on making an EPOA and AHD, and the appointment of an independent advocate to assist those who do not have a

227 Government Bill, cl.223; Private Member's Bill, cl. 235.
228 Government Bill, cl. 224; Private Member's Bill, cl. 236.
229 Government Bill, cl. 223.
230 Government Bill, cl. 224 (c).
231 Submission 14, page 15.

nominated support person, particularly at Tribunal hearings. The organisation recommends the Queensland Government provide funding to individual advocacy agencies to enable the later.[232]

The QLS recommends that the obligation to communicate with a patient's nominated support person, family member, carer or support person be extended to include a person who is also the patient's decision maker i.e. a personal guardian or a person exercising an EPOA.[233]

Committee comment

The Bills replace the role of allied persons with more comprehensive provisions about nominated support persons.

The Committee notes the Government Bill provides for up to two nominated support persons, whereas the Private Member's Bill provides for one.

The Government Bill includes a number of additional provisions, including expanded provisions regarding the appointment and revocation of nominated support persons and providing for a nominated support person to request a psychiatrist report, where the patient is charged with a serious offence and was subject to a treatment authority, forensic order or treatment support order.

The Committee supports the expanded provisions in the Government Bill.

Recommendation 7

The Committee recommends that, in the event that either of the Bills pass, the following provisions in the Mental Health Bill 2015 relating to nominated support persons be retained:

- to allow the appointment of up to two nominated support persons ;
- relating to appointment and revocation of nominated support persons; and
- to allow a nominated support person to request a psychiatrist report where the patient is charged with a serious offence and was subject to a treatment authority, forensic order or treatment support order.

7.8 Representation at Tribunal Hearings

7.8.1 Right to be represented

The current Act provides a right of representation for a patient who is the subject of a proceeding before the Tribunal, however the leave of the Tribunal is required for a person other than a lawyer to represent the patient. If a patient is not represented, the presiding member of the Tribunal may appoint a person to represent the patient's views, wishes and interests. [234]

Both Bills provide that a person who is the subject of a proceeding may be:

- represented by a nominated support person, lawyer, or another person, and
- accompanied by one nominated family member, carer or other support person or, with the Tribunal's leave, more than one of these individuals. [235]

The Government Bill also provides additional safeguards where a person attends the Tribunal to represent the person who is the subject of a proceeding (the subject). In presenting to the Tribunal, that person must represent the subject's views, wishes, preferences and best interests, to the extent that they are able to do so.[236]

232 Submission 28, pages 3-4.
233 Submission 53, page 2.
234 *Mental Health Act 2000*, s.455.
235 Government Bill, cl.737; Private Member's Bill, cl.630.
236 Government Bill, cl.737(3).

7.8.2 Representation in persons best interests

Both Bills provides that the Tribunal may appoint a lawyer or another person to represent the person if the tribunal considers it is in the person's best interests to be represented at the hearing.[237]

7.8.3 Representation provided for specified hearings

Both Bills require the Tribunal to appoint a lawyer to represent a person at a hearing if

- the person is a minor (see Chapter 14),
- the hearing relates to a review of a person's fitness for trial, or an application to approve the use of ECT (see Chapters 12 and 14), or
- the Attorney-General is to appear or be represented.[238]

The Private Member's Bill also requires that a lawyer be appointed if the hearing relates to a review of the imposition of conditions on a forensic order that require the wearing of a tracking device (see Chapter 15). The Government Bill provides that a lawyer must be appointed if the hearing is prescribed by regulation.[239]

Both Bills provide that the lawyer is appointed at no cost to the person.[240]

7.9 Patient confidentiality

7.9.1 Confidential information obtained by designated persons

Chapter 17 of both Bills provide for patient confidentiality in ways similar to the current Act, however the provisions which enable personal information to be disclosed in particular circumstances are more detailed.

Generally, a person who has access to personal information through performing a function under either Bill may not disclose personal information except to perform their role. This applies to staff of a Hospital and Health Service (HHS), the Tribunal, the Chief Psychiatrist, an administrator of an AMHS, a patient rights adviser, an authorised mental health practitioner and an authorised doctor.[241]

The Government Bill additionally applies the duty of confidentiality to an inspector and authorised person.[242]

7.9.2 Permitted disclosure of confidential information

Both Bills provide for a number of circumstances which allow the disclosure of personal and identifying information, and clarify that the use or disclosure of information provided for in Chapter 17 applies, despite any prohibition or limitation on disclosure in the *Hospital and Health Boards Act 2011.* [243]

Both Bills provides that personal and confidential information may be disclosed:

- to assist in identifying a person who may have been of unsound mind at the time of an alleged offence or who may be unfit for trial.[244]

237 Government Bill, cl. 738(2); Private Member's Bill, cl.631(2).
238 Government Bill, cl. 738(3); Private Member's Bill, cl.631(3).
239 Government Bill, cl. 738(3); Private Member's Bill, cl.631(3).
240 Government Bill, cl. 738(6); Private Member's Bill, cl.631(7).
241 Government Bill, cl. 776; Private Member's Bill, cl.732.
242 Government Bill, cl. 776 (1)(h) and (i).
243 Government Bill, cl. 776((3) and (4); Private Member's Bill, cl.732(3) and (4).
244 Government Bill, cl. 778; Private Member's Bill, cl. 734.

- to assist in identifying a person who is or may be a victim of an unlawful act committed by a person who has a mental illness or condition, for the purposes of offering support services. The Government Bill also includes a definition of victim.[245]
- to a private psychiatrist engaged by the patient to assist in preparation of a report. [246]
- to a lawyer to enable the provision of legal services to the patient or the State for a Mental Health Court or Tribunal proceeding. [247]
- between the Chief Psychiatrist and a victim support service or person who is, or may be, the victim of an unlawful act committed by a person who is a classified patient. The Government Bill extends this provision to include a close relative of the victim or another individual who suffered harm because of the unlawful act.[248]
- between the Chief Psychiatrist or the administrator of an AMHS and the director of forensic disability or the administrator of a forensic disability service to facilitate transfer of a person between services or the provision of care.[249]
- to the police or another person performing in an official capacity, a photograph of an involuntary patient or classified patient (voluntary) who has become a *patient required to return, [250]* to help locate the person. [251]

The Private Member's Bill also provides for disclosure of personal and confidential information to a patient rights adviser to enable the adviser to perform their functions.[252]

The Government Bill provides for circumstances in which the Mental Health Court may disclose relevant information about a patient to a person undertaking research.[253]

7.10 Advanced health directives

The Bills provides that an advanced health directive (AHD) may provide views about treatment and care, and that these views must be must be taken into account in deciding the nature and extent of treatment and care to be provided under a treatment authority.[254]

The Bills require the Chief Psychiatrist to establish and maintain a system for keeping electronic records of AHDs and appointments of nominated support persons. The Government Bill extends this provision to include enduring powers of attorney (EPOA) for a personal matter.[255]

The Bills provide that administrators of an AMHS must keep a record of AHDs, EPOAs and nominated support person appointment, when requested by the patient.[256]

Additional measures in the Government Bill

The Government Bill also requires an authorised doctor to document in the patient's health records, and explain to the patient if an AHD is not followed. This applies if a treatment authority is made (despite the existence of an AHD) or where the treatment and care provided under a treatment authority is not in accordance with an AHD.[257]

245 Government Bill, cl. 779; Private Member's Bill, cl. 735.
246 Government Bill, cl.780; Private Member's Bill, cl.736.
247 Government Bill, cl. 783; Private Member's Bill, cl.740.
248 Government Bill, cl. 781; Private Member's Bill, cl.738.
249 Government Bill, cl. 782; Private Member's Bill, cl.739.
250 A patient for whom the administrator of an AMHS has made a direction or request under cl.351 (Private Member's Bill) or cl. 362 (Government Bill) and the patient has not returned.
251 Government Bill, cl. 784; Private Member's Bill, cl.741.
252 Private Member's Bill, cl.737;
253 Government Bill, cl. 785.
254 Government Bill, cl. 222; Private Member's Bill, cl. 234.
255 Government Bill, cl.225; Private Member's Bill, cl.237.
256 Government Bill, cl.226; Private Member's Bill, cl.238.
257 Government Bill, cl.54.

7.10.1Stakeholder views

In response to concerns the Committee sought further information from the Department on how AHDs would be tracked and monitored. For example, if a person made an AHD, the Committee wanted to better understand how an authorised doctor would know, and what safeguards there are around the currency and sufficiency of ADHs.

The Department advised:[258]

> *The Bill requires administrators of authorised mental health services to keep a record of advance health directives and enduring powers of attorney related to a person's future treatment and care for a mental illness, when requested (cl.226). These will be recorded on the State-wide mental health information management system which is accessible to all specialist mental health clinicians in Queensland.*
>
> *The Bill also requires an authorised doctor to document in the patient's health records, and explain to the patient, if an advance health directive is not followed. This applies if a treatment authority is made (despite the existence of an advance health directive) or where the treatment and care provided under a treatment authority is not in accordance with an advance health directive (cl.54).*
>
> *The existence and operation of an advance health directive for a patient will be considered as part of regular clinical reviews for the patient.*
>
> *The Chief Psychiatrist will develop a policy on the use of advance health directives which, under the Bill, will be binding on mental health services. This will be used to collect data on the number of occasions that directives are, or are not, used, and the reasons they are not used. This information can then be used to review the effectiveness of the new arrangements after the first 12 months of operation of the Bill.*

Committee comment

The Committee notes the Department's advice that the Chief Psychiatrist will collect data on advanced health directives to review the effectiveness of the new arrangements and considers there is value in the Minister for Health and Minister for Ambulance Services reporting publicly on the outcomes of this review.

258 Correspondence Michael Walsh, Director-General, Queensland Health, dated 5 November 2015.

8. Patient rights advisers

This chapter provides an overview of provisions relating to the new position of patient rights advisers and discusses issues raised during the inquiry regarding their independence and functions.

8.1 Appointment and independence

Both Bills require an AMHS to have systems in place to ensure patients are advised of their rights under the Bills. This includes a requirement for services to appoint one or more patient rights advisers (referred to as independent patient rights advisers in the Government Bill), in compliance with a policy or practice guideline.[259] Similarly, both Bills provide that the Chief Psychiatrist may make a policy or practice guideline relating to:

- supporting the rights of patients and nominated support persons, family, carers and other support persons of patients, including the ways in which information will be communicated, and
- the appointment and functions of patient rights advisers.[260]

The Private Member's Bill provides that a patient rights adviser must be an employee of the health service, or another entity engaged to provide services, must report directly to the administrator of the service and must not be a member of the treating team.[261] The Government Bill states a patient rights adviser may be an employee of an entity that the health service has engaged to provide services, or an employee of the health service who is not employed in the service's mental health service.[262]

Both Bills require advisers to act independently and impartially and state advisers are not subject to the direction of another person when performing their functions under the Bill.[263]

Many stakeholders questioned whether patient rights advisers can be truly independent when employed within the health service. This issue is discussed in chapter 8.3.

8.2 Functions

Both Bills provides that the functions of a patient rights adviser are to:

- ensure that a patient and the patient's nominated support persons, family, carers and other support persons, are advised of their rights and responsibilities under the Bill,
- help the patient and the patient's nominated support person, family, carers and other support persons to communicate their wishes and preferences about treatment to health practitioners,
- advise the patient and the patient's nominated support person, family, carers and other support persons of the dates and times of Tribunal hearings and the patient's rights at the hearings and, if requested, help the patient engage a representative for the hearing,
- identify whether the patient has a personal guardian or attorney and if so, work cooperatively with them to further the patient's interests, and
- if appropriate, advise the patient of the benefits of an AHD or EPOA.[264]

The Government Bill includes two additional functions:

259 Government Bill, cl. 291; Private Member's Bill, cl.285.
260 Government Bill, cl. 303 (2) (h) and (i); Private Member's Bill, cl.294 (2) (h) and (i).
261 Private Member's Bill, cl.285.
262 Government Bill, cl. 291.
263 Government Bill, cl. 293; Private Member's Bill, cl.287.
264 Private Member's Bill, cl.286.

- working with community visitors performing functions under the *Public Guardian Act 2014*, and
- consulting with staff of an AMHS and the Chief Psychiatrist on the rights of patients under this Bill, the *Guardianship and Administration Act 2000*, the *Powers of Attorney Act 1998* and other laws. [265]

8.2.1 Stakeholder views – functions

The College submitted 'a number of functions of this position should be conducted by the treating team as part of sound clinical and ethical practice.'

The QMHC suggests support outside of usual business hours may be necessary and refers to PalAssist, a 24 hour, 7 day a week support line for palliative care, as an example of a model which better supports families, carers and supporters.

Committee comment

The Committee notes both Bills provide that the functions of patient rights advisers include:

- assisting patients and their families, carers and other support persons to:
  - understand their rights and responsibilities under the Bill,
  - communicate their wishes and preferences about treatment,
  - understand their rights at a Tribunal hearing and, if requested, engage a representative,
- identifying whether patients have a personal guardian or attorney and if so, working cooperatively with them to further the patient's interests, and
- if appropriate, advising patients of the benefits of an AHD or EPOA.

The Committee notes that the Government Bill expands the functions of patient rights advisers to include working cooperatively with community visitors under the *Public Guardian Act 2014* and consulting with treating practitioners, administrators and the Chief Psychiatrist on the rights of patients under the Government Bill, guardianship legislation and other laws.

The Committee considers these functions further strengthen patient rights.

8.3 Independence of patient rights advisers

8.3.1 Stakeholder views

The Committee received a number of submissions from stakeholders with concerns about the independence of patient rights advisers.

The QMHC submitted that 'there is a need to ensure that the role is able to operate in a way that is perceived as independent.' Rights in Action states the position of patients rights adviser should be independent and recommends omission of clause 291(3)(b) of the Government Bill, which provides an independent patient rights adviser may be an employee of a HHS but not employed in the service's mental health service.[266]

The College questions 'how truly independent the position can be' and recommends 'Consideration be given to reporting structure for patient rights advisors and whether central oversight via the office of the Chief Psychiatrist is appropriate.' [267]

The QMHC also notes that the Chief Psychiatrist may develop a policy regarding the appointment and functions of the patient rights advisers and recommends clause 291 of the Government Bill be

265 Government Bill, cl.292.
266 Submission 14, page 16; Submission 28, pages 2-3.
267 Submission 59, page 13.

amended to make it clear that patient rights advisers are to be employed and engaged consistent with the policy issued by the Chief Psychiatrist.[268]

The QMHC also states patients should have the opportunity to raise concerns outside the system and refers to independent oversight mechanisms in other systems where people are involuntarily detained.[269] The QMHC describes Community Visitors in the Office of the Public Guardian, who are able to visit mental health wards at the request of patients and raise any concerns with the HHS, who must investigate. The QMHC is concerned there is 'no corresponding requirement for HHSs to respond to issues raised' and suggests:

> *A cross reference in Chapter 9 that requires an Authorised Mental Health Service or other visitable site within the definition of the* Public Guardian Act 2014 *to respond to any recommendations of the Adult Guardian arising from a visit by a Community Visitor would strengthen the oversight of that function.*
>
> *Alternatively this might be best achieved through an amendment to the* Public Guardian Act 2014*.*[270]

In a subsequent public hearing the Australian Medical Association of Queensland (AMAQ) again raised concerns about independence:

> *We welcome the advent of patients' rights advisers, although we would just caution that it may not be the best in terms of their independence if they are actually employed by a particular HHS and maybe they should be centrally employed as to avoid a conflict of interest.*[271]

8.3.2 Government and Private Member's advice

The issue of independence was discussed at length during the public briefings and hearing on the Bill.

During the first public briefing on the Bills, the Department referred to the provisions in the Government Bill as follows:

> *With regard to independent patient rights advisers, under this bill an independent patient rights adviser may be employed by a non-government organisation or a hospital and health service but cannot be employed within the mental health service. That strengthens the independence.*[272]

With regard to consultation on the provisions in the Government Bill, the Department advised:

> *There was certainly a strong view about the need for genuine independence for independent patient rights advisers. Again, the model is very strongly supported. I think all stakeholders and the government acknowledge the need for advisers to be independent. There are some stakeholders that would argue that the person should always be employed in a non-government organisation. The bill allows either—in an NGO or employed within the service but outside the mental health service. We believe that gives all services the best opportunity to put a model in place that is most appropriate to the circumstances.*[273]

The Member for Caloundra also spoke on this issue during this briefing. When asked by the Member for Thuringowa how the Private Member's Bill will 'achieve independence for the patient rights advisers if they are employed within the mental health service' Mr McArdle replied:

268 Submission 14, page 17.
269 Submission 14, pages 16-17.
270 Submission 14, pages 17.
271 Public hearing transcript, 28 October 2015, page 12.
272 Public briefing transcript, 14 October 2015, page 7.
273 Public briefing transcript, 14 October 2015, page 8.

> *I do not see the employment by an agency or a body as a bar to independence. I think we have many people now within the hospital system who are employed by the system and are independent when it comes to patients' rights and patients' needs. I do not see that employment is a bar to independence. The other benefit of that, of course, is that they are exposed on a daily basis to what takes place in a hospital. They are exposed in terms of what takes place with regard to the rollout of policy. They also involved in the delivery and planning of policy. The trade-off in terms of them being from an independent body is that they are also employed. You can have both quite readily and actually come up with a good solution. Working in the system has its distinct advantage as opposed to being an outsider who comes in every now and then. That is a flow-on that we can capture and utilise for the benefit of the patient.*[274]

At the request of the Committee, the Department subsequently provided additional written advice on this issue. In summary, the Department advised:

- While mandating external appointment was considered, the Department recognised that for some HHS, there may not be external organisations with sufficient capacity to supply these services and in other cases, the most appropriate person for the job may already be an HHS employee. Consequently, the Bill provides HHS with the flexibility to engage advisers through an external entity, or through the HHS, providing that the individual is not employed within the mental health service.
- The governance, accountability and reporting framework within each HHS will depend on which of the two appointment mechanisms is selected and the management structure of the HHS.
- The Department will review the operation of advisers over time.
- The Chief Psychiatrist will issue a binding policy on the appointment and functions of independent patient rights advisers. This will include minimum competencies and standards for service delivery, and require compliance with a monitoring framework.
- The state-wide adviser network will be established and a State-wide coordinator appointed, to oversee and support the network of advisers. The coordinator will provide the Chief Psychiatrist with regular reports on activity.
- Patient rights advisers will be able to liaise directly with the office of the Chief Psychiatrist. This could include raising concerns if a service was not being sufficiently responsive to a complaint or to concerns about a patient's rights.[275]

Committee comment

The Committee acknowledges the concerns of a number of stakeholders about the independence of patient rights advisers. These stakeholders suggest that advisers should either be employees of an external agency or centrally employed, not employees of the Hospital and Health Service (HHS).

The Committee is of the view that wherever possible, patient rights advisers should be employed by an external agency, rather than the HHS. While this is the ideal model, the Committee acknowledges that this may not always be possible.

The Department advised that there are some circumstances where this is not possible or preferable. For some HHS there may not be external organisations with sufficient capacity to supply these services while in other cases, the most appropriate person for the position may already be an HHS employee.

274 Public briefing transcript, 14 October 2015, page 23

275 Correspondence, Department of Health, 5 November 2015, page 4.

The Committee also acknowledges related advice provided by the Department, which identifies a number of mechanisms to support and review the independence of patient rights advisers under the Government Bill, including:

- The development of a policy on the appointment and functions of independent patient rights advisers by the Chief Psychiatrist, which will include minimum competencies and standards for service delivery, and require compliance with a monitoring framework.
- The establishment of a state-wide adviser network and the appointment of a state-wide co-ordinator, to oversee and support the network and to report to the Chief Psychiatrist on activity.
- Plans to review the operations of patient rights advisers, in conjunction with the Queensland Mental Health Commissioner and consumers, in 12 to 18 months' time once arrangements had been bedded down.

The Committee is therefore satisfied that it is not appropriate to mandate external appointment of patient rights advisers, and that significant consideration has been given to developing a framework which will support their independence.

The Committee also notes that the Bills provide for independence in different ways, and to different degrees.

The Private Member's Bill provides that a patient rights adviser must be an employee of the health service, or another entity engaged to provide services, must report directly to the administrator of the service and must not be a member of the treating team. The Government Bill states a patient rights adviser may be an employee of an entity that the health service has engaged to provide services, or an employee of the health service who is not employed in the service's mental health service.

While both Bills provide HHS with the flexibility to engage advisers through an external entity or through the HHS, the Committee considers the provisions in the Government Bill enable a greater degree of independence as they prohibit anyone employed in the HHS mental health service from being a patient rights adviser.

8.4 Implementation issues

A number of potential implementation issues were raised during the inquiry, including questions relating to the qualifications, governance and monitoring of patient rights advisers. The Department responded to these issues while giving evidence at the public briefing on 9 November 2015.

When asked by the Member for Greenslopes what qualifications patient rights advisers would be required to have, Mr Sheehy stated:

> *That is quite open at this stage. It would be a mixture of skills. We will need to work on position descriptions. We are not looking for a particular qualification. A person may have a clinical background. Certainly, having some ability to understand legislation would be useful. They may not necessarily be a lawyer, but if someone has very good interpersonal skills, very good communication skills, that would be critical—someone who can operate in a robust way in this environment and ensure that rights are protected. So the skills would be across-the-board without pursuing a particular sort of qualification, if I could put it that way.* [276]

The Department also provided the following written advice on this issue after the briefing:

> *It is not anticipated that Independent Patient Rights Advisers would have a specific qualification. Advisers will need strong communication skills and a demonstrated ability*

276 Public briefing transcript, 9 November 2015, page 8.

> *to support patient rights in a challenging environment. Persons may have a clinical or legal/advocacy background. There will be significant initial and ongoing training for advisers. It is expected that their functions will be overseen and co-ordinated by a State-wide Co-ordinator position.*[277]

Members asked whether there would be systems for monitoring the advice that the advisers are giving. In response, the Department advised:

> *It is proposed, as part of the implementation, that there will be a state-wide system. So there will be a network of advisers as part of the implementation that require intense training. It is envisaged that there would be a state-wide coordinator who could monitor the situation. So we think that, with those various checks and balances, there is a good potential that the system will work. The Department is happy to review it down the track to ensure that it is working. The issues around the independence of advice has been raised and, certainly, that is something that is essential. So Department is certainly happy to review that as part of an implementation strategy.* [278]

The Department advised it would review the operations of patient rights advisers in conjunction with the Mental Health Commissioner and consumers once arrangements had been bedded down. Twelve to eighteen months was identified as a possible timeframe. [279]

Members also asked where the state-wide coordinator position would be located and whether the Department has considered how they might work in with related organisations, such as the Mental Health Ombudsman and Mental Health Commissioner.

In response, Mr Sheehy stated the state-wide coordinator will be located in the Office of the Chief Psychiatrist and described establishing relationships with relevant organisations as a work in progress:

> *We would have to look at that. Certainly we have had some discussions with the Public Guardian, for example, and we have agreed to have an MOU with the Public Guardian on those issues. So in terms of the way in which the health protections such as independent patient rights advisers and the community visitors program work in together. We have committed to do that with the Public Guardian and certainly we are happy to talk to the Health Ombudsman about any connection points there as well.*[280]

Committee comment

The Committee appreciates stakeholders are concerned about matters relating to the qualifications, governance and monitoring of patient rights advisers.

With regard to qualifications, the Committee understands the Department is developing position statements and is of the view that patient rights advisers will have a mixture of skills, rather than a particular qualification. The Department has stated advisers 'will need strong communication skills and a demonstrated ability to support patient rights in a challenging environment' and 'may have a clinical or legal/advocacy background.'

The Department has also advised that there will be significant initial and ongoing training for advisers, that their functions will be overseen and co-ordinated by a state-wide coordinator and that the policy developed by the Chief Psychiatrist will include minimum competencies and standards for service delivery.[281]

277 Correspondence, Department of Health, 18 November 2015, Attachment.
278 Public briefing transcript, 9 November 2015, page 8.
279 Public briefing transcript, 9 November 2015, page 8.
280 Public briefing transcript, 9 November 2015, page 9.
281 Correspondence, Department of Health, 18 November 2015, Attachment.

With regard to governance and monitoring, the Committee again refers to advice provided by the Department, including that:

- a state-wide patient rights adviser network will be established, and a state-wide coordinator appointed to oversee and support the network and to report to the Chief Psychiatrist on activity,
- the policy developed by the Chief Psychiatrist will require compliance with a monitoring framework, and
- there are plans to review the operations of patient rights advisers, in conjunction with the Mental Health Commissioner and consumers, in 12 to 18 months' time once arrangements had been bedded down.

The Committee also recognises related concerns around how patient rights advisers will work with relevant external agencies. The Committee understands that this a work in progress, and that the Department has made a start on the issue by engaging with the Public Guardian around the development of a Memorandum of Understanding.

While the Committee is satisfied that significant consideration has been given to these implementation matters, the Committee believes there is benefit in the Minister and the Member for Caloundra advising the House further on these matters.

9. Restrictive practices – mechanical restraint and seclusion

9.1 National focus on reducing use

In 2005, all state and territory governments ratified an agreement to reduce and eliminate, where possible, the use of seclusion and mechanical restraint.[282] All jurisdictions are tightening the circumstances in which restraint and seclusion can be used and enhancing the collection of data used in annual reports so that progress may be monitored.[283]

In Australia, seclusion rates in acute mental health units have dropped from 13.5 seclusion events per 1,000 bed days in 2009-10 to 8.0 events in 2013-14.[284] This represents an average annual reduction of 12.2% over the five year period.[285] Seclusion rates have also fallen in Queensland over this period but the seclusion rate remains above the national average.[286]

The National Mental Health Commission has established an independent National Seclusion and Restraint Project to look at best practice nationally and overseas to reduce and eliminate, where possible, the use of seclusion and mechanical restraint.[287]

9.2 Overview

In his explanatory speech, the Minister discussed how key policy areas such as the proper regulation of restrictive practices are addressed in the Government Bill:

> *This bill expands the controls on restrictive practices to better protect involuntary patients. In addition to provisions relating to seclusion and mechanical restraint, this bill also includes provisions to regulate the use of physical restraint in authorised mental health services.* [288]

This chapter discusses provisions relating to mechanical restraint and seclusion while chapter 10 of the report outlines additional provisions in the Government Bill regarding physical restraint and medication.

Chapter 8 of both Bills regulate the use of mechanical restraint on and seclusion of patients of an AMHS.[289] While many of the provisions are similar to those in chapter 4A of the current Act, the Bills include more detail about the authorisation and use of mechanical restraint and seclusion on a patient. Key amendments include:

- revised definitions of mechanical restraint and seclusion,

282 National Mental Health Working Group, *National safety priorities in mental health: a national plan for reducing harm,* Canberra, Department of Health and Ageing, 2005, pp 3, 17-19; Australian Government, National Mental Health Commission, *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention,* 2013, p 11; Australian Government, Australian Institute of Health and Welfare, *Mental Health Services in Australia: Use of restrictive practices during admitted patient care,* (accessed on 16 December 2014).

283 L Springborg (Minister for Health), ' Minister's Explanatory Speech : Mental Health Bill' , *Queensland Debates*, 27 November 2014, p 4085, p 4086; Council of Australian Governments, *Response of the Council of Australian Governments to " A Contributing Life : the 2012 National Report Card o n Mental Health and Suicide Prevention " - a report by the National Mental Health Commission,* December 2012, p 6.

284 Australian Government, Australian Institute of Health and Welfare, *Continued decline in use of seclusion in mental health facilities,* 17 December 2014.

285 Australian Government, Australian Institute of Health and Welfare, *Mental Health Services in Australia: Use of restrictive practices during admitted patient care,* (accessed on 16 December 2014).

286 Australian Government, Australian Institute of Health and Welfare, *Mental Health Services in Australia: Use of restrictive practices during admitted patient care,* (accessed on 16 December 2014).

287 Australian Government, National Mental Health Commission, *National Seclusion and Restraint Project,* 2014.

288 Hansard Transcript, 17 September 2015, page 2004.

289 Private Member's Bill, cl.241; Government Bill, cl. 242.

- authorisation to use mechanical restraint is from the Chief Psychiatrist instead of within an AMHS,
- explicit criteria for the appropriate use of mechanical restraint and seclusion,
- clear time limits on the use of mechanical restraint and seclusion, and
- provision for reduction and elimination plans.

9.3 Obligations of authorised mental health service and staff

Both Bills and the Act place obligations on particular staff when a patient is mechanically restrained or secluded. These include ensuring that the:

- restraint or seclusion complies with the approval, authorisation or order where a patient is secluded under the Act,
- patient's 'reasonable needs' are met, for example, sufficient bedding, clothing, food and drink and access to toileting facilities, and
- relevant details are recorded appropriately.[290]

9.4 Definition of mechanical restraint

The Act defines mechanical restraint as '…the restraint of the person by the use of a mechanical appliance, approved under section 162B, which prevents the free movement of the person's body or a limb of the person.'[291] The use of a surgical or medical appliance for the proper treatment of physical disease or injury is not mechanical restraint.[292]

The Bills include essentially the same definition of mechanical restraint. The only difference is the phrase identified in bold at (2)(b) below, which is included in the Government Bill definition, but not the Private Member's Bill definition:

> (1) **Mechanical restraint** is the restraint of a person by the application of a device to the person's body, or a limb of the person, to restrict the person's movement.
>
> (2) However, mechanical restraint does not include—
>
> (a) the appropriate use of a medical or surgical appliance in the treatment of physical illness or injury; or
>
> (b) restraint of a person that is authorised **(or permitted)** under a law other than this part.
>
> Example for paragraph (b)—
>
> The restraint of a person by a police officer may be authorised under the Police Powers and Responsibilities Act 2000, section 615.[293]

While the definitions in the Act and the Bills are similar, the Bills do not refer to the current approval requirement for mechanical appliances, and specify that mechanical restraint does not include the restraint of a person authorised under another law.

9.4.1Approved mechanical devices

Under the current Act, the Director of Mental Health approves the mechanical appliances that may be used for the mechanical restraint of a patient.[294] Queensland Health's *The Mental Health Act 2000 Resource Guide, 2015* states the director has restricted the use of mechanical restraint to "wrist cuffs

290 *Mental Health Act 2000*, s.162G; Government Bill, cl.250 and cl.259; Private Member's Bill, cl.251 and s.259.
291 *Mental Health Act 2000*, s.162A (1).
292 *Mental Health Act 2000*, s.162A (2).
293 Private Member's Bill, cl.244; Government Bill, cl.243.
294 *Mental Health Act 2000*, s.162B.

to waist belt", that is a band fastened around the waist which links to bands fastened around the wrists.[295]

Both Bills replace approval of mechanical appliances with a requirement that the Chief Psychiatrist make a policy about the use of mechanical restraint and seclusion, which includes information about minimising their use and impact. This is discussed further at Chapter 9.9.[296]

9.5 Regulation of mechanical restraint

9.5.1 Offence

The Act provides that it is an offence to use mechanical restraint on a patient in an AMHS, other than under the Act. The maximum penalty is 50 penalty units.[297] An equivalent offence provision is included in both Bills. The Bills specify that the offence applies to voluntary patients as well as involuntary patients, and include an increased maximum penalty of 200 penalty units.[298]

9.5.2 Requirements for use

The Bills provide that an authorised doctor (or a health practitioner authorised by the authorised doctor) may use mechanical restraint on an involuntary patient only if:

- the service is a high security unit or another AMHS approved by the Chief Psychiatrist,
- the device used is an approved device,
- the Chief Psychiatrist has given approval for an authorised doctor to use mechanical restraint,
- the use of mechanical restraint is authorised by an authorised doctor,
- the restraint complies with the restraint and seclusion policy and any reduction and elimination plan for the patient,
- the restraint is done with no more force than is necessary and reasonable in the circumstances, and
- the patient is observed continuously while restrained.[299]

Similarly, the Bills include like provisions for the approval and authorisation of mechanical restraint.

9.5.3 Approval

An authorised doctor may apply to the Chief Psychiatrist for an approval which enables the authorised doctor to authorise the use of mechanical restraint. The application must include specified information including:

- why mechanical restraint may be necessary to protect the patient or others from physical harm,
- why there is no other reasonably practicable way to protect the patient or others from harm,
- the proposed device and period of approval, and
- the way in which the patient will be continuously observed while restrained.

295 Queensland Health, *Mental Health Act 2000* Resource Guide, 2015, p.13-4, https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/resource_guide_intro.pdf, accessed 15 November 2015.
296 Private Member's Bill, cl.294(1)(g); Government Bill, cl. 272.
297 *Mental Health Act 2000*, s.162C.
298 Government Bill, cl.242 and cl. 244; Private Member's Bill, cl.245.
299 Government Bill, cl.245; Private Member's Bill, cl.246.

A reduction and elimination plan may be included in the application (see Chapter 9.8 below).[300] If a reduction and elimination plan is not included, the Chief Psychiatrist may require the applicant to amend the application to include such a plan.[301]

In determining whether to provide approval, the Chief Psychiatrist must be satisfied that the use of mechanical restraint is necessary to protect the patient or others from physical harm and that there is no other reasonably practicable way to achieve this.[302] The approval must state:

- the period during which the mechanical restraint may be used,
- the approved device,
- any limitations relating to the use of mechanical restraint on the patient,
- the way in which the patient must be continuously observed while restrained, and
- any other conditions the Chief Psychiatrist considers appropriate.

An approval from the Chief Psychiatrist may be for a maximum of seven days.[303]

9.5.4 Authorisation

Before authorising the use of mechanical restraint, the authorised doctor must be satisfied of the same matters that the Chief Psychiatrist considered before granting an approval. The authorised doctor must be satisfied, among other things, that the use of mechanical restraint is necessary to protect the patient or others from physical harm, and that there is no other reasonably practicable way of protecting the patient or others from physical harm.[304]

If the doctor authorises the use of mechanical restraint, the following details must be documented:

- the start and end times and the period during which it may be used,
- the device,
- measures to ensure patient comfort and safety,
- the method of continuous observation, and
- whether a health practitioner may end the use of mechanical restraint before the end time.[305]

A patient may not be mechanically restrained for more than a total of nine hours in a 24 hour period, unless a reduction and elimination plan provides for that period.[306]

9.5.5 Stakeholder views

The QNU emphasise workplace health and safety must be taken into account when using mechanical restraints as a form of confinement. The QNU considers that nurses must not be exposed to violent situations through the use of these measures.

The QNU believe comprehensive consultation is required when developing policy and protocols, to ensure they respect the exercise of professional judgement, are evidence based, are able to be applied to each individual and appropriately balance the safety of staff, other patients and the individual's recovery.[307]

300 Government Bill, cl. 246; Private Member's Bill, cl. 247.
301 Government Bill, cl. 247; Private Member's Bill, cl. 248.
302 Government Bill cl.248(1); Private Member's Bill, cl.249(1).
303 Government Bill, cl. 248 (2); Private Member's Bill, cl.249(2).
304 Government Bill, cl. 249(1); Private Member's Bill, cl.250(1).
305 Government Bill, cl. 249(2); Private Member's Bill, cl.250(2).
306 Government Bill, cl. 249 (3-4); Private Member's Bill, cl.250(3-4).
307 Submission 27, pages 81-82.

9.6 Definition of seclusion

The current Act defines seclusion as 'the confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented.' The Act states the overnight confinement for security purposes of an involuntary patient in a high security unit or an in-patient facility of an AMHS is not seclusion.[308]

Both Bills include essentially the same definition of seclusion. The only difference is the phrase identified in bold at (2)(a) below, which is included in the Government Bill definition, but not the Private Member's Bill definition.

> *(1) Seclusion is the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.*
>
> *(2) However, seclusion does not include—*
>
> *(a) confinement of a person in a high security unit or in another authorised mental health service approved by the Chief Psychiatrist* ***(for the purposes of this part)****, if the confinement is—*
>
> *(i) for a period, approved by the administrator of the service, of not more than 10 hours between 8p.m. and 8a.m.; and*
>
> *(ii) for security purposes; or*
>
> *(b) confinement that is authorised under a law other than this part.*[309]

9.7 Regulation of seclusion

9.7.1 Permitted only under the Act

The current Act provides that it is an offence to keep a patient in an AMHS in seclusion, other than under the Act. The maximum penalty is 50 penalty units.[310] An equivalent offence provision is included in both Bills. The Bills specify that the offence applies to voluntary patients as well as involuntary patients, and include an increased maximum penalty of 200 penalty units.[311]

9.7.2 Authorisation

The current Act provides that any doctor may authorise seclusion. Under both Bills, an authorised doctor may authorise the seclusion of an involuntary patient. While the Chief Psychiatrist does not approve or authorise seclusion, the Bills provide that the Chief Psychiatrist may give a service a written direction about seclusion, and the Chief Psychiatrist is required to prepare a policy about mechanical restraint and seclusion, including minimising their use and impact.[312]

A written authorisation for the use of seclusion on a patient may be made by an authorised doctor if satisfied that:

- it is necessary to protect the patient or others from physical harm,
- there is no other reasonably practicable way to protect the patient or others from physical harm, and
- the authorisation complies with any written direction given by the Chief Psychiatrist, the restraint and seclusion policy and any reduction and elimination plan for the patient (see 9.9).

An authorisation must state the period (of not more than three hours) during which seclusion may be used and the time at which the use of seclusion is to start and end. The total period of seclusion for a

308 *Mental Health Act 2000*, s.162J.
309 Government Bill, cl.253; Private Member's Bill, cl.254.
310 *Mental Health Act 2000*, s.162K.
311 Government Bill, cl.254; Private Member's Bill, cl.255.
312 Government Bill, cl.256 and cl. 272; Private Member's Bill, cl. 257 and cl. 294.

patient in a 24 hour period is nine hours, unless a reduction and elimination plan provides for seclusion for that period.

The authorisation must state the measures to be taken to ensure the health, safety and comfort of the patient, the way in which the patient must be observed, either continuously, or at intervals of not more than 15 minutes. The authorisation must also state whether a health practitioner may remove the patient from seclusion before the end time.[313]

9.7.3 Requirements for use

An authorised doctor or health practitioner may keep an involuntary patient in seclusion only if:

- it is authorised by an authorised doctor,
- it complies with the restraint and seclusion policy, any written directive from the Chief Psychiatrist and any reduction and elimination plan for the patient,
- it is done with '… no more force than is necessary and reasonable in the circumstances', and
- the patient is observed continuously, or at intervals of not more than 15 minutes.[314]

9.7.4 Stakeholder views

The RANZCP oppose the provisions which allow the Chief Psychiatrist to issue seclusion directions about individual patients 'because it interferes with the clinical governance of these patients.' [315]

The QNU consider that these provisions need to strike a balance between the safety of staff and patients and the rights of the patient.[316]

9.7.5 Emergency seclusion

The current Act provides that the senior registered nurse on duty may approve seclusion.[317] The Bills provide for emergency seclusion of a patient by a health practitioner in charge of an inpatient unit, or an appropriately qualified person authorised by the health practitioner. The Bills set a maximum period of one hour and more clearly specify the criteria and requirements for emergency seclusion.

The Bills allow a patient to be kept in seclusion if it is:

- immediately necessary to protect the patient or others from harm and there is no other reasonably practicable way to achieve this,
- not prevented by a direction given by the Chief Psychiatrist,
- the patient is observed continuously while secluded,
- the period of seclusion is not more than an hour, and
- the authorised doctor is advised as soon as practicable afterwards.

The authorised doctor must examine the patient, or arrange for the patient to be examined by another authorised doctor, and decide whether to authorise the seclusion. A patient secluded under this provision may not be kept in seclusion for more than three hours in a 24 hour period.[318]

9.7.6 Stakeholder views

The QNU expressed the same concerns about seclusion as those identified for mechanical restraint and advise that policy development in this area should take account of and allow for clinical judgement to be respected.[319]

313 Government Bill, cl. 257; Private Member's Bill, cl.258.
314 Government Bill, cl. 255; Private Member's Bill, cl.256.
315 Submission 33, page 2.
316 Submission 27, page 52.
317 *Mental Health Act 2000*, s.162R and s.162S.
318 Government Bill, cl.262; Private Member's Bill, cl.262.
319 Submission 27, pages 81-82.

9.8 Removal and re-application before authorisation ends

Both the Act and the Bills provide for mechanical restraint to be removed from a patient, and a patient to be removed from seclusion, before an authorisation or order ends. Similarly, the Act and the Bills also provide for a mechanical restraint to be re-applied, and a patient returned to seclusion, if the authorisation or order has not ended and states this may occur. In both cases, the test is whether seclusion or restraint is considered necessary to protect the patient or others from physical harm. The power to make these decisions rests in the Act with the Director of Mental Health and senior registered nurse on duty, and with the Chief Psychiatrist and health practitioner in charge of the inpatient unit under the Bills.[320]

9.9 Reduction and elimination plans

As noted above, the Bills provide for reduction and elimination plans, which are developed by an authorised doctor to provide for the reduction and elimination of either or both the use of mechanical restraint or seclusion on a patient.[321]

A reduction and elimination plan must include information about any previous use of mechanical restraint and seclusion on the patient, the type and effectiveness of past strategies to reduce the use of mechanical restraint and seclusion and proposed future strategies to reduce the use of mechanical restraint and seclusion.[322]

The Chief Psychiatrist may approve a reduction and elimination plan. An authorised doctor's application may be included with an application for approval to use mechanical restraint.[323] The Chief Psychiatrist may require an authorised doctor to amend an application for approval to use mechanical restraint to seek approval of a reduction and elimination plan.[324]

9.9.1 Stakeholder views

The QMHC strongly supports the development of reduction and elimination plans.[325]

9.10 Chief Psychiatrist policy

Both Bills include a requirement for the Chief Psychiatrist to make a policy about the use of mechanical restraint and seclusion. There are, however, some key differences between the Bills.

Clause 294(1)(g) of the Private Member's Bill states the policy must cover 'the use of mechanical restraint and seclusion, including minimising the use and impact of mechanical restraint and seclusion on patients.'

Clause 272 of the Government Bill specifies that the policy required to be made by the Chief Psychiatrist is about both physical and mechanical restraint, and also the use of medication:

> *(a) the use of mechanical restraint, seclusion and physical restraint under section 267(1), and the appropriate use of medication, including ways of minimising any adverse impacts on patients; …*

In addition, the policy is to include the information to be recorded or given to the Chief Psychiatrist about the use of these treatments, and the time and the way the information is to be provided. Clause

320 *Mental Health Act 2000*, s.162H and s.162Q; Government Bill, cl. 251-252 and cl. 260-261; Private Member's Bill, cl.252-253 and cl. 260-261.
321 Government Bill, cl. 263; Private Member's Bill, cl.263.
322 Government Bill, cl. 264; Private Member's Bill, cl.264.
323 Government Bill, cl. 246(3) and cl. 266; Private Member's Bill, cl. 266 and cl. 247(3).
324 Government Bill, cl. 247(2); Private Member's Bill, cl.248(2).
325 Submission 14, page 23.

272(2) requires authorised doctors, authorised mental health practitioners, administrators of an AMHS and others performing a function under the legislation to comply with the policy.

9.10.1 Stakeholder views

The QMHC 'particularly support's the Bill's provisions which requires the Chief Psychiatrist to develop a restraint, seclusion and other practices policy regarding the use of mechanical restraint, seclusion and physical restraint and the appropriate use of medication ...'[326]

Committee comment

The Committee acknowledges the national focus on reducing the use of seclusion and mechanical restraint and commends both Bills for including a strong regulatory framework in these areas.

The Bills build on the *Mental Health Act 2000* by including more detail about the authorisation and use of mechanical restraint and seclusion on a patient. This includes:

- elevating the requirement to approve mechanical restraint to the Chief Psychiatrist,
- setting clear time limits on the use of mechanical restraint and seclusion,
- providing for reduction and elimination plans, as a means of reducing and eliminating the use of physical restraint and seclusion on a patient, and
- requiring services to comply with policies made by the Chief Psychiatrist.

The Committee appreciates that mechanical restraint and seclusion are emotive issues, and that patients, advocates and staff alike have concerns about how and when they may be used. The Committee acknowledges that it is necessary and appropriate to strike a balance between the safety of staff and patients and the rights of the patient in this regard.

The Committee notes the concerns raised by the QNU that nurses must not be exposed to violent situations through the use of these measures. The QNU also calls for comprehensive consultation when developing evidence based policy and protocols in these areas, which respect the exercise of professional judgement and are able to be applied to each individual and appropriately balance the safety of staff, other patients and the individual's recovery.

The Committee notes that both Bills require the Chief Psychiatrist to make a policy about the use of mechanical restraint and seclusion, and the Government Bill provides that this policy must also include physical restraint and medication (discussed in Chapter 10). The Committee recommends the Minister require the Chief Psychiatrist to actively engage with all relevant stakeholders on the development of this policy.

Recommendation 8

The Committee recommends that, in the event that either Bill pass, the provisions in the Mental Health Bill 2015 which require the Chief Psychiatrist to develop policies relating to mechanical restraint, seclusion, medication and physical restraint be retained.

Recommendation 9

The Committee recommends that the Minister for Health and Minister for Ambulance Services require the Chief Psychiatrist to actively engage with all relevant stakeholders on the development of policies relating to mechanical restraint, seclusion, medication and physical restraint.

326 Submission 14, page 23.

10.Restrictive practices – medication and physical restraint

10.1 Background

The Government Bill provides significant additional safeguards in relation to medical and physical restraint. The Government Bill distinguishes between physical restraint and mechanical restraint and specifies the circumstances in which a patient may be physically restrained.

Importantly, the Government Bill provides significant additional safeguards requiring that medication may only be administered when it is clinically necessary.

The Private Member's' Bill does not provide for these matters.

When introducing the Government Bill the Minister said:

> *There is strong evidence that physical restraint can lead to serious harm to patients and staff. The provisions in this bill will enable the use of physical restraint to be carefully monitored to ensure that it is only used as a last resort.*
>
> *The bill also ensures the appropriate use of medication on patients in authorised mental health services. This addresses a longstanding concern of patient advocates. The provisions in this bill will enable the use of medications to be carefully monitored to ensure that their use is appropriate for a patient's treatment and care.*[327]

10.2 Physical restraint

Clause 267 of the Government Bill defines physical restraint, as outlined below, while clause 268 makes it an offence to use physical restraint on a patient, other than under the Act, with a maximum penalty of 200 penalty units.

> *(1) Physical restraint, of a patient, is the use by a person of his or her body to restrict the patient's movement.*
>
> *(2) However, physical restraint of a patient does not include—*
>
> *(a) the giving of physical support or assistance reasonably necessary—*
>
> *(i) to enable the patient to carry out daily living activities; or*
>
> *(ii) to redirect the patient because the patient is disoriented; or*
>
> *(b) physical restraint of the patient that is authorised under a law other than this part; or*
>
> *(c) physical restraint of the patient that is required in urgent circumstances.*

Clause 269 provides that an authorised doctor (or a health practitioner in charge of an inpatient unit or other unit within an AMHS) may authorise the use of physical restraint on a patient if there is no other reasonably practicable way to:

- protect the patient or others from physical harm,
- provide treatment and care to the patient,
- prevent the patient from causing serious damage to property, or
- for a patient detained in an AMHS—to prevent the patient from leaving the service.

Committee comment

The Committee supports the additional provisions in the Government Bill which distinguish between mechanical and physical restraint, and specify the circumstances in which a patient with a mental illness may be physically restrained.

327 Hansard Transcript, 17 September 2015, page 2004.

The Committee acknowledges that physical restraint is an emotive issue, and that the physical restraint of a patient can sometimes be harmful to patients and staff. The provisions in the Bill strike an appropriate balance between the safety of patients and staff and the rights of the patient by only allowing staff to use physical restraint within a defined set of parameters, which include appropriate safeguards for patients who may need to be restrained.

Specifically, the Committee notes the definition of physical restraint is limited to staff using their body to restrict a patient's movement. Physical restraint may only be used in limited circumstances, the Chief Psychiatrist must make a policy about the use of physical restraint, which includes ways to minimise any adverse impacts on patients, and staff of an AMHS must comply with this policy.

Recommendation 10

The Committee recommends that, in the event that either Bill pass, the provisions in the Mental Health Bill 2015 which distinguish between mechanical and physical restraint, and specify the circumstances in which a patient with a mental illness may be physically restrained, be retained.

10.3 Medication

Clause 270 of the Government Bill defines medication to include the sedation of a patient. Clause 271 makes it an offence to administer medication to a patient unless the medication is clinically necessary for the patient's treatment and care, and provides that a patient's treatment and care includes preventing imminent serious harm to the patient or others. The maximum penalty is 200 penalty units.

The QMHC welcomes the Bill's provisions making it an offence to give medication to an involuntary patient unless the medication is clinically necessary.[328]

The Government Bill contains related provisions, notably that:

- conditions imposed on a forensic order or treatment support order by the Mental Health Court may not require the person to take a particular medication or a particular dosage of a medication,[329]
- the Chief Psychiatrist must include details about the type of medication being provided to the relevant patient in an information notice, and [330]
- medication may be administered to an involuntary patient for the purpose of transport, without their consent, under certain circumstances.[331]

10.4 Stakeholder views

The Committee discussed issues surrounding medication during the public hearings on the Bills, with a particular focus on staff and patient safety, and clinical decision-making.

The Member for Mudgeeraba asked the AMAQ:

> *Do you have some concerns that with this provision in the bill eventually it might be interpreted that chemical restraint and seclusion rooms be used as an absolute, absolute last resort so that we are taking away one of the tools, I guess, of the medical staff and nursing staff to utilise chemical restraints for not only the safety and medical safety of the patient themselves but of the staff who are looking after them?* [332]

328 Submission 14, page 23.
329 Government Bill, cl. 135 and clause 144
330 Government Bill, cl. 318(4)(a)
331 Government Bill, cl. 372
332 Public hearing transcript, 28 October 2015, page 13

In response, AMAQ cautioned against using the term chemical restraint as it 'implies that people are using medications for purposes other than their therapeutic effect' and suggested more neutral terminology. The AMAQ sated:

> *I share your concern that an over-enthusiastic interpretation of that could limit treatment options. In terms of the existing wording, it seems appropriate in terms of current clinical practice.*[333]

The Member for Mudgeeraba voiced her concerns that a possible push to reduce the ability of clinicians to restrain a patient for their own safety, particularly whether clinical decisions about medicating an involuntary patient should be left with the clinical staff, rather than the courts. The RANZCP replied:

> *I think, yes. Basically, what we are saying in section 135 is that, if the Mental Health Court has to impose conditions on treatment, they may not go in the favour of what a psychiatrist and treating clinicians think is the best for that patient. At times, with the Mental Health Court—you are right—it can come as a directive which we may have to follow and at times which may or may not be helpful for the patient, and the victims, and the families and the carers. So I think the college is supportive of the bill so that the court may not impose the conditions with regard to a patient's medication because they can adversely affect the patient's treatment and their recovery. Yes, I do think that, because the risk of what you call chemical restraints is more if we do that. The college wants to make a recommendation that we should not be imposing conditions, but we should be giving the recommendations and the actual treatment decision are then left to the treating team.*[334]

Professor Harry McConnell considered that there is a role for seclusion and chemical restraint in emergency situations, which should be differentiated from the use of restrictive practices in somebody who has a chronic illness, particularly in the community.[335] He noted that there does not appear to be a clear set of standard practice guidelines for clinical staff:

> *There is no standard format that occurs in each of the hospitals in Queensland. I think that is a shame. It needs to be standardised.*
>
> *In terms of excellence, if you look at what is done overseas you will see that they have frequently dedicated code black teams. These are clinicians, usually nurses, who are highly skilled and highly trained specifically in dealing with code black. We are not talking about security people, we are not talking about big bulky guys taught to sit on top of people; we are talking about people who are highly skilled at bringing the situation under control very quickly. They do it usually with a combination of medication, with different types of holds, with de-escalating techniques and they are able to do that amazingly within a period of minutes. So when it escalates and gets out of control, that is when it becomes difficult.*
>
> *Clearly, in an emergency situation there is a very important role for the use of seclusion, for the use of medication, and there are very clear international guidelines that have been developed to do that that we do not currently follow in Queensland, it should be said.*

Committee comment

The Committee supports the additional provisions in the Government Bill, which provide for and regulate the administration of medication.

333 Public hearing transcript, 28 October 2015, page 13.
334 Public hearing transcript, 28 October 2015, pages 18-19.
335 Public hearing transcript, 23 November 2015, pages 2-3.

The Committee acknowledges that the appropriate use of medication has been a longstanding concern for patient advocates, and that AMHS staff are also concerned that too stringent provisions around the administration of medication may limit treatment options and potentially endanger other patients and staff.

The Committee considers the provisions in the Bill strike an appropriate balance between the safety of patients and staff and the rights of the patient. Specifically, the Committee notes staff of an AMHS may only administer medication when it is clinically necessary for the patient's treatment and care, and that this includes preventing imminent serious harm to the patient or others.

The Committee also notes additional safeguards in the Bill, including that the Chief Psychiatrist must make a policy about the use of medication, which includes ways to minimise any adverse impacts on patients, and that staff of an AMHS must comply with this policy.

Recommendation 11

The Committee recommends that, in the event that either Bill pass, the provisions in the Mental Health Bill 2015 that provide for and regulate the administration of medication be retained.

11.Prohibited treatments including psychosurgery

11.1 Overview

The current Act regulates the use of psychosurgery. The Bills prohibit psychosurgery, insulin induced coma therapy and deep sleep therapy, and make it an offence to perform or administer these treatments on another person. The maximum penalty is 200 penalty units, or 2 years imprisonment.[336]

11.2 Psychosurgery

The current Act defines psychosurgery as 'a neurosurgical procedure to diagnose or treat a mental illness, but does not include a surgical procedure for treating epilepsy, Parkinson's disease or another neurological disorder.'[337]

Both Bills define psychosurgery and distinguish between psychosurgery and non-ablative neurosurgery, as follows:

> ***Psychosurgery****:* a procedure on the brain, that involves deliberate damage to or removal of brain tissue, for the treatment of a mental illness.
>
> ***Non-ablative neurosurgical procedure****:* a procedure on the brain, that does not involve deliberate damage to or removal of brain tissue, for the treatment of a mental illness.[338]

Psychosurgery is defined as using ablative procedures which require the surgical removal of brain tissue causing a focal lesion, which is irreversible, for example, a lobotomy. Such procedures have been described as posing serious risks with the potential for irreversible side effects.

Non-ablative procedures, while still a surgical intervention, aim to stimulate one or more regions of the brain rather than produce an irreversible lesion to treat mental illness. According to the RANZCP, because brain stimulation techniques are not ablative, that is, they do not create a focal lesion, they are not considered to come under the term 'psychosurgery'. Non-ablative procedures, such as deep brain stimulation (DBS), are also used to treat conditions other than mental illness, such as Parkinson's disease.

The Committee's predecessor Committee was advised that the initial intention of psychosurgery provisions in the current Act was to ensure that irreversible procedures were not undertaken without an appropriate review occurring first, and that procedures such as DBS would not have been considered when the current Act was introduced.

Non-ablative neurosurgical procedures are a regulated treatment, together with electroconvulsive therapy, and are discussed in Chapter 13.

11.3 When psychosurgery may be used

At the Departmental briefing, the Committee was advised that the arrangements for psychosurgery are changed under the Bill, and that it '… may only take place with the consent of both the relevant person and the approval of the Mental Health Review Tribunal.' [339]

> *If it is a procedure, which is the old use of the term, where brain tissue is intentionally damaged or removed, that procedure will be prohibited. The bill does, however, allow for deep brain stimulation techniques. That can only occur with the informed consent of the individual and with the approval of the tribunal.*[340]

The Department explained why psychosurgery is prohibited under the Government Bill:

336 Government Bill, cl. 239-240; Private Member's Bill, cl. 232-233.
337 *Mental Health Act 2000*, Schedule, Dictionary.
338 Government Bill, Schedule 3; Private Member's Bill, Schedule 3.
339 Public briefing transcript, 14 October 2015, page 2.
340 Public briefing transcript, 14 October 2015, page 6.

> *Ablative surgery was associated with permanent personality change and brain damage in many cases, and it has not been used in Queensland in my memory, which is a long time, and I cannot think of any occasions where it has been used interstate either. It is banned completely in New South Wales. It is theoretically available in Victoria, but it is a very complicated process and they have a psychosurgery board that needs to review the application. So we thought there was no risk in preventing that from occurring.*[341]

11.4 Transitional provisions for psychosurgery

The Bills provide that a decision to approve an application to perform psychosurgery that is a non-ablative neurosurgical procedure continues in effect and is not affected by the commencement of the proposed new Act.[342]

11.5 Stakeholder views

In its submission to the Committee, the QNU expressed support for the '… distinction between psychosurgery and non-ablative neurosurgery as this as it appears to be an evidence based safeguard.'[343] It noted that terminology in the Act regarding regulated treatments is not contemporary and recommends:

> *The term 'psychosurgery' be replaced with 'neurosurgery for psychiatric conditions' and be defined as follows: Neurosurgery for psychiatric conditions' means a neurological procedure to treat or ameliorate symptoms of a psychiatric condition.*[344]

Dr Neil McLaren, Psychiatrist, strongly opposes the use of psychosurgery under any circumstance, including non-ablative neurosurgical procedures. He considers that '… psychosurgery has no basis in science.'[345] Similarly, Mr Anthony Parker submitted that he objects '… to the use of psycho-surgery as, again, there are no facts to support the use of this brutal torture as a 'treatment'.[346]

A number of submissions received follow a set form and contained common views. These submitters do not support the use of the term 'neurosurgical procedure', for example with regard to DBS, as they consider it disguises psychosurgery. These submitters propose that both psychosurgery, including neurosurgical procedures, be banned.[347]

Committee comment

The Committee notes that while psychosurgery is a regulated treatment under the current Act, the Bills prohibit the use of psychosurgery and make it an offence to perform or administer the treatment on another person.

The definition of psychosurgery has been changed under the Bills to distinguish between psychosurgery and non-ablative neurosurgical procedures. The Committee understands this change prohibits procedures that involve the deliberate damage to, or removal of, brain tissue for the treatment of a mental illness (psychosurgery). Procedures on the brain that do not involve deliberate damage to, or removal of, brain tissue, for the treatment of a mental illness (non-ablative neurosurgical procedures) are regulated treatments within defined circumstances. The Committees views on regulated treatments are outlined in Chapters 12 to 14.

341 Public briefing transcript, 14 October 2015, page 13.
342 Private Member's Bill, cl. 779; Government Bill, cl. 823.
343 Submission 27, page 81.
344 Submission 27, page 81.
345 Public hearing transcript, 28 October 2015, page 31.
346 Submission 11, page 1.
347 See for example, Submission 3.

The Committee considers these provisions better safeguard the rights of patients and therefore supports the distinction made between psychosurgery and non-ablative neurosurgical procedures, and the prohibition of psychosurgery, under the Bills.

Recommendation 12

The Committee recommends that, in the event either Bill pass, the following common provisions should be retained:

- definitions of psychosurgery and non-ablative neurosurgical procedure,
- prohibition of psychosurgery, and
- prescribing non-ablative neurosurgical procedures as a regulated treatment.

12.Regulated treatments – Electroconvulsive Therapy

12.1 Overview

The Bills define regulated treatment, prescribe requirements for the approval and performance of regulated treatment and make it an offence to perform a regulated treatment on a person, except under the Bills.

Regulated treatment includes electroconvulsive therapy (ECT) and a non-ablative neurosurgical procedure.[348] This chapter provides an overview of informed consent and outlines provisions relating to the approval and performance of ECT. Provisions relating to non-ablative neurosurgical procedures are discussed in Chapter 13.

12.2 Informed consent

The Bills require the informed consent of the person, or the approval of the Tribunal, before a regulated treatment can be performed.

The Bills provide that a person gives informed consent only if the person has the capacity to consent to the treatment, the consent is in writing and is signed by the person, and is freely and voluntarily given. Capacity is defined as the person having the ability to both understand the nature and effect of their decision, and to make and communicate their decision.

A person can give informed consent in an AHD.[349]

The Bills also require that before a person gives informed consent, the doctor proposing to provide the regulated treatment must explain the following, in a way that the person can understand:

- the purpose, method, likely duration and expected benefit of the treatment,
- possible pain, discomfort, risks and side effects of the treatment,
- alternative methods of treatment available, and
- the consequences of not receiving treatment.[350]

12.3 What is ECT and how is it used

ECT is defined in both Bills as the application of an electric current to specific areas of the head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent for the treatment of a mental illness.[351] The current Act uses the same definition, omitting reference to the treatment of a mental illness.[352]

ECT is most commonly used to treat clinical depression, mania and psychosis. The RANZCP states that its primary purpose is to quickly and significantly alleviate psychiatric symptoms and it is used:

> *… for the quite severe selective patient population who are suffering from severe depression. Many are at times psychotic features, which means losing touch of reality, where they are putting themselves or other people at acute risk.*[353]

ECT treatments are usually given one to three times a week, and the length of a course varies. The average number of sessions used to treat depression ranges from eight to twelve sessions. The RANZCP told the Committee that the whole procedure takes less than five minutes.[354]

348 Government Bill, cl. 231; Private Member's Bill, cl.224.
349 Government Bill, cl. 232; Private Member's Bill, cl.225.
350 Government Bill, cl. 233; Private Member's Bill, cl.226.
351 Government Bill and Private Member's Bill, Schedule 3.
352 *Mental Health Act 2000*, Schedule, Dictionary.
353 Public hearing transcript, 28 October 2015, page 18.
354 Public hearing transcript, 28 October 2015, page 18.

The RANZCP stated the treatment approach must be individualised to the patient, his/her disorder and response to ECT and advised that the practice is supported by active research aimed at improving efficacy and minimising side effects.[355]

12.4 Side effects

ECT is generally regarded as safe, with no evidence of long-term damage to brain function.[356] The most commonly cited side effects for ECT are:

- headaches, muscle aches or nausea,
- memory loss (there are conflicting reports as to how long this may last -some researchers say it is temporary, others state it can be permanent), and
- emotional distress, as a result of the stigma and controversy surrounding the treatment.[357]

During the second public briefing on the Bill, the Department spoke to the issue of side effects and safety. Dr Kingswell stated:

> *I am a psychiatrist by background and I have long experience with treating people with ECT. I am aware that it is a highly emotive issue and tends to divide the community's opinions, but there is absolutely no doubt from the literature that ECT is a safe and effective treatment for a group of patients, particularly if they have either severe depressive illnesses, mania and in some cases persistent symptoms of schizophrenia that do not respond to medications. Much of what you read in the submissions is really quite false. With regard to the structural brain damage for instance, there is no evidence that ECT causes structural brain damage. There is no evidence that ECT causes seizures. In fact, it can be used to treat seizures. There is no evidence that it causes lasting memory deficit. It does cause memory deficit for the period with which it is being administered and for a short time after, but the memory then recovers completely. The difficulty that you get in long-term studies is that people's memory is then confounded by many years of psychiatric illness and hospitalisation and medications and other issues like that.* [358]

Dr Michelle Fryer spoke to the Committee of the stigma associated with ECT and the inaccurate portrayal in modern media:

> *In caution I would say this is often an emergency treatment, so it important that those safeguards are there but they are not so onerous as to delay effective treatment that might be lifesaving. So the key points are that it is a safe and effective treatment and that there need to be appropriate safeguards in place.*
>
> *The analogy I want to draw is with pre-anaesthetic surgery. I think we would all agree that the early days of surgery could be called pretty barbaric. Surgery pre anaesthetic was always traumatic—sometimes lifesaving and sometimes fatal. We now consider surgery a very safe and effective intervention. Our public perceptions and professional perceptions of surgery reflect what we see around us. We often know people who have had surgery. We might have had surgery ourselves. People talk about having had surgery quite freely. Our media depictions of surgery are very positive and balanced and generally show good outcomes.*
>
> *ECT has undergone a similar evolution. It was misused in the early days. In context there was very little else that worked, but it did have a history of misuse and pre-anaesthetic ECT had severe side effects, and no-one would contemplate doing that now. Unfortunately, there is very little in the way of accurate depiction or balanced depiction of*

355 RANZCP, Position Statement 74 Electroconvulsive Therapy (ECT), August 2013.
356 https://www.sane.org/mental-health-and-illness/facts-and-guides/ect-electroconvulsive-therapy
357 http://bluepages.anu.edu.au/index.php?id=electroconvulsive-therapy
358 Public briefing transcript, 9 November 2015, pages 3-4.

> *ECT in the media. Public perceptions are still very negative, and people do not talk about it because of the stigma. It is a very rare to hear someone talking about the ECT that they had that cured their mental illness or that really helped them. An exception to that was an Insight program a few months ago that did show ECT and patients who had been successfully treated with ECT talking very positively about their experiences. But that sort of presentation is rare. I use that analogy to say I think it is very important that we do not deny an effective treatment to anybody of any age because of the history of that treatment.*[359]

12.5 Offence

The Bills provide that it is an offence to perform ECT on a person other than under the proposed new Acts. The Government Bill sets a maximum penalty of 200 penalty units, or 2 years imprisonment, while the Private Member's Bill sets the same maximum penalty as that in the current Act of 100 penalty units, or one year's imprisonment.[360]

12.6 Authority and approval

The Government Bill provides that a doctor of an AMHS may perform ECT on a person if:

- the person is an adult and has given informed consent to the therapy or, where the person is unable to give informed consent, the Tribunal has approved the therapy, or
- the person is a minor, and the Tribunal has approved the therapy.

A doctor who applies to the Tribunal for approval to use ECT must tell the patient the application has been made and explain the application to the patient.[361]

When deciding whether to give or refuse approval for ECT, the Tribunal must consider:

- where the application relates to an adult who is unable to give informed consent, any views, wishes and preferences expressed about the therapy in an AHD, or
- where the application relates to a minor, the views of the minor's parents and the views, wishes and preferences of the minor.

Provisions relating to the treatment of minors are outlined in Chapter 14.

The Tribunal may give approval only if satisfied:

- performing the therapy is in the person's best interests,
- evidence supports the effectiveness of the therapy for the person's particular mental illness,
- if the therapy has previously been performed on the person, the therapy is effective for the person, and
- if the person is a minor, evidence supports the effectiveness of the therapy for persons of the minor's age.

If the Tribunal gives approval, the approval must state the number of treatments that may be performed in a stated period and any conditions the Tribunal considers appropriate. [362]

The Private Member's Bill includes the same provisions, with one difference - the application and approval to perform ECT is linked to a psychiatrist rather than a doctor of an AMHS. [363]

359 Public hearing transcript, 23 November 2015, page 9.
360 Government Bill, cl. 234; Private Member's Bill, cl.227.
361 Government Bill, cl. 235.
362 Government Bill, cl.507; Private Member's Bill, cl. 473.
363 Private Member's Bill, cl.228.

12.7 Written notice of approval hearings

The Tribunal must provide the subject of the application, the applicant and the administrator of the AMHS with written notice of a hearing for an ECT application. The notice must be given at least three days before the hearing where it relates to an application to perform emergency ECT, or at least seven days prior for other applications. The notice time can be reduced if the person subject to the approval, or an interested person, agrees to a shorter period. [364]

12.8 Performing ECT in an emergency

The Government Bill provides that a doctor of an AMHS may treat a relevant patient with ECT in an emergency. Relevant patient is defined as an involuntary patient subject to a treatment authority, forensic order or treatment support order, and a person who is detained in a AMHS following an unpermitted absence from an interstate mental health service.

ECT may only be performed in an emergency if the doctor and senior medical administrator of the AMHS:

- certify, in writing, that the therapy is necessary to save the patient's life, or to prevent the patient from suffering irreparable harm, and
- have made an application to the Tribunal to perform ECT on the patient, which has yet to be decided.[365]

While the Private Member's Bill includes similar provisions, performing the therapy is linked to a psychiatrist rather than a doctor of a AMHS, and restricted to involuntary patients.[366]

12.9 Jurisdictional comparison – ECT on minors

Two Australian states have recently introduced mental health legislation which provide for the use of ECT on minors. The Victorian Mental Health Act 2014 provides that ECT can be performed on a young person subject to certain criteria, including an application to Victoria's Mental Health Tribunal.367 The Western Australian Mental Health Act 2014 prohibits ECT on a child under 14 years of age and requires the approval of the West Australian Mental Health Tribunal to use ECT on a minor between 14 and 18 years of age.[368] This matter is discussed further in Chapter 14.

12.10 Stakeholder views – safety and safeguards

Many stakeholders have concerns about the use of ECT on minors. These issues are discussed in detail in Chapter 14.

Some stakeholders also expressed concerns about the use of ECT generally. Other submitters, on the other hand, consider ECT can be a beneficial form of mental health treatment when used on a suitable person and with the appropriate legislative safeguards in place.

The Department acknowledged these concerns during the first public briefing on the Bills. The Department told the Committee that provisions in relation to ECT were looked at closely and outlined the following safeguards in the Government Bill:

> *In all cases where a minor is involved—that is, a person under the age of 18—the approval to use electroconvulsive therapy must go to the tribunal. The criteria for electroconvulsive therapy has been strengthened: it must be demonstrated that it is in the person's interest,*

364 Government Bill, cl. 506; Private Member's Bill, cl. 472.
365 Government Bill, cl. 236.
366 Private Member's Bill, cl.229.
367 See section 94 of the *Mental Health Act 2014* (Vic).
368 See sections 194 & 195 of the *Mental Health Act 2014* (WA).

> *both minors and adults, and there must be evidence that the procedure is appropriate for that particular mental illness and for a minor that it is appropriate for a person of that age. As I will refer to subsequently, the bill requires legal representation to be provided in all cases of an application for electroconvulsive therapy.*[369]

Stakeholder views varied when asked whether they considered the safeguards adequate.

The AMAQ questioned the adequacy of the evidence base for using ECT on minors, but were confident with regard to its use on adults:

> *As far as I am aware, the ECT evidence in adults, particularly in terms of RCT use, is pretty robust.*[370]

In comparison, a number of submitters included the following extract, which they attributed to the World Health Organisation (WHO).

> *Although significant controversy surrounds electroconvulsive therapy (ECT) and some people believe it should be abolished, it has been and continues to be used in many countries for certain mental disorders. If ECT is used, it should only be administered after obtaining informed consent. And it should only be administered in modified form, i.e. with the use of anaesthesia and muscle relaxants. The practice of using unmodified ECT should be stopped.*
>
> *There are no indications for the use of ECT on minors, and hence this should be prohibited through legislation.* [371]

Dr McLaren expressed this same view during the public hearing, stating ECT '… must not be approved under any circumstances.' [372]

In response, the Department advised that the extract is from the WHO Resource Book on Mental Health, Human Rights and Legislation, 2005, which it described as follows

> *The Resource Guide aims to assist countries in drafting, adopting and implementing legislation for persons with mental disorders, in the context of internationally accepted human rights standards and good practices. As such, the report is a guidance document and is not binding on WHO member countries.*[373]

The Department's advice also referred to two leading documents in the area of mental illness and human rights,[374] neither of which refer to prohibiting the use of ECT on minors. This matter is discussed further in Chapter 14.

The Committee further heard from Dr Michelle Fryer:

> *I am aware briefly of the WHO statement. Again, I would come back to my analogy that that seems to be looking at developing worlds and the misuse of ECT. Clearly there need to be safeguards in place to make sure ECT is used appropriately. I think there are a lot of surgical procedures done in a way in the developing countries that would not happen in Australia and in the developed world, and similarly with ECT there are practices that just would not be considered or acceptable here…*

369 Public briefing transcript, 14 October 2015, page 6.
370 Public hearing transcript, 28 October 2015, page 15.
371 World Health Organisation, *WHO Resource Book on Mental Health*, Human Rights Legislation, 2005, page 64.
372 Submission 22, page 2.
373 Correspondence, Department of Health, 18 November 2015, Attachment.
374 The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991), and the Convention on the Rights of Persons with Disabilities and Optional Protocol (United Nations, December 2006).

I have brought along the American Academy of Child and Adolescent Psychiatry's brief overview and ethical issues statement in regard to ECT in children and adolescents. They similarly support its use with appropriate safeguards in place and make the similar comment that this is an effective treatment and it is unethical to deny it to young people simply because of the stigma that surrounds it.[375]

Committee comment

The Bills provide a regulatory framework for a range of serious practices and treatments, which can be separated into three categories – restricted practices, regulated treatments and prohibited treatments. The Committee's views on restricted practices and prohibited treatments are outlined in Chapters 9 to 11.

Regulated treatments include electroconvulsive therapy (ECT) and non-ablative neurosurgical procedures, such as deep brain stimulation (DBS). The Bills provide that regulated treatments can be performed on both adults and younger people with a mental illness, or minors as they are often referred to in the Bills, in certain circumstances.

Stakeholders expressed strong views during the inquiry about the safety and efficacy of ECT. A number of stakeholders were particularly concerned about whether regulated treatments like ECT should be available to minors. The Committee's views about the use of regulated treatments on minors are discussed in Chapter 14. This commentary relates to the use of ECT on adults with a mental illness.

<u>Efficacy</u>

The Committee notes the advice of the Department, the RANZCP and AMAQ about the efficacy of ECT.

The Department told the Committee 'there is absolutely no doubt from the literature that ECT is a safe and effective treatment for a group of patients' while the RANZCP described the practice as 'supported by active research aimed at improving efficacy and minimizing side effects.'

Similarly, AMAQ stated that the evidence for the efficacy of ECT on adults is 'pretty robust'.

The Committee also notes that both the Department and the RANZCP consistently refer to the treatment being effective for a limited range of mental illnesses, such as clinical depression, mania and psychosis, and particular groups of patients, including those whose illnesses do not respond to medication, rather than promoting the treatment more broadly.

The Committee is satisfied that ECT is an established and effective treatment for a limited range of mental illnesses.

<u>Side effects</u>

A number of stakeholders expressed concern about possible side effects of ECT, citing memory loss, seizures and structural brain damage. The Committee again refers to the Department's advice on this issue.

The Department stated any memory loss experienced by patients relates to the period during which the therapy is administered and for a short time after, and that the memory then recovers completely, and that there is no evidence that ECT causes structural brain damage, seizures or lasting memory deficit.

The Committee also considered these concerns within the context of the regulatory framework outlined in the Bills, to determine whether it was satisfied that sufficient safeguards are in place prior to ECT being approved.

375 Public hearing transcript, 23 November 2015, page 10.

The Committee notes the Bills require the informed consent of the person, or the approval of the Tribunal, before a regulated treatment such as ECT can be performed. Before a person can give informed consent, the treating doctor must explain a number of things, including the purpose, method, likely duration and expected benefit of the treatment, the risks and side effects of the treatment, alternative treatments and the consequences of not receiving treatment.

Where a person lacks the capacity to give informed consent, the Tribunal must consider any views, wishes and preferences expressed about ECT in an advanced health directive and may only give approval if it is satisfied that:

- the therapy is in the person's best interest,
- there is evidence to support its effectiveness for the person's particular mental illness, and
- if it has previously been performed on the person, that the therapy was effective.

The Committee considers this framework provides adequate safeguards for patients who may receive ECT.

12.11 Stakeholder views - adequacy of offence penalty

The adequacy of the ECT offence penalties was highlighted in the form submissions, which compared the maximum penalties under the current Act and Bills for performing ECT on another person (see Chapter 12.5) with those applying to the mistreatment of an animal:

> *In comparison the Qld Animal Care and Protection Act [section 18], has a fine of $235,600 (2,000 penalty units*) or 3 years imprisonment for causing pain to, abusing, terrifying or worrying an animal. All criminal fines and imprisonment terms must be increased in any new bill.*[376]

Committee comment

The Committee notes that the Bills provide for different maximum penalties. The Government Bill sets a maximum penalty of 200 penalty units, or 2 years imprisonment, while the Private Member's Bill sets the same maximum penalty as that in the current Act i.e. 100 penalty units, or one year's imprisonment.

Given the seriousness of the treatment and the level of stakeholder concern around ECT, the Committee supports the stronger offence provisions included in the Government Bill.

Recommendation 13

The Committee recommends the offence and penalty provisions in the Mental Health Bill 2015 relating to performing ECT on a person other than under the proposed legislation be retained in the event that either Bills passes the House.

376 See for example, Submission 3.

13.Regulated treatments - non-ablative neurosurgical procedures

13.1 Definition

The Bills define a non-ablative neurosurgical procedure as a procedure on the brain that does not involve deliberate damage to or removal of brain tissue, for the treatment of a mental illness.[377] Deep brain stimulation (DBS) is provided as an example of a non-ablative neurosurgical procedure. [378]

At the first public briefing, the Department explained, with regard to the Government Bill:

> *The bill changes the arrangements for what is now called psychosurgery. If it is a procedure, which is the old use of the term, where brain tissue is intentionally damaged or removed, that procedure will be prohibited. The bill does, however, allow for deep brain stimulation techniques. That can only occur with the informed consent of the individual and with the approval of the tribunal.*[379]

At the public hearing, the AMAQ explained that DBS was '… originally developed for chronic neurological disorders such as Parkinson's. There is emerging evidence that it has a place in chronic intractable psychiatric disorders such as obsessive compulsive disorders and major depression.' [380]

Committee comment

The Committee notes that non-ablative neurosurgical procedures may only be performed on voluntary patients, and remain a regulated treatment under the Bills, as is the case in the current Act, because specialist colleges believe there is insufficient evidence as to whether they are an effective treatment for conditions such as depression and obsessive compulsive disorder.

Given the experimental nature of some of these procedures, the Committee considers it is appropriate that these procedures continue to be regulated, and restricted to voluntary patients who are able to provide informed consent.

13.2 Offence

Both Bills provide that it is an offence to perform a non-ablative neurosurgical procedure on a person for the purpose of treating the person's mental illness, other than under the Bills. The Government Bill sets a maximum penalty of 200 penalty units, or 2 years imprisonment, while the Private Member's Bill sets a maximum penalty of 100 penalty units, or 1 year's imprisonment.[381]

The Bills also specify a number of conditions which are not considered a mental illness. These include chronic tic disorder, dystonia, epilepsy, Parkinson's disease or tremor, Gilles de las Tourette syndrome and another neurological disorder prescribed by regulation.[382]

Committee comment

Given the seriousness of the procedures, the level of stakeholder concern around procedures like Deep Brain Stimulation and the immature evidence base for the effectiveness of non-ablative neurosurgical procedures more generally, the Committee supports the stronger offence provisions included in the Government Bill.

377 Private Member's Bill, Schedule 3; Government Bill, Schedule 3.
378 Private Member's Bill, cl. 231; Government Bill, cl. 238.
379 Public briefing transcript, 14 October 2015, page 6.
380 Public hearing transcript, 28 October 2015, pages 13-14.
381 Private Member's Bill, cl.230; Government Bill, cl. 237.
382 Private Member's Bill, cl. 231; Government Bill, cl. 237.

Recommendation 14

The Committee recommends that, in the event that either Bill pass, the offence and penalty provisions in the Mental Health Bill 2015 relating to performing a non-ablative neurosurgical procedure on a person for the purpose of treating the person's mental illness, other than under the legislation, be retained.

13.3 Authority and approval

The Government Bill provides that a doctor for an AMHS may perform a non-ablative neurosurgical procedure on a person if the person has given informed consent to the treatment and the Tribunal has approved the performance of the procedure on the person.

The Tribunal may give approval only if satisfied:

- the applicant has met the explanation requirements required for informed consent, and the person has given informed consent,
- the procedure has clinical merit and is appropriate in the circumstances,
- alternative procedures, which have been provided previously, have not provided 'sufficient and lasting benefit', and
- the procedure is to be performed by an appropriately qualified person.

The approval may include any conditions the Tribunal considers appropriate. [383]

While the Private Member's Bill includes similar provisions, performing the procedure is linked to a psychiatrist rather than a doctor of an AMHS. [384]

13.4 Written notice of approval hearings

The Tribunal must provide the subject of the application, the applicant and the administrator of the AMHS with written notice of a hearing for a non-ablative neurosurgical procedure at least seven days before the hearing. [385]

13.5 Stakeholder views

At the public briefing, the Department provided background on the policy reason behind limiting non-ablative neurosurgical procedures to voluntary patients:

> *The reason it remains a regulated treatment at all in the Mental Health Act is the feedback that we got from the specialist colleges. They felt that the jury was still out on whether it was an effective treatment for conditions like depression and excessive compulsive disorder and that we should continue to monitor its use in Queensland. So it is included in this act and it will not be available to involuntary patients. If there were a robust evidence base that this was an effective treatment for people who were incompetent then we would need to consider how we manage that in legislation.*[386]

Issues regarding the evidence base for non-ablative neurosurgical procedures such as DBS were addressed by the AMAQ, who consider that this type of treatment has a place '… in the context of fully informed consent.'

> *We have actually done a review on randomised controlled trials for deep brain stimulation. The first thing to say that in terms of randomised controlled trials, which as you know are the most robust form of evidence, the total number of patients we were able to find that had been in a randomised controlled trial was 40 across the whole world and that the*

383 Private Member's Bill, cl. 473; Government Bill, cl.510.
384 Private Member's Bill, cl.231; Government Bill, cl. 238.
385 Private Member's Bill, cl. 475; Government Bill, cl. 509.
386 Public briefing transcript, 14 October 2015, page 13.

> *evidence was most strong for obsessive compulsive disorder. But again when I say most strong, it meant that there was a moderate improvement in their scores for obsessive compulsive disorder, but that masked the fact that some people had no benefit whatsoever and other people obviously had a huge benefit.*
>
> *But the other thing you have to consider is also the side effects. About a third of the patients had significant side effects, including things like infection from the procedure and brain haemorrhage... The evidence shows that some people did very well but some people equally did not benefit a great deal and, as I say, they averaged around a moderate improvement not a complete cure and that there are side effects.*[387]

An overview of 'informed consent' is provided at Chapter 12.2.

The AMAQ further clarified that DBS has a place as a therapeutic option '… for the most intractable cases and in the context of fully informed consent about the likely benefits and risks.'[388]

The RANZCP told the Committee that '[t]he college has not made any position statement for deep brain stimulation at this stage.[389]

In Professor Kisley's personal opinion, he considers that '… deep brain stimulation should be viewed as an experimental treatment rather than an established treatment such as appendisectomy. Therefore, I think there could be an argument made that given it is an experimental treatment in terms of this particular area that some degree of oversight would not be a bad idea.' [390]

At the request of the Committee, the Department provided additional written advice on the clinical efficacy and effectiveness of DBS, in both adults and children. Efficacy and effectiveness in children is discussed in Chapter 14.

The Department advised that DBS has only recently been studied as a treatment for mental illnesses such as depression and obsessive-compulsive disorder (OCD). A small body of research shows the treatment is promising in relation to depression. The evidence for efficacy in OCD is more robust.
The Department included an extract from a 2015 research paper published in the Journal of Psychiatry, which stated:

> *There is insufficient evidence at this point in time to support the use of deep brain stimulation as a clinical treatment for any psychiatric disorder outside of research and programmes where formal outcome data are being systematically collated. While some promising initial data exist to support its potential efficacy for a number of psychiatric conditions, further research is required to establish optimal implantation targets, patient characteristics associated with positive therapeutic outcomes and optimal deep brain stimulation parameters and parameter-programming methods.*[391]

In conclusion, the Department stated it is important the Government Bill 'continue to give patients the opportunity to elect to have these procedures under tightly defined conditions.'

The Department also provided the following data on DBS:

> *In 2014-15, the Mental Health Review Tribunal approved two applications for the use of deep brain stimulation procedures on patients who wished to have the procedure in a private authorised mental health service. In Queensland, DBS is only performed as part of*

387 Public hearing transcript, 28 October 2015, pages 13-14.
388 Public hearing transcript, 28 October 2015, page 14.
389 Public hearing transcript, 28 October 2015, page 20.
390 Public hearing transcript, 28 October 2015, page 14.
391 Paul B Fitzgerald and Rebecca A Segrave, "Deep brain stimulation in mental health: Review of evidence for clinical efficacy"; Australian and New Zealand Journal of Psychiatry, 2015, Vo. 49(11).

> *an ethics Committee approved clinical research study and is not available as general clinical treatment.*[392]

The RANZCP also provided the Committee with further written information on DBS after the public hearing. This included an information sheet developed by the College in November 2015 to provide information on the procedure, clinical indications, side effects, patient selection and consent, and use of DBS in Australia.

The RANZCP states DBS is a well-established procedure for the treatment of advanced movement disorders, particularly Parkinson's disease, has been used to a much lesser extent to treat severe and medically intractable Tourette's syndrome (TS) and obsessive compulsive disorder (OCD), and is currently being trialled to treat other psychiatric disorders such as depression, addiction, and anorexia.

The RANZCP also provided the following information on hospital clinics in Brisbane which use DBS.

> *In Queensland, the Movement Disorders Clinic at St. Andrew's War Memorial Hospital in Brisbane provides DBS for patients with TS and OCD, however the majority of patients at the hospital receive the treatment for Parkinson's disease and other movement disorders. The hospital has considerable experience administering the procedure by international standards with approximately 800 DBS procedures carried out to date. A small number of DBS procedures to treat Parkinson's disease are conducted each year at the Princess Alexandra Hospital in Brisbane. They are the only hospitals or clinics that conduct the DBS procedure in Queensland.*[393]

392 Correspondence, Department of Health, 5 November 2015, pages 1-2

393 Correspondence from the Royal Australian & New Zealand College of Psychiatrists, 18 November 2015.

14.Treatment of minors

The Bills recognise the importance of providing appropriate treatment for younger people with a mental illness by including a specific principle for minors, making provisions for the approval and review of the detention of minors in high security units, incorporating safeguards around the use of ECT on minors, and providing for free legal representation for minors appearing before the Tribunal.

14.1 Principle for minors

The Bills prescribe principles for persons with a mental illness, which must be applied when administering the Bills. These include:

> *(i) Minors*
>
> *to the greatest extent practicable, a minor receiving treatment and care must have the minor's best interests recognised and promoted, including, for example, by receiving treatment and care separately from adults if practicable and by having the minor's specific needs, wellbeing and safety recognised and protected*.[394]

The meaning of least restrictive way also makes provisions for minors. Both Bills include improving and maintaining the health and wellbeing of persons with a mental illness who do not have the capacity to consent to treatment as a key object and state this must be achieved in a way that is the least restrictive of the rights and liberties of the person with the illness.[395] For minors this means, where possible, seeking parental consent to treatment rather than the minor being subject to involuntary treatment.[396]

During the first public briefing on the Government Bill the Department described this approach as follows:

> *The starting point is that if there is a supportive parent, a child under 18 needs treatment and the parent gives consent then they must be treated that way. That gives the family control over the situation.*[397]

Committee comment

The Committee acknowledges the focus both Bills place on providing appropriate treatment for younger people with a mental illness.

The Committee commends the inclusion of a specific principle for minors which requires persons acting under the Bills to recognise and promote a minor's best interests. This includes receiving treatment and care separately from adults if practicable and having their specific needs, wellbeing and safety recognised and protected.

The Committee also supports the additional measures included in the Bills to better safeguard minors in an AMHS, many of which are discussed below. These measures include:

- requiring the Chief Psychiatrist to approve the transport of minors to a high security unit, and requiring administrators of these units to advise the Chief Psychiatrist when a minor is admitted and released,
- prescribing processes for the Tribunal to review the detention of minors in high security units, and to approve all applications for the use of ECT on a minor, and
- providing free legal representation for minors appearing before the Tribunal.

394 Private Member's Bill, cl. 5(i); Government Bill, cl.5(i).
395 Private Member's Bill, cl.3 ; Government Bill, cl.3.
396 Private Member's Bill, cl. 13(a); Government Bill, cl.13(a).
397 Public briefing transcript, 14 October 2015, pages 8-9.

The Committee considers these provisions provide adequate safeguards for the treatment of minors.

14.2 Minors in a high security unit

The Government Bill provides for the transport of a minor who is in custody to a high security unit where the minor:

- is subject to a recommendation for assessment, a treatment authority, forensic order (mental health) or treatment support order, or
- consents to receiving treatment in an inpatient unit of an AMHS.

The administrator of the high security unit cannot consent to the transport unless the Chief Psychiatrist has given prior written approval. In deciding whether to grant approval, the Chief Psychiatrist must consider the minor's mental state and psychiatric history, treatment and care needs, and security requirements. The Chief Psychiatrist must also give a copy of the written approval to the administrator as soon as practicable.[398] Similarly, the administrator of the high security unit must give the Tribunal written notice, as soon as practicable, when the minor has been admitted, and when the minor stops being detained.[399]

14.3 Review of detention of minors in a high security unit

The Bills prescribe a process for the Tribunal to review the detention of minors in high security units. The process requires the Tribunal to review the minor's detention:

- within 7 days after being notified by the Chief Psychiatrist, and at three monthly intervals thereafter, and
- on application by the minor or an interested person.

The Tribunal may also review the minor's detention in the unit any time, on its own initiative.

The Tribunal must provide specific persons with written notice of a review hearing, including the minor, the administrator of the high security unit, the Chief Psychiatrist and the applicant, if the applicant is not the minor.

The Tribunal may also give the notice to the minor's parents if the minor may not understand, or benefit from receiving the notice, or it appears to be in the minor's best interests. The Private Member's Bill also provides that the notice may only be given to a parent given if the minor 'has not asked for communication with the parent not to happen.'

The notice must be given at least seven days before the hearing, unless the hearing relates the first review of the minor's detention.

The Tribunal must decide whether the minor should continue to be detained in the high security unit, or transferred to an AMHS that is not a high security unit. In deciding whether to continue the detention, the Tribunal must consider the minor's mental state and psychiatric history, treatment and care needs, and security requirements.[400]

14.3.1Stakeholder views

The issue of minors being placed in adult mental health services received considerable attention during the inquiry.

The Australian Psychological Society's College of Forensic Psychologists (the College) suggests that recognising and protecting a minor's specific needs, wellbeing and safety' is inconsistent with the

398 Private Member's Bill, cl.63-64; Government Bill, cl.69-70.
399 Private Member's Bill, cl. 68; Government Bill, cl. 77.
400 Private Member's Bill, cl. 280(5) and cl.462-465; Government Bill, cl. 285(5) and cl. 496-499.

notion that a minor could be treated in an adult facility if treatment separate from adults is not practicable. The College state minors should have the right to treatment in an appropriate facility and that the principles of the Bills should be 'overarching and not subject to resourcing.' [401]

The Department advised, during the first public briefing on the Government Bill, that placing children in services with adults is not routine, or long term:

> *I have to emphasise that children are not put in with adults as a routine and they are not put in there for very long. It might just be a last-resort issue—and keep in mind that minors can be 16, six-feet tall and 150 kilos and quite difficult to manage in paediatric wards. That is the practical concern that we have. If a minor is on an involuntary treatment order—and that does occur—they will have free legal advice provided for them at any Mental Health Review Tribunal to ensure their rights are properly advocated.* [402]

Dr Kingswell provided data on the on the number of minors being treated on involuntary treatment orders during the second public briefing on the Bill:

> *As of last week there were 94 minors on involuntary treatment orders, 80 per cent of whom were either 16 or 17, out of about 4,000 involuntary treatment orders in place for the state.*[403]

The Member for Moggill also asked during this later briefing 'whether all staff in those mental health wards are required to have blue cards, whether they be clinical or operational staff?'[404] The Department subsequently advised:

> *The current legislation (the Working with Children (Risk Management and Screening) Act 2000) provides that a blue card is not required for health practitioners registered under the Health Practitioner Regulation National Law (other than as a student) where the relevant work relates to being a registered health practitioner.*
>
> *However, persons who are not registered health practitioners need a blue card if:*
>
> *• the person provides health services to children at a health facility that provides services only or mainly to children, such as a children's hospital, or*
>
> *• the person provides health services at another health facility where the person's employment involves providing services only or mainly to children, such as in the paediatrics ward of a general hospital, or*
>
> *• the person provides health services other than at a health facility that requires physical contact with a child or where the person may be alone with a child.*
>
> *Employees who do not provide services to a child, such as administration officers, cleaners and maintenance workers do not need a blue card while working in health facilities.*[405]

A number of submissions, which follow a set form and contain common views, strongly opposed the involuntary treatment of children without parental consent and argued 'laws must be amended to ensure that children are not placed in adult wards.' [406]

More considered commentary was included in the submission from the Office of the Public Guardian. In relation to minors, the Public Guardian would like to see provisions in the Bill which require the

401 Submission 59, page 2.
402 Public briefing transcript, 14 October 2015, page 14.
403 Public briefing transcript, 9 November 2015, page 2.
404 Public briefing transcript, 28October 2015, page 3.
405 Correspondence, department of health, 18 November 2015, Attachment.
406 See for example Submission 3.

Guardian to be notified as soon as a minor is admitted to a high-security or adult unit and whenever seclusion, physical or mechanical restraint is used on a minor. This would allow the Guardian to 'prioritise a visit by a community visitor to that minor and to report back to the Public Guardian.' [407]

Committee comment

The Committee recognises the concerns raised by stakeholders regarding minors being placed in adult mental health services and acknowledges that is far from ideal to have younger people with a mental illness receiving care and treatment in these services.

The Committee notes the Australian Psychological Society's College of Forensic Psychologists statement that minors should have the right to treatment in an appropriate service and that the principles of the Bills should be 'overarching and not subject to resourcing'. The Committee would however, not wish to see a situation where a minor did not receive appropriate treatment and care for their mental illness because the only service available to them is a service which provides care primarily to adults.

The Committee considers, on balance, it is more appropriate for a minor to receive treatment and care in a service with adults, rather than not receive the level of treatment and care required to address their mental illness.

The Committee notes the advice of the Department that placing children in services with adults is neither routine, or long term and that there are situations where managing, older, larger minors on paediatric wards becomes difficult.

The Committee also understands that if a minor is on an involuntary treatment order, they have free legal representation at Mental Health Review Tribunal proceedings, to ensure their rights are properly advocated.

The Committee is concerned, however, that the advice provided by the Department suggests that clinical and operational staff working in an AMHS are not necessarily required to hold a blue card.

The Committee also notes the information provided by the Public Guardian regarding the jurisdiction of the Community Visitor Program. The Committee understands community visitors are able to visit minors in an AHMS and agrees with the Public Guardian that safeguards for minors could be enhanced by including provisions in the Bills which require an AMHS to notify the Guardian as soon as a minor is admitted to a high-secure or adult unit, and whenever seclusion, physical or mechanical restraint is used on a minor. This would allow the Guardian to 'prioritise a visit by a community visitor to that minor and to report back to the Public Guardian.'

Recommendation 15

The Committee recommends that the Bills be amended to require authorised mental health service to notify the Public Guardian when:

- minors are admitted to a high-secure and adult unit; and
- whenever seclusion, physical or mechanical restraint is used on a minor.

14.4 Proceedings of the Mental Health Tribunal

The Bills provide that the Tribunal must appoint a lawyer to represent a minor at a hearing, and that the appointment is at no cost to the person.[408] The Bills also require that where a proceeding relates to a minor, the Tribunal membership must include at least one psychiatrist with expertise in child psychiatry. The Government Bill expands this requirement to specify a psychiatrist with expertise in

407 Public hearing transcript, 28 October 2015, page 26.
408 Private Member's Bill, cl. 631; Government Bill, cl. 738.

child and adolescent_psychiatry.[409] The Committee understands that the difference in terms is incidental, as child psychiatrists are also referred to as child and adolescents psychiatrists.

14.4.1Stakeholder views

The QMHC supports the requirement for membership of the Tribunal to include at least one psychiatrist with expertise in child and adolescent psychiatry where proceedings involve a minor.[410]

Committee comment

The Committee notes the Department's advice that the use of ECT on minors under the current Act, which also requires approval by the Tribunal, is extremely rare and unlikely to be approved for younger adolescents.

The Committee also acknowledges the position statement issued by the Royal Australian and New Zealand College of Psychiatrists, which states that it is exceptionally rare for ECT to be used in children in the preadolescent age group and that where ECT is considered for a child or adolescent, the opinion of a child and adolescent psychiatrist should be sought.

The Committee supports these provisions in the Bills.

14.5 Hearings of the Mental Health Court

The Bills provide that if a minor is the subject of a proceeding in the Mental Health Court, the hearing of the proceeding is not open to the public. The Court may, however, permit a person to be present during the hearing if it is satisfied it is in the interests of justice.[411]

14.6 Stakeholder views - Use of ECT on minors

14.6.1 Overview

Both Bills provide that ECT can be performed on minors in certain circumstances. Requirements for the approval and performance of ECT on minors are discussed in Chapter 12.

Broadly speaking, ECT may only be performed on a minor if the Tribunal has provided approval. The Tribunal must consider the views of the minor's parents and the views, wishes and preferences of the minor when deciding whether to grant the approval, and may only give approval if, among other things, there is evidence which supports the effectiveness of the therapy on minors.

14.6.2 Tribunal approval

The QNU supports Tribunal approval for ECT on minors, describing it as '… an important safeguard.'[412]

14.6.3 Safety and efficacy and safeguards

Dr McLaren states ECT on minors 'must not be approved under any circumstances.' [413] Similar views were expressed in a number of submissions, which contain an extract from the WHO Resource Book on Mental Health, Human Rights and Legislation, 2005 (see 12.10).[414]

409 Private Member's Bill, cl. 610(2); Government Bill, cl. 717(2).
410 Submission 14, page 28.
411 Private Member's Bill, cl. 721; Government Bill, cl. 693.
412 Submission 27, page 81.
413 See for example Submission 3.
414 Submission 22, page 2.

In response, the Department advised that there are two leading documents in the area of mental illness and human rights[415], and that neither of these documents refer to prohibiting the use of ECT on minors.

During the first public briefing the Department advised that ECT provisions 'were looked at closely' and noted a number of safeguards, for both minors and adults, under the Government Bill. Mr Sheehy stated:

> *In all cases where a minor is involved—that is, a person under the age of 18—the approval to use electroconvulsive therapy must go to the tribunal. The criteria for electroconvulsive therapy has been strengthened: it must be demonstrated that it is in the person's interest, both minors and adults, and there must be evidence that the procedure is appropriate for that particular mental illness and for a minor that it is appropriate for a person of that age. As I will refer to subsequently, the bill requires legal representation to be provided in all cases of an application for electroconvulsive therapy.*[416]

Mr Sheehy also stated that ECT is 'used very, very infrequently on persons under 18' and again emphasised the requirement for the Tribunal to 'consider and demonstrate that it is in the individual's best interests.'[417] Dr Kingswell provided data during the second briefing on the Bill which supported Mr Sheehy's statements:

> *Under the current Act, the Mental Health Review Tribunal is required to approve all instances of ECT on persons who do not have the capacity to consent to treatment. During the last financial year, of 559 applications made to the Mental Health Review Tribunal only four applications were made and approved by the tribunal in relation to minors: one person of 17 years of age; two of 16 years of age; and one of 15 years of age. In the previous financial year only three applications were made and approved by the tribunal for minors. On one occasion the approval related to a 16 year old and on the other two occasions it related to 15 year olds. ECT is used on persons under the age of 18 extremely rarely and on persons in their mid to late teens.* [418]

Dr Kingwell went on to explain to the Committee how the Government Bill will provide a more complete picture of the use of ECT in minors by ensuring that the Tribunal hears all applications for ECT use on minors, rather than only applications relating to minors who lack the capacity to consent:

> *Under the existing Act it is only those people that require an MHRT decision because they lack the capacity to go through this process. Other minors are able to receive ECT as voluntary patients under the existing act and we have no visibility over that. It may occur in private hospitals and in authorised mental health facilities without us knowing that it is occurring. This act will address that: all cases of ECT treatment for minors, including where the minor consents, will need to be approved by the tribunal and the minor will be legally represented at that tribunal hearing. So we will have a complete picture of the use of ECT for minors with or without consent.* [419]

The AMAQ were not as confident with the use of ECT on minors, expressing concerns about the adequacy of the evidence base:

> *I think ECT in children is a difficult issue. It is very much obviously age dependent and one of the things is actually establishing whether someone who is under-age actually has an adult type illness that is responsive to ECT. We know that much of the evidence in terms*

415 The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991), and the Convention on the Rights of Persons with Disabilities and Optional Protocol (United Nations, December 2006).

416 Public briefing transcript, 14 October 2015, page 6.

417 Public briefing transcript, 14 October 2015, page 8.

418 Public briefing transcript, 9 November 2015, pages 1-2.

419 Public briefing transcript, 9 November 2015, page 2.

> *of the efficacy of ECT comes from the adult populations because that is where most people have done the trials. There is much less evidence in terms of its use in children. There is a general maxim that we should not be looking at children as small adults, that things that have been proven in adulthood do not necessarily work in children. We said that basically across-the-board in terms of our interventions.*
>
> *As far as I am aware, the ECT evidence in adults, particularly in terms of RCT use, is pretty robust. It is much less so in children. Again, we see it as more an experimental rather than an established intervention with sufficient safeguards that it is only used in children who have adult type illnesses that will respond to ECT and, again, in the context of fully informed consent in terms of the state of the evidence and the possible adverse effects.*[420]

The issue of legislative inconsistencies was also discussed within this context, with the Member for Moggill asking the Department to comment on Western Australian legislation, which prohibits the use of ECT on minors under 14 years of age. In response, Dr Kingswell advised that he is 'not sure what the drivers are' and cited evidence from Associate Professor Stephen Stathis, Medical Director of the Child and Youth Mental Health Service at Children's Health Queensland:

> *As noted in my letter, there is no evidence to show that ECT has long-term detrimental side effects for children or adolescents. Having an arbitrary age of 14 is not in a child's best interests and precludes them from accessing a potentially lifesaving medical procedure. Given the growing evidence for ECT's benefits and the lack of significant side effects in minors, in my view such a policy is therefore discriminatory on the basis of age. I am surprised that child and adolescent psychiatrists in WA have not been more vocal about this. I'll raise the issue with the Faculty of Child and Adolescent Psychiatry. While it would be very rare for a child under 14 to have ECT, it needs to be allowed under the Mental Health Act though protected by rigid review processes and guidelines.*[421]

Dr Kingswell later stated that while he is aware ECT is a highly emotive issue, there is no doubt that it 'is a safe and effective treatment for a group of patients, particularly if they have either severe depressive illnesses, mania and in some cases persistent symptoms of schizophrenia that do not respond to medications.' He also concluded that he tends 'to support Dr Stathis's view that to prevent minors from accessing this treatment would be to deny them potentially lifesaving intervention.' [422]

Dr Michelle Fryer also commented on the Western Australian age restrictions, stating:

> *I understand that Western Australia is the only place that has put in place an age limit and they have not given any rationale for their choice of age. Clinically there is no rationale for a choice of age. The frequency of severe mental illness such that ECT would be indicated in children is extremely rare. The frequency increases during adolescence and into adulthood. That is the predominant reason that it is very rarely used in children and rarely used in adolescents. We do not see the type and severity of mental illness that is an indication for ECT. However, I think we should not preclude an effective treatment even from a child who may benefit, especially when the evidence is that it is safe and that it is effective.*
>
> *…*
>
> *There is no rationale that I know of for an age limit, as long as there is suitable review that the indications are there for ECT and that other alternatives have either been exhausted*

420 Public hearing transcript, 28 October 2015, page 15.
421 Public briefing transcript, 9 November 2015, page 3.
422 Public briefing transcript, 9 November 2015, pages 3-4.

> *or that the risks of leaving the child untreated for a longer period of time or waiting for treatment to take effect outweigh the risks of ECT.*[423]*.*

The Department subsequently provided additional written advice, which included references to an RANZCP position statement on ECT and the original written advice from Associate Professor Stathis to the Department on the use of ECT in children and adolescents. Extracts from both are included below.

> *Position Statement 74 of the RANZCP*
>
> *There appear to be no differences in the effectiveness and safety of ECT in adolescents, compared to adults. It is exceptionally rare for ECT to be used in children in the preadolescent age group. In all cases in which ECT is considered for a child or adolescent, the opinion of a child and adolescent psychiatrist should be sought*. [424]
>
> *Associate Professor Stephen Stathis to Doctor Bill Kingswell*
> *In summary:*
>
> - *ECT is a safe and effective form of treatment in children and adolescents, with a growing evidence base.*
> - *ECT is endorsed in a Position Statement by the RANZCP*
> - *ECT in children and adolescents is permitted, with safeguards, in every state and territory in Australia and New Zealand, though Western Australia prohibits ECT in children younger than 12 years of age. No reason was been given for that age cut-off.*
> - *The safeguards for the use of ECT in children and adolescents proposed in Queensland' new Mental Health Act rank amongst the most comprehensive in Australia.*
> - *Although the WHO has stated that there is in indication for ECT in minors, this statement was made in the context of children and adolescent who have not afforded even the most basic of human rights. This is not the case in Queensland.*
> - *To deny a minor access to a safe and effective medical treatment such as ECT solely on the basis of their age is discriminatory, and a breach of their human rights.*
>
> *I therefore support the use of ECT in children and adolescents, as proposed in Queensland's new Mental Health Act.*[425]

14.6.4 Potential legal issues

Potential legal issues associated with the use of ECT on children was addressed by the QLS. It advised

> *[t]he issue is to consent and the recommendation of treating doctors in relation to that… there are processes and there is a Mental Health Review Tribunal and my understanding is that they would ultimately decide if that treatment is contested.*[426]

Committee comment

The Committee received significant evidence on regulated treatments during the inquiry. Some of this evidence was emotive, and at times contradictory. Stakeholders had particularly strong views on whether regulated treatments such as ECT and DBS should be available to minors. The issue of DBS and minors is discussed below.

The Committee understands that there are a range of safeguards in the Bills which must be met before ECT can be performed on a minor. Broadly speaking, ECT may only be performed on a

423 Public hearing transcript, 23 November 2015, page 10.
424 Correspondence, Department of Health, 18 November 2015, Attachment
425 Correspondence, Associate Professor Stathis to Dr Bill Kingswell, 22 October 2015
426 Public Hearing Transcript, page 3.

minor if the Tribunal has provided approval. The Tribunal must consider the views of the minor's parents and the views, wishes and preferences of the minor when deciding whether to grant the approval, and may only give approval if, among other things, there is evidence which supports the effectiveness of the therapy on minors.

The Bills also require the Tribunal to appoint a lawyer to represent a minor at all hearings, at no cost to the minor, and to ensure that, where a proceeding relates to a minor, the membership of the Tribunal include at least one psychiatrist with expertise in either child or child and adolescent psychiatry.

The Committee has diligently considered whether these safeguards are sufficient.

The Committee notes the concerns expressed by AMAQ that much of the evidence for the effectiveness of ECT comes from adult populations because that is where trials have occurred, and that things that have been proven in adulthood do not necessarily work in children. The Committee considers the Bills provide adequate safeguards as the Tribunal may only give approval if, among other things, there is evidence which supports the effectiveness of ECT on minors.

The Committee also notes the advice of the Department and Associate Professor Stathis that ECT is rarely performed on minors; that ECT in children and adolescents is permitted, with safeguards, in every state and territory in Australia. The safeguards in these Bills 'rank amongst the most comprehensive in Australia' and to deny someone access to an effective treatment such as ECT solely on the basis of their age is discriminatory and a breach of their human rights.

14.7 Stakeholders views – Use of DBS on minors

The RANZCP provided the Committee with further written information on DBS after the public hearing. The College advised

> *There is little clinical evidence worldwide of the use of DBS to treat children or adolescents for movement disorders or psychiatric disorders. It is rare for the DBS procedure to be used to treat children or adolescents with psychiatric disorders, and in Australia it is not currently used to treat children or adolescents with psychiatric disorders.* [427]

The Department provided similar advice, stating that there is currently no evidence available for the efficacy or safety of DBS in children. The Department noted that it may be unethical to exclude children or adolescent patients from receiving DBS, particularly if it is the only treatment available that could improve their quality of life. The Department also stated that any application for DBS on a minor would require the informed consent of the minor, approval by the Tribunal and a hearing at which the minor is legally represented.[428]

427 Correspondence from the Royal Australian & New Zealand College of Psychiatrists, 18 November 2015.
428 Correspondence, Department of Health, 5 November 2015, pages 1-2

15. Monitoring patients in the community – tracking devices

On 5 May 2015, the Minister informed the Legislative Assembly that there were a range of problems with the 2014 Bill, including that it overlooked key policy areas, such as provisions relating to GPS monitoring.[429]

15.1 Provisions in the current Act

Section 131A of the current Act provides for the Director of Mental Health (the Director) to require monitoring conditions for particular classes of patient undertaking limited community treatment. [430] The Director may require, by written notice to the administrator of the treating health service, that a monitoring condition be included in the patient's treatment plan.

The Act provides examples of the types of monitoring conditions which may be imposed on a patient undertaking limited community treatment, including that the patient:

- telephone a stated person before moving from one location to another
- provide a detailed plan of where they will be, and with who they will be with, or
- wear a monitoring device.

Section 131A (2) provides that this section does not apply to a young patient, that is involuntary patients under 17 years of age.

While both Bills amend the Act to restrict monitoring provisions to patients on a forensic order who are receiving treatment in the community, there are significant differences between the Bills in relation to who may impose and review monitoring conditions.

15.2 Differences between the Bills

Below is an extract from the Table at **2.3** showing the differences between the Bills with regard to electronic tracking devices:

	Information provided by the Minister on the Government Bill	Comment
Electronic tracking devices	Remove the ability of the Chief Psychiatrist to require a forensic patient to wear a GPS tracking device. This authority is limited to the Mental Health Court and the Mental Health Review Tribunal, where the issues can be considered in a transparent way, rather than by the chief psychiatrist exercising an administrative power.	The Private Member's Bill allows the Chief Psychiatrist to amend a forensic order to impose a monitoring condition which requires a patient to wear an electronic tracking device.

15.3 Authority to impose monitoring conditions

15.3.1 Government Bill

Clauses 135 (1) and (2) of the Government Bill provide for the Mental Health Court to impose the conditions it considers appropriate in a forensic order for a person. The definition of condition at Schedule 3 of the Bill includes requiring a person to wear a tracking device.

It is the clear intention in the Government Bill to provide an additional safeguard by providing that the Mental Health Review Tribunal and the Mental Health Review Court are the appropriate decision makers as to whether a person is subject to a GPS tracking device as part of their limited community

429 Hansard, 5 May 2015, page 282.

430 Forensic patients, classified patients and patients for whom the Mental Health Court has made an order under section 273(1)(b).

treatment. This provision removes the decision from being an administrative decision, to one before a tribunal where the person is able to present a case against the imposition.

Private Member's Bill

Clause 144 (1)(a) of the Private Member's Bill provides for the Mental Health Court to impose monitoring conditions in a forensic order, and provides examples of monitoring conditions, including that the person must wear a tracking device and that the person must be contactable by mobile phone at all times.

The Private Member's Bill would allow a decision on whether a person is subject to a GPS tracking device to be made in an administrative setting. Clause 217 of the Private Member's Bill provides for the Chief Psychiatrist to amend a forensic order, to impose a monitoring condition, which can include requiring the patient to wear a tracking device. Where this occurs, the Chief Psychiatrist must notify the treating health service and the Tribunal, in writing, to tell the patient about the condition and explain the effect.

There is no comparable provision in the Government Bill as the decision in the Government Bill is not administrative – as noted above, that decision rests with the Tribunal or the Court.

15.3.2 Discussion around the authority to impose monitoring conditions

The controversy surrounding GPS tracking devices and the differences between the Bills about who has the authority to require a patient to wear such a device was discussed during the first public briefing on the Bills.

When describing consultation on the Government Bill, the Department stated:

> *The application of GPS devices was very controversial and there was a lot of feedback in the consultation around those. There was a strong view that they should not be applied as an administrative decision of the Chief Psychiatrist and that it should be authorised by a properly constituted body such as the Mental Health Review Tribunal or the Mental Health Court.* [431]

Dr Kingswell stated that many would prefer such devices were not used at all, but if they were to be used, that they 'be applied by a competent authority with appealable rights.'[432]

The Member for Caloundra also spoke during the hearing on the provisions in the Private Member's Bill, which retain a role for the Chief Psychiatrist to impose GPS monitoring on a forensic patient. He stated:

> *I think the Chief Psychiatrist is a person of impeccable qualifications. The person would have a large pedigree and background in psychiatry. They would have extensive knowledge as to the type of person or persons they are dealing with. They are appointed by a government to a position akin to the Chief Health Officer or the Mental Health Commissioner. That person is certainly qualified to make a judgement call in those circumstances.*[433]

Professor Harry McConnell supports the decision as to the imposition of GPS monitoring devices being made in a clinical setting with the option for the person to review the clinical decision in the MHRT:

> *GPS tracking can be a very useful tool clinically. Here we have to differentiate between GPS tracking that is mandated by a court and GPS tracking that can actually be a clinical decision that the patient and/or their decision maker agrees with, in combination with the treatment team, as the least restrictive practice. It should be said that GPS tracking is often*

431 Public briefing transcript, 14 October 2015, page 6.
432 Public briefing transcript, 14 October 2015, page 6.
433 Public briefing transcript, 14 October 2015, pages 20-21.

the least restrictive practice, so patients are actually not that opposed to it when they see what the alternatives are. People do like to have freedom to be able to move about. I think that is an important thing.

When it comes to GPS tracking mandated by a court, then I think that is a still a clinical decision. In my mind, a clinical decision needs to be made by a clinician and the Chief Psychiatrist is clearly, by definition, an experienced clinician, so I would have faith that the Chief Psychiatrist would be the appropriate person to make that call. You can have the Mental Health Review Tribunal agree with that decision or disagree with that decision, but at the end of the day the Mental Health Review Tribunal is a committee and committees are not really ideal at making clinical decisions; individual experienced clinicians are the best people for making clinical decisions. You can get second and third opinions, but individual clinicians make clinical decisions on a daily basis. In my mind, GPS tracking is a clinical decision. At the end of the day, if a patient wants to appeal that, the Mental Health Review Tribunal can agree or disagree with the Chief Psychiatrist's decision, but it is a clinical decision and an experienced clinician should make it, such as the Chief Psychiatrist.[434]

The Department described the difference between the Bills as follows:

Dr Kingswell: *The Chief Psychiatrist would make an administrative decision that the person subject of the decision would have no capacity to take part in. This current government bill puts the decision making into competent jurisdiction—either the Mental Health Review Tribunal or the Mental Health Court—and gives the opportunity to the person that might be subject to the device the opportunity to seek legal representation and be properly represented.*

Ms BATES: *Sure, but does not the private member's bill do both—it is the Mental Health Review Tribunal, the Mental Health Court and the Chief Psychiatrist?*

Mr Sheehy: *If I can answer that. Yes, the private member's bill, which we understand is equivalent to the 2014 bill, does enable the Chief Psychiatrist to impose that condition. There is an automatic review by the tribunal but, as Dr Kingswell said, it still does allow the Chief Psychiatrist to make that decision in an administrative environment, not in an environment where the party has an opportunity to present the case. So that is essentially the difference between the two bills.*[435]

15.4 Definition of tracking device

Both Bills define a tracking device as 'any electronic device capable of being worn, and not removed, by a person for the purpose of finding or monitoring the geographical location of the person.'[436]

15.5 Review of monitoring conditions

Clause 28(1)(e) of the Private Member's Bill provides for the Tribunal to review the imposition of monitoring conditions that include a tracking device. Similarly, Clause 445 of the Government Bill provides for the Tribunal to change, remove or impose a condition on a forensic order. Again, the definition of condition at Schedule 3 of the Bill includes requiring a person to wear a tracking device.

Clause 459 of the Private Member's Bill provides for the Tribunal to review a decision, under section 217, by the Chief Psychiatrist to require a patient to wear a tracking device. The review must occur within 21 days. As stated above, the Chief Psychiatrist does not have this power under the Government Bill. Consequently, there is no comparable review provision in the Government Bill.

434 Public hearing transcript, 23 November 2015, page 3.
435 Public briefing transcript, 9 November 2015, page 5.
436 Private Member's Bill, Schedule 3; Government Bill, Schedule 3.

15.6 Transitional provisions

Clause 817 of the Government Bill places greater restrictions on the use of tracking devices. The clause provides that if the patient was a forensic patient subject to a monitoring condition under section 131A of the current Act, the monitoring conditions remain in force unless the monitoring condition required the person to wear a tracking device, or the patient was not a forensic patient, in which case, it stops having effect on commencement.

In contrast, clause 773 of the Private Member's Bill provides that monitoring conditions under section 131A of the current Act are taken to have been imposed under the new Act and continue to have effect.

15.7 Stakeholder views - decisions should be made by Court or Tribunal

There was broad support among stakeholders for the approval and review provisions in the Government Bill, which restrict decisions about GPS tracking devices to the Mental Health Court and Tribunal.

The Australian Association of Social Workers (AASW) state:

> *We acknowledge and support the changes within the Bill allocating the Mental Health Court or Mental Health Review Tribunal the delegation for decision making regarding the requirement for and use of electronic (GPS) tracking devices; a delegation previously held by the Chief Psychiatrist.*[437]

Similar views are expressed by the Australian Medical Association Queensland (AMAQ) and the Queensland Mental Health Commission (QMHC).

> *AMA Queensland has consistently stated that we believe only the Mental Health Review tribunal or the Mental Health Court should have the ability to place monitoring conditions – including the use of GPS monitoring devices – given the potential to impose upon individual liberty. We stridently believe that this power should not rest with the Chief Psychiatrist.*[438]

> *… we are concerned about continuing power of the Chief Psychiatrist to impose a tracking device as proposed in the Recovery Model Bill (clause 217). While this decision is reviewable by the Tribunal (clause 459), the Commission is of the view that a more independent authority should make decisions regarding the imposition of a condition requiring a person to wear a tracking device.*[439]

The Queensland Law Society (QLS) provided comparable testimony during the public hearing.

> *On my understanding of the 2015 bill, the decision for tracking devices is a decision for the Mental Health Review Tribunal. That is an improvement in terms of procedural fairness, because it is an extreme impact on people's liberty so, in our view, it needs to be done through a legal process rather than strictly clinical. My understanding is that the Mental Health Review Tribunal, the Mental Health Court and the various forensic liaison officers within each district can become very good at monitoring conditions and imposing strict conditions on mental health orders.* [440]

The QMHC also recommends including provisions that require the Tribunal to 'include expertise in forensic mental health when applications to apply tracking devices are being considered.' [441]

437 Submission 10, page 1.
438 Submission 56, page 1.
439 Submission 14, page 32.
440 Public hearing transcript, 28 October 2015, page 2.
441 Submission 14, page 7.

Evidence provided by the Department supported this view.

> *The Director of Mental Health's ongoing oversight of LCT for forensic patients (i.e. approximately 450 notifications per annum) has highlighted the very limited need for GPS monitoring devices. GPS devices have been implemented in two instances since March 2013.*
>
> *Overall, given this very limited number and the need to ensure proper safeguards in the decision making process, it is appropriate that this matter is determined by the Mental Health Court or Mental Health Review Tribunal.* [442]

Committee comment

Government members do not support the provisions in the Private Member's Bill (clause 217) which allow the Chief Psychiatrist to amend a forensic order to impose a monitoring condition which requires a patient to wear an electronic tracking device. Government members consider the authority to impose and review monitoring conditions which require a patient to wear an electronic tracking device should be restricted to the Mental Health Court and Mental Health Review Tribunal, where the person who is or may be subject to the device is able to seek legal representation and be properly represented.

Opposition members support the provisions in the Private Member's Bill (clause 217) which allow the Chief Psychiatrist to amend a forensic order to impose a monitoring condition, which requires a patient to wear an electronic tracking device. Opposition members consider the Chief Psychiatrist appropriately qualified to exercise this power.

The Committee supports amending the Bills to require the Tribunal to include expertise in forensic mental health when applications to apply tracking devices are being considered.

15.8 Stakeholder views - monitoring conditions for forensic patients only

Both the AASW and the QMHC support removing the application of monitoring provisions from the treatment of classified patients and court ordered patients. [443]

15.9 Stakeholder views - no electronic tracking devices for people with a mental illness

Many stakeholders strongly oppose requiring any person experiencing mental illness to wear an electronic tracking device.[444]

The AASW argues requiring patients to wear electronic tracking devices is:

- inconsistent with the principles of 'least restrictive way' and 'recovery-oriented practice',
- has not been shown to reduce risks to the community, or flight risk,
- stigmatises people living with a mental illness, who are already subject to stigma and discrimination, and
- negatively impacts on families and other carers, who also experience stigma and discrimination.[445]

Similar views are expressed by the Queensland Branch of the RANZCP and the Queensland Section of the Australian Psychological Society's College of Forensic Psychologists (the College):

> *Patients wearing tracking devices (e.g. GPS bracelets) are at risk of being stigmatised due to being singled out as mentally ill or misapprehension that they are a sexual offender. It*

442 Correspondence, Department of Health, 5 November 2015, pages 3-4
443 Submission 10, page 1; Submission 14, page 32.
444 See for example Submissions 10, 27, 33, 56.
445 Submission 10, pages 1-2.

> *is the RANZCP's view that tracking devices are contrary to key elements of a therapeutic alliance and recovery principles.*[446]
>
> *The use of electronic tracking devices on mental health patients contributes to the stigmatisation of mental illness. Electronic monitoring devices were only used in Queensland for the monitoring of offenders under the Dangerous Prisoner (Sex Offenders) Act 2003 (DPSOA). Those under the DPSOA legislation are considered to be dangerous sex offenders who repeatedly offend. The suggestion of a similar level of risk for those with mental illness is stigmatising and does not recognise reduction of risk with effective treatment, or the essential principles of recovery. Rather it suggests to the general public that mental illness is something to be scared of.* [447]

The QNU states the need for a monitoring device should be linked to the clinically assessed risk in addition to the potential for patients to abscond.[448]

The AASW calls for research into the relevance, use and effectiveness of electronic monitoring devices as a method of monitoring people with a mental illness prior to such provisions being included in the Bill. [449]

The College states that using electronic monitoring in Aboriginal and Torres Strait Islander communities 'can compound the impact of historical paternalistic policy approaches having an ongoing impact in communities today.' The College also argues that limited GPS and mobile phone coverage in rural and remote areas would mean that a number of patients may not be able to meet basic monitoring obligations which in turn may impact on the recovery process.[450]

The AASW recommends removing '… all references to the use and wearing of electronic monitoring devices that are counter to recovery oriented practice, stigma reduction and least restrictive approach to care and treatment.' Similarly, the College recommends 'The capacity to monitor mental health patients with electronic tracking devices be removed from legislation.'[451]

In response, the Department advised that that the majority of forensic patients requiring mental health treatment access limited community treatment without GPS monitoring devices. The Department states this degree of monitoring is obviated by 'Attention to leave planning, use of mobile phones and requiring regular contact with the treating team through family and carers, or by the patient directly.' The Department also advised that there is very limited experience with, or research on the efficacy and impact of, using GPS devices for this purpose, and that GPS devices are not used in this way in any other Australian jurisdiction.

The Department also acknowledged the concerns raised by service providers and consumer groups that the devices 'unnecessarily portray mentally ill people as convicted criminal offenders, which is not the case' and potentially have an 'adverse impact on therapeutic relationships between the clinician and patient.' [452]

During the public hearing on 9 November 2015 the Department identified the relatively few number of instances in which GPS devices have been used:

> *Data on the authorisation and application of GPS monitoring conditions since the commencement of the relevant legislative provisions in March 2013 are as follows: a GPS*

446 Submission 33, page 2.
447 Submission 59, pages 8-9.
448 Submission 27, page 10.
449 Submission 10, pages 2-3; Submission 27, page 10.
450 Submission 59, page 9.
451 Submission 10, page 2; Submission 59, page 9.
452 Correspondence, Department of Health, 5 November 2015, pages 3-4

> *monitoring condition has been approved for five patients in total. In four instances the condition was required by the Director of Mental Health but only implemented in two of those instances. In one instance a GPS monitoring condition was approved by the Mental Health Review Tribunal but was subsequently revoked by the tribunal before it was implemented.*[453]

The Department emphasised that GPS devices are only used when someone has committed a serious offence, and again acknowledged that there are concerns about stigma, particularly in relation to the first devices, which it stated are used in the sex offender treatment program and described as 'pretty clunky.' Despite these concerns, the Department suggested GPS devices may be a better option, from the patient's point of view, to having to 'sit in a secure hospital for the rest of their life.'

15.10 Stakeholder views - less obvious devices should be used

In its submission the QNU states it 'opposes the use of obvious monitoring devices, such as an ankle bracelet, that is commonly used for tracking offenders, as it contributes to marginalisation and stigma. We believe that other, less obvious GPS devices should be considered.'[454]

When asked during the public hearing if the Union's concerns would be alleviated if less obvious devices were used, QNU replied:

> *That is only one of the issues, but it would certainly reduce the opportunity for stigma and marginalisation because it would not be obvious. Certainly, as I said earlier, what we would be hoping for—and reflecting on what was said earlier by the other witnesses—is that the courts and the mental health tribunal who are making those decisions based on a solid mental health and psychiatric report would be in a position to make judgements about where it is really absolutely necessary in terms of balancing the needs of the community and the rights of the patient.*

The Department also spoke to this issue during the second public briefing on the Bills. When asked by the Member for Greenslopes whether there are less obvious options, Dr Kingswell stated there are a range of better technologies available:

> *There are mobile phone apps, for instance, that tell parents that their children have not arrived at school and you can use those in these populations as well. We did do a bit of market sounding to find out what is out there, because there are some really interesting applications here, maybe not so much in mental health but in aged care, for instance—position-locating beacons and beacons that let you know that somebody has not moved, which is even worse than when they have. There are enormous opportunities for us to explore technology and try to understand better how it might help our patients.* [455]

Whether the use of GPS devices has been driven as much by restricting absconders and reducing associated costs as concerns about ensuring public safety was also discussed. The QNU believe these concerns are more reflective of its response to the 2014 Bill.

> *We should try to achieve both. But probably that comment related initially to the first bill that we responded to because at the same time there had been a decision to lock in patient units indiscriminately. One of the concerns we had was in regard to what was the motivation for doing those types of restrictive practices, and that bill at that time seemed to be another step in that direction.*[456]

453 Public briefing transcript, 9 November 2015, page 2
454 Submission 27, page 39.
455 Public briefing transcript, 9 November 2015, pages 5-6
456 Public hearing transcript, page 8.

Committee comment

The Committee acknowledges the widespread concern that using obvious electronic monitoring devices, such as ankle bracelets, on patients with a mental illness contributes to stigma and marginalisation as many people in the community equate these devices with dangerous criminals.

The Committee notes the advice of the Department that the first electronic tracking devices used on people with a mental illness were the same as those used in the sex offender treatment program, that these devices are 'pretty clunky' and that there are better, less obvious options now available. The Committee encourages the use of less obvious devices, and also suggests consideration be given to alternative monitoring arrangements for people in rural and remote areas where limited mobile coverage can impact on a patient's ability to meet monitoring obligations.

15.11 Stakeholder views – balancing patient rights with public safety

The issue of balancing public safety with the rights of a mental health patient was discussed at length during the Committee's public hearing.

The QLS agreed that both public safety and the rights of the patient need to be taken into account and was again of the view that the 'Mental Health Review Tribunal is best placed to place conditions that are brought to the notice of the tribunal by the clinicians.'[457]

Both the QNU and the RANZCP acknowledge that balancing the rights of both parties is a complex issue, and there is no easy solution, or answer.[458]

The QNU stated it recognised the value of GPS tracking, and emphasised the importance of having an appropriately skilled workforce, to ensure sound decisions are made with regard to patients being allowed to leave a service.

> *The big concern is about stigma and continuing marginalisation of people who have a mental illness and the idea that they are in some way dangerous. The risk assessment and management that is possible if you have an appropriately qualified mental health workforce should minimise that in terms of patients being permitted to take leave from the facility. So we stress again the significance of having a qualified mental health workforce with the appropriate skill mix so that those decisions about risk management can be made at that moment in time. We acknowledge the value of those devices, but we think that really the best solution would be to have the appropriate staffing and facilities at the services that are provided.*[459]

The RANZCP stated it continues to have concerns that patients who wear these devices are identified as criminals and emphasised that the role of psychiatrists is to ensure proper and effective treatment. The College argued that forensic patients who have a history of sexual offences are unlikely to re-offend when they are receiving effective treatment.

> *The college is saying that we should be responsible for treating them and making sure that they are on proper treatment and that there are safeguards in place so that they do not offend again. This condition should be minimised by treatment. However, if we are responsible for making sure that they have the tracking devices—because tracking devices can be either a GPS or they can be other tracking devices that we can use—making sure that they attend appointments under the Mental Health Act, that they receive the treatment daily, we should be more responsible for making sure that treatments are in*

457 Public hearing transcript, page 2.
458 Public hearing transcript, page 19.
459 Public hearing transcript, page 7.

place. But tracking devices just makes you identify the patients as if they are criminals still. They might not offend again, because their mental illness is treated, but just because of their offence they might be identified across society that they are still criminals. They might not be because of their illness; they are now fully treated.

But the college has made a statement on this that it is tricky, because it just singles out a patient who might have got involved in an offence because of their illness. But if the illness is treated, why then is a tracking device needed because of the nature of the offence that they have done?[460]

Committee comment

The Committee acknowledges the concerns surrounding the use of electronic tracking devices on patients receiving limited community treatment, including the need to balance the rights of the patient with concerns about public safety. The Committee considers public safety must be a paramount consideration where these matters appear to conflict.

460 Public hearing transcript, page 19.

16.Compliance with the Legislative Standards Act 1992

16.1 Fundamental Legislative Principles

Section 4 of the Legislative Standards Act 1992 states that 'fundamental legislative principles' are the 'principles relating to legislation that underlie a parliamentary democracy based on the rule of law'. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals, and
- the institution of Parliament.

The Committee has examined the application of the fundamental legislative principles to the Bill. The Committee brings the following to the attention of the House.

16.2 Powers under an examination authority – individual rights and liberties

Clause 32 of both Bills set out identical powers that a doctor or authorised mental health practitioner may use if the tribunal has issued an examination authority under clause 468.

Clause 32 will allow a doctor or authorised mental health practitioner to examine a person without their consent and also detain that person for a necessary period. The examination of a person without consent potentially breaches section 4(2)(a) of the *Legislative Standards Act 1992* which provides that sufficient regard should be had to the rights and liberties of individuals.

The Explanatory Notes for the Government Bill address the issue of consent, and a patient's rights and liberties, as follows:

> *The Bill will impact on the rights and liberties of individuals by enabling examinations, assessments, treatment and, if necessary, detention without consent.*
>
> *The Bill addresses the situation where a person does not have capacity to consent to treatment and may be at risk of harm or deterioration in his or her health, with no ability to make decisions to avert these adverse consequences. To remedy this, the Bill establishes legislative arrangements for treatment without consent under a treatment authority. (See chapter 2, part 4).*[461]

The Committee notes that the Bills provide safeguards for people who do not consent to treatment. For example, clause 53 of both Bills provides that in deciding the nature and extent of the treatment and care to be provided to a person under the treatment authority, the authorised doctor must discuss the treatment and care to be provided with the person and also have regard to the views, wishes and preferences of the person, to the extent they can be expressed, including, for example, in an advance health directive.

In addition, clause 56 of both Bills provides that if an authorised doctor who made a treatment authority is not a psychiatrist, an authorised psychiatrist must review the treatment authority and decide to:

- confirm the treatment authority, with or without amendment, or
- revoke the treatment authority.

Committee comment

The Committee notes that clause 3(2) of both Bills provides that one of the main objects of the Bills is to safeguard the rights of persons and to be the least restrictive of a person's rights and liberties. In light of the object of the Bills, and the protections provided, for example in clauses

461 Explanatory Notes, Government Bill 2015, page 8-9.

53 and 56, the Committee considers that sufficient regard has been given to the rights and liberties of individuals.

16.3 Psychiatrist's report without person's consent – individual rights and liberties

Clause 93 the Government Bill and clause 88 of the Private Member's' Bill enable the Chief Psychiatrist, on their initiative, to arrange for a psychiatrist's report about a person charged with a serious offence. While the drafting differs between the two Bills, both raise the same issue regarding individual rights.

Both Bills will allow the Chief Psychiatrist to arrange for a report to be prepared about a person without their consent. This is a potential breach of section 4(2)(a) of the *Legislative Standards Act 1992* which requires that sufficient regard should be had to the rights and liberties of individuals.

The Explanatory Notes to the Bills provide the following justification for the clause:

> *The discretion to exercise this power is to be used by the Chief Psychiatrist only if the Chief Psychiatrist determines that it is in the public interest to do so. The Bill will provide safeguards for persons undergoing these examinations, including restrictions on the use of the resultant report.*[462]

A safeguard in both Bills is that a person being examined for a psychiatrist's report may be accompanied by a support person, including, for example, a nominated support person, lawyer or personal guardian.[463] In addition, clause 99 of the Private Member's' Bill and clause 102 of the Government Bill limit the persons who may receive a copy of the psychiatrist's report.

Committee comment

Given the circumstances in which the Chief Psychiatrist can request a report (i.e in the public interest) and the safeguards provided to the person who is the subject of the report, the Committee considers that the clauses in both Bills have sufficient regard to the rights and liberties of individuals.

16.4 Monitoring a patient on a forensic order – individual rights and liberties

The Private Member's Bill enables the Chief Psychiatrist to amend a patient's forensic order to impose a monitoring condition under clause 217, including, for example, that a patient wear a tracking device.

Examples of other monitoring conditions include that the patient:

- telephone a stated person at the patient's treating health service before moving from one location to another,
- be contactable by mobile phone at all times, and
- provide a detailed plan of where, and with whom, the patient will be while receiving limited community treatment.

A decision by the Chief Psychiatrist to impose a monitoring condition requiring the patient to wear a tracking device must be reviewed by the Tribunal within 21 days of being notified of the decision.[464]

A monitoring condition such as a tracking device potentially breaches section 4(2)(a) of the *Legislative Standards Act 1992*. A tracking device impinges upon a person's liberty, self-determination and freedom.

Currently section 131A of the *Mental Health Act 2000* provides that the Director may require a monitoring condition for classified and forensic patients undertaking limited community treatment.

The Explanatory Notes for the Private Member's Bill provide the following justification for the clause:

462 Explanatory Notes, Government Bill, page 10 and Private Member's Bill, page 11.
463 Government Bill, cl.97; Private Member's Bill, cl. 93.
464 Private Member's Bill, cl. 479.

> *The Bill will continue the powers under the Mental Health Act 2000 for the Chief Psychiatrist to place monitoring conditions on forensic patients. Monitoring conditions may include a requirement that a patient wear a GPS tracking device while being treated in the community.*
>
> *The purpose of monitoring conditions is to provide an additional level of protection for the health and safety of a patient or others, where warranted. The imposition of monitoring conditions offers a mechanism to quickly locate a patient who has not returned from community treatment where there are concerns about the patient's safety or the safety of others. These conditions may only be placed on an order by the Chief Psychiatrist, the Mental Health Court or the Mental Health Review Tribunal.*
>
> *As an additional safeguard, the Bill will require that the imposition of monitoring conditions by the Chief Psychiatrist be reviewed by the tribunal within 21 days of the conditions being imposed.*[465]

Committee comment

Opposition members of the Committee note that clause 217 of the Private Member's Bill sets out the circumstances in which the Chief Psychiatrist may impose an additional monitoring condition, and notes that the purpose is to provide an additional level of protection for the patient and others.

The Opposition members also note that the requirement for the tribunal to review decisions to impose additional monitoring within 21 days of being notified of the decision. The Opposition members consider that this is an adequate safeguard. The Government members of the Committee do not support the provision and do not consider that this is an adequate safeguard.

The Opposition members consider that, on balance, the clause enabling the Chief Psychiatrist to impose an additional monitoring condition on a patient's forensic order does have sufficient regard to the rights of an individual patient. The Government members of the Committee do not support the provision and consider that it does not have sufficient regard to the rights of an individual patient.

16.5 Use of ECT on a minor if approved by tribunal – individual rights and liberties

Clauses 235 of the Government Bill and clause 228 of the Private Member's Bill provide for the performance of electroconvulsive therapy (ECT) on certain patients. The Government Bill authorises a doctor for an authorised mental health service to perform ECT, while the Private Member's Bill authorises a psychiatrist to perform it. The circumstances in which ECT may be performed are on a patient who is:

- an adult, with their informed consent,
- an adult who is unable to give informed consent and the tribunal has approved use of ECT, and
- a minor if the tribunal has approved the use of ECT.

In relation to minors, clause 5 sets out principles for administration of the Act in both Bills, and states that:

> *To the greatest extent practicable, a minor receiving treatment and care must have the minor's best interests recognised and promoted, including, for example, by receiving treatment and care separately from adults if practicable and by having the minor's specific needs, wellbeing and safety recognised and protected.*[466]

465 Explanatory Notes, Private Member's Bill, page 10.
466 Government Bill, cl. 5; Private Member's Bill, cl. 5.

The use of ECT will have a significant impact on a minor and will potentially breach section 4(2)(a) of the *Legislative Standards Act 1992* which provides that sufficient regard should be had to the rights and liberties of individuals.

The use of ECT on both adults and minors is an often debated topic. The World Health Organisation has stated that legislation should prohibit the use of ECT on minors.[467] The alternative view is that ECT can be a beneficial form of mental health treatment when used on a suitable person and with the appropriate legislative safeguards in place.

Both Bills provide safeguards about the use of ECT without a patient's consent. The Tribunal must have regard to criteria set out in clause 507 of the Government Bill and clause 473 of the Private Member's Bill. The criteria are summarised in Chapter 12 of this report.

The tribunal may appoint a lawyer or another person to represent a person if the Tribunal considers it would be in that person's best interests. If the person is a minor, the Tribunal must appoint a lawyer to represent a person at a hearing at no cost under clauses 738 (Government Bill) and 631 (Private Member's' Bill).

Committee comment

The Committee notes the range of stakeholder views about the rights of patients who are minors and the performance of ETC, subject to approval by the Tribunal. The Committee also notes that some Australian jurisdictions have recently legislated to permit ECT to be performed on minors, with safeguards that are similar to those in the Bills.

The Committee considers that the safeguards provided, particularly in relation to Tribunal decisions and representation of minors interests at Tribunal proceedings are sufficient on balance to have regard to the rights of minors.

16.6 Suspension of limited community treatment – individual rights and liberties

Clause 302 of the Private Member's Bill specifies actions the Chief Psychiatrist may take if the Chief Psychiatrist considers that a matter has arisen in relation to one or more forensic patients, and there is a serious risk to the life, health or safety of a person or to public safety. One action the Chief Psychiatrist may take is to order the suspension of limited community treatment for a forensic patient or a class of forensic patients for not more than seven days. Clause 302(3) provides that the Chief Psychiatrist must consult with the administrator of each AMHS likely to be affected by the order.

The purpose of limited community treatment is to support a patient's recovery by transitioning them to living in the community with appropriate treatment and care.[468]

The suspension of community treatment for a class of patients by the Chief Psychiatrist may be seen as infringing on the rights and liberties of a class of persons and thereby potentially breaching section 4(2)(a) of the *Legislative Standards Act 1992*.

The Explanatory Notes to the Private Member's Bill provide the following justification for the clause:

> *…this power is consistent with the purpose of the Bill in relation to the protection of the community. This power may be exercised, for example, where there are concerns of systemic management issues within an authorised mental health service that need rectification. It may be necessary to suspend community treatment pending the rectification of these issues. As in the current Act, the proposed Bill will incorporate safeguards, including the requirement to consult with the administrator of the authorised mental health service on the impact of*

467 World Health Organisation, *WHO Resource Book on Mental Health*, Human Rights Legislation, 2005, page 64.
468 Private Member's Bill, cl. 16.

suspending community treatment on patients before taking action under these provisions. The Chief Psychiatrist's decision is appealable to the tribunal.[469]

Committee comment

The Committee considered the purpose of the clause and the safeguards provided. It also considered the conclusions reached by the former Health and Community Services Committee in its report on the 2013 Bill which introduced provisions that enabled the Director (now proposed to be the Chief Psychiatrist) to suspend limited community treatment for a class of persons. The relevant current provisions are sections 493AC to 493AD of the *Mental Health Act 2000.*

The former Health and Community Services Committee reported that the submissions received focussed largely on the suspension of limited community treatment for a class of patients. In considering the application of fundamental legislative principles, the former Committee reported:

However, in light of concerns about potential fundamental legislative principles issues, the Committee has recommended that the Bill be amended. Recommendation 10 would require the Director to take all reasonable steps to consult each patient's treating psychiatrist before making an order to suspend LCT. Recommendation 11 would require the Director to give detailed written reasons for his or her decision. Recommendation 12 would require the Tribunal to review an order suspending a class of patients' LCT within seven days after it has been made.[470]

The Opposition members of the Committee consider that, on balance, the power to suspend community treatment for a class of patients, with Tribunal review of the decision after 21 days, does have sufficient regard to the rights and liberties of individuals.[471]

The Government members of the Committee do not support the provision and consider that the clause does not have sufficient regard to the rights and liberties of individuals.

16.7 Examination and treatment without consent and with use of reasonable force

Currently, section 518 of the *Mental Health Act 2000* provides that an involuntary patient or a person on a forensic order may be treated without consent, and that a person lawfully providing treatment or helping to provide treatment may 'use minimum force, that is necessary and reasonable in the circumstances'.

Both the Government Bill (at clause 629) and the Private Member's Bill (at clause 590) provide, with different drafting, that subject to the Act, an involuntary patient may be examined and assessed without consent.[472] Both Bills also provide that a person who is lawfully making an examination or assessment or helping to make it, may use 'the force that is necessary and reasonable in the circumstances.'

Clauses 630 of the Government Bill and clause 589 of the Private Member's Bill provide that an involuntary patient may be treated without consent, and that the '…force that is necessary and reasonable in the circumstances' may be used.

These provisions potentially breach section 4 of the *Legislative Standards Act 1992.* The Committee notes that the Bills provide a number of safeguards to balance the infringement of individual rights

469 Explanatory Notes, Private Member's Bill, page 9.

470 Health and Community Services Committee, *Queensland Mental Health Commission Bill 2012*, Report No. 17, February 2013, page 31.

471 Note: Clause 532 of the Government Bill provides for a person to apply for a review of the decision to be lodged with the Tribunal within 28 days of the decision – there is no equivalent minimum mandatory timeframe before which an appeal cannot be lodged.

472 Government Bill, cl. 629; Private Member's' Bill, cl.590.

that arise from examination, assessment and treatment without consent. The Bills provide a number of protections for patients in relation to examination. Further protections in the Bills include a requirement for an authorised mental health service to appoint a patient rights adviser to advise a patient, their family carers and other support persons of their rights under the Act. The Bills specify the functions of a patient rights adviser. Another safeguard in both Bills is a patient's right to appeal at any time, under clause 28(4) to the Mental Health Review Tribunal for a review.

Committee comment

The Committee considers that, on balance, the examination, assessment and treatment of an involuntary patient without their consent, and with the use of the force that is necessary and reasonable in the circumstances, is reasonable. While individual rights are affected, the Committee considers that the safeguards and supports contained in the Bills are reasonable.

16.8 Powers of entry – individual rights and liberties

Clause 563 of the Government Bill and clause 543 of the Private Member's Bill confer powers to enter premises, including in some circumstances such as entry to a public health services facility, to enter without a warrant. The Explanatory Notes for the Government Bills state:

> *The Bill will continue the power under the Mental Health Act 2000 for authorised persons to visit an authorised mental health service to investigate whether the legislation is being complied with. The exercise of this power does not require a warrant (clause 563). However, this power of entry is very limited – to authorised mental health services – nearly all of which are within the public sector. The powers is considered reasonable given the need for involuntary patients to have their rights protected.*[473]

The Explanatory Notes for the Private Member's Bill provides a very similar rationale.

Committee comment

The Committee considers that, in light of the reasons for the power of entry without a warrant, the clauses in both Bills are justified in the circumstances.

16.9 Transitional regulation making power – retrospectivity

Both Bills enable a transitional regulation to be made to provide for a matter necessary to allow or facilitate the transition from the operation of the repealed Act to the operation of the new Act. The transitional regulation would operate retrospectively to the commencement and expire one year after the commencement of the new legislation.[474]

Section 4(3)(g) of the *Legislative Standards Act 1992* provides that legislation should not adversely affect rights and liberties, or impose obligations retrospectively. The Explanatory Notes for both Bills provide the following justification for the clause:

> *Although the Bill provides for a range of transitional issues, it is possible that unanticipated matters may arise given the complexity of transitioning to the new Bill. It should be noted that this provision expires 12 months after commencement.*[475]

Committee comment

The Committee considers that, given the substantial number of provisions in the Bill and the automatic expiry of the transitional regulation making power after one year, the clauses have sufficient regard to fundamental legislative principles in this instance.

473 Explanatory Notes, Government Bill, page 10.
474 Government Bill, cl. 862; Private Member's Bill, cl. 816.
475 Explanatory Notes, Government Bill, page 11.

16.10 Scrutiny by the Legislative Assembly

The Bills provide for a claim to be made from the State for the cost of repairing or replacing possessions that are damaged in the exercise of specified powers under the Act. A claim may be brought in a proceeding in a court of competent jurisdiction; or decided during a proceeding for an offence against the Act brought against the claimant. The Bills provide that a regulation may prescribe matters that may, or must, be taken into account by the court when considering whether it is just to make the order.

These provisions in the Bills potentially breach the fundamental legislative principle in section 4(5)(c) of the *Legislative Standards Act 1992*. Whether subordinate legislation has sufficient regard to the institution of Parliament depends on whether, for example, the subordinate legislation contains only matters appropriate to subordinate legislation. The Bills provide that a regulation may prescribe matters that a court may or must consider in relation to compensation[476]. Given the potential importance of these matters to a court's determination of compensation it is arguable that they should appear in the primary Act and not in subordinate legislation.

The Committee considered whether the Legislative Assembly's powers to disallow subordinate legislation provides for sufficient regard to the institution of Parliament. The Committee noted that the proposed subordinate legislation may be significant in relation to a court's determination of compensation to a person.

Committee comment

The Committee sought further information from the Department (and the Member for Caloundra) as to how a regulation under the provision may affect a court's ruling and when the relevant regulation is proposed to be developed.

The Member for Caloundra advised that as he understood the Committee had written to the Minister on the same matter, he would not 'burden the Office of Parliamentary Council in amending the aforementioned clauses in two very similar Bills.' He stated he would 'review the steps the Government has taken to address these clauses in Mental Health Recovery Bill 2015', assess what actions should be taken to address the concerns and, if necessary, seek to move amendments to the Bill.[477]

The Department provided the following advice:

> *Parliamentary Counsel advise that this is common provision that appears in about 30-40 Acts across the statute book, although it does not appear that a regulation has been made under these provisions. As such, this type of clause could be described as taking a cautionary approach to the issue. In relation to having sufficient regard to the institution of Parliament:*
>
> *• the clauses of the Bill themselves deal with the main subject matter of giving jurisdiction to the court to make an order for compensation that is just in the circumstances*
>
> *• the regulation-making power deals only with subsidiary matters, as it provides for matters that*
>
> *may or must be taken into account, and*
>
> *• a regulation could not override the Act in any way - the jurisdiction of the court would still be to make the order the court considers just, which is the jurisdiction conferred by the Act.*

476 Clauses 405 and 600, Government Bill; clauses 393 and 566, Private Member's' Bill

477 Correspondence, Member for Caloundra, 13 November 2015

It may be that particular unforeseen circumstances occur which would make it appropriate for a regulation to provide for certain matters to be taken into account by the courts when making an order. Such a regulation would be subject to the normal scrutiny processes of the Parliament.[478]

Committee comment

After considering the Department's advice, the Committee considers the provisions have sufficient regard to the institution of Parliament.

16.11 Explanatory Notes

Section 22 of the *Legislative Standards Act 1992* (LSA) requires a Member, when introducing a Bill to circulate an Explanatory Note for the Bill.

The requirements for the Explanatory Note are contained in section 23 of the LSA and state:

(1) An explanatory note for a Bill must include the following information about the Bill in clear and precise language—

(a) the Bill's short title;

(b) a brief statement of the policy objectives of the Bill and the reasons for them;

(c) a brief statement of the way the policy objectives will be achieved by the Bill and why this way of achieving the objectives is reasonable and appropriate;

(d) if appropriate, a brief statement of any reasonable alternative way of achieving the policy objectives and why the alternative was not adopted;

(e) a brief assessment of the administrative cost to government of implementing the Bill, including staffing and program costs but not the cost of developing the Bill;

(f) a brief assessment of the consistency of the Bill with fundamental legislative principles and, if it is inconsistent with fundamental legislative principles, the reasons for the inconsistency;

(g) a brief statement of the extent to which consultation was carried out in relation to the Bill;

(h) a simple explanation of the purpose and intended operation of each clause of the Bill;

(i) if the Bill is substantially uniform or complementary with legislation of the Commonwealth or another State—

(i) a statement to that effect; and

(ii) a brief explanation of the legislative scheme.

(2) If the explanatory note does not include the information mentioned in subsection (1), it must state the reason for non-inclusion.

The *Guidelines for the preparation of explanatory notes* available on the website of the Department of Premier and Cabinet state explanatory notes need to be clear, precise and informative as they are used to:

- inform Cabinet decision making;
- contribute to informed debate in Parliament;
- ensure effective Parliamentary scrutiny of bills and subordinate legislation;
- assist in the interpretation of legislation, including by practitioners, lawyers and courts;
- make legislation more accessible by assisting people to understand the effect on their rights and obligations imposed by legislation; and
- inform public discussion about legislation, including whether the legislation has sufficient regard to rights and liberties of individuals and democratic principles

478 Correspondence, Department of health, 18 November 2015, Attachment.

16.11.1 Private Member's Bill

The Explanatory Note does not contain a simple explanation of the purpose and intended operation of each clause of the Bill, as required by section 23(1)(h) of the *Legislative Standards Act 1992*.

Committee comment

Given the importance of Explanatory Notes, the Committee considers all Members must take care when preparing material that accompanies a Bill. The Explanatory Note, as tabled, did not meet the standard required by the *Legislative Standards Act 1992*.

16.11.2 Government Bill

The Explanatory Note is reasonably detailed and contains the information required by Part 4 of the *Legislative Standards Act 1992,* with a reasonable level of background information and commentary to facilitate understanding of the Bills aims and origins.

16.12 Penalties

The Bills contains a number of new or amended offences each carrying a maximum penalty set, as out in the table below.

Bill and clause	Offence	Proposed maximum penalty
Government Bill 164(3)	Contravening, without reasonable excuse, a court ordered prohibition on the disclosure of a victim impact statement.	200 penalty units
Government Bill 164(6)	Disclosure by a person's lawyer to the person, without reasonable excuse, of a victim impact statement, without consent of the victim or close relative.	200 penalty units
Private Member's Bill 227	Performing electroconvulsive therapy on another person, other than under this Act.	100 penalty units or 1 year's imprisonment
Government Bill 234	Performing electroconvulsive therapy on another person, other than under this Act.	200 penalty units or 2 years imprisonment
Private Member's Bill 230	Performing a non-ablative neurosurgical procedure on another person for the purpose of treating the other person's mental illness, other than under this Act.	100 penalty units or 1 year's imprisonment
Government Bill 237(1)	Performing a non-ablative neurosurgical procedure on another person for the purpose of treating the other person's mental illness, other than under this Act.	200 penalty units or 2 years imprisonment
Private Member's Bill 232	Administering to another person— (a) insulin induced coma therapy; or (b) deep sleep therapy.	200 penalty units or 2 year's imprisonment
Government Bill 239	Administering to another person— (a) insulin induced coma therapy; or (b) deep sleep therapy.	200 penalty units or 2 years imprisonment

Bill and clause	Offence	Proposed maximum penalty
Private Member's Bill 233	Performing psychosurgery on another person.	200 penalty units or 2 year's imprisonment
Government Bill 240	Performing psychosurgery on another person.	200 penalty units or 2 years imprisonment
Private Member's Bill 245(1)	Using mechanical restraint on a relevant person in an authorised mental health service, other than under this Act.	200 penalty units
Government Bill 244	Using mechanical restraint on a patient in an authorised mental health service, other than under this Act.	200 penalty units
Private Member's Bill 255(1)	Keeping a relevant person in seclusion in an authorised mental health service, other than under this Act.	200 penalty units
Government Bill 254	Keeping a patient in seclusion in an authorised mental health service, other than under this Act.	200 penalty units
Government Bill 268	Using physical restraint on a patient, other than under this Act.	200 penalty units
Government Bill 271(1)	Administering medication to a patient unless the medication is clinically necessary for the patient's treatment and care for a medical condition.	200 penalty units
Private Member's Bill 315(2)	Publishing information obtained under an information notice unless the publication is required or permitted under the information notice, or an Act or law.	100 penalty units
Government Bill 324(2)	Publishing certain information unless the publication is required or permitted under an information notice, or an Act or law.	200 penalty units
Private Member's Bill 335	Failure, without reasonable excuse, of an authorised doctor or authorised mental health practitioner to return their identity card to the administrator of the authorised mental health service, which appointed them, within 21 days after their office ends.	20 penalty units
Government Bill 346	Failure, without reasonable excuse, of the holder of an office in section 344(1) to, within 21 days after the office ends, return their identity card to the administrator of the authorised mental health service that appointed them.	20 penalty units

Bill and clause	Offence	Proposed maximum penalty
Private Member's Bill 371(1)	Preventing or impeding in any way— (a) the delivery, to a patient of an authorised mental health service, of a postal article addressed to the patient; or (b) the sending of a postal article for a patient of an authorised mental health service.	20 penalty units
Government Bill 383(1)	Preventing or impeding in any way— (a) the delivery, to a patient of an authorised mental health service, of a postal article addressed to the patient; or (b) the sending of a postal article for a patient of an authorised mental health service.	20 penalty units
Private Member's Bill 380(2)	Failure by a visitor to the high security unit to comply with a direction to immediately leave the unit.	20 penalty units
Government Bill 392(2)	Failing to comply with a direction to leave the service.	20 penalty units
Private Member's Bill 382(3)	Failure by a visitor to the high security unit to comply with a direction to immediately leave the unit.	20 penalty units
Private Member's Bill 383(2)	Failure by a visitor to the high security unit to immediately leave the unit.	20 penalty units
Government Bill 394(3)	Failure, by a visitor, to comply with a direction to leave the service.	20 penalty units
Government Bill 395(2)	Failure, by a visitor, to leave the service under that section.	20 penalty units
Private Member's Bill 524	Failure, without reasonable excuse, of a former inspector to return their identity card to the Chief Psychiatrist within 21 days after their office ends.	20 penalty units
Government Bill 560	Failure, without reasonable excuse, of a former inspector to, within 21 days after their office ends, return their identity card to the Chief Psychiatrist.	20 penalty units
Private Member's Bill 541	Failure, without reasonable excuse, of a person to comply with a help requirement made of them.	100 penalty units

Bill and clause	Offence	Proposed maximum penalty
Government Bill 560	Failure, without reasonable excuse, of a former inspector to, within 21 days after their office ends, return their identity card to the Chief Psychiatrist.	20 penalty units
Private Member's Bill 547	Failure, without reasonable excuse, of a person to comply with a requirement made of the person under section 546(2)(c).	100 penalty units
Government Bill 577(1)	Failure, without reasonable excuse, to comply with a help requirement.	100 penalty units
Private Member's Bill 548(1)	Where access to a seized thing is restricted under section 546 - tampering with the thing, or with anything used to restrict access to the thing, without an inspector's approval or a reasonable excuse.	100 penalty units
Government Bill 582	Failure, without reasonable excuse, to comply with a requirement made of the person in relation to securing a seized thing.	100 penalty units
Private Member's Bill 548(2)	Where access to a place is restricted under section 546 - entering the place in contravention of the restriction or tampering with anything used to restrict access to the place, without an inspector's approval or a reasonable excuse.	100 penalty units
Government Bill 583(1)	Tampering with a seized thing to which access has been restricted, or with anything used to restrict access, without reasonable excuse or an inspector's approval.	100 penalty units
Government Bill 583(2)	Entering a place in contravention of an access restriction, or tampering with anything used to restrict that access, without reasonable excuse or an inspector's approval.	100 penalty units
Private Member's Bill 560(1)	Failure, without reasonable excuse, of a person to comply with a personal details requirement made of them.	100 penalty units
Government Bill 594(1)	Failure, without reasonable excuse, by a person of whom a personal details requirement has been made to comply with the requirement.	50 penalty units
Private Member's Bill 562(1)	Failure, without reasonable excuse, of a person to comply with an information requirement made of them.	100 penalty units
Government 596(1)	Failure, without reasonable excuse, by a person of whom an information requirement has been made to comply with the requirement.	50 penalty units

Bill and clause	Offence	Proposed maximum penalty
Private Member's Bill 578(2)	Ill-treatment of a patient by a person who, under this Act or under the *Public Health Act 2005*, is examining, assessing, detaining or providing treatment and care to the patient or who has custody of the patient.	100 penalty units or 1 year's imprisonment
Government Bill 619(2)	Ill-treatment of a patient.	200 penalty units or 2 years imprisonment
Private Member's Bill 579(3)	Wilfully allowing a patient to abscond from the person's charge - during transportation to a mental health service, forensic disability service, court appearance or to a place of custody, or whilst they are being accompanied to receive limited community treatment or a temporary absence under section 223.	200 penalty units or 2 year's imprisonment
Government Bill 620(3)	Wilfully allowing a patient to abscond from your charge.	200 penalty units or 2 years imprisonment
Private Member's Bill 579(4)	Knowingly helping a patient to abscond from a relevant person's charge in the s.579 circumstances above.	200 penalty units or 2 year's imprisonment
Government Bill 620(4)	Knowingly helping a patient to abscond from a person's charge.	200 penalty units or 2 years imprisonment
Private Member's Bill 580(1)	Inducing, or knowingly helping a patient detained in an authorised mental health service or public sector health service facility, to unlawfully absent themselves from the service or facility; Or Knowingly harbouring a patient who is unlawfully absent from an authorised mental health service or public sector health service facility.	(a) for a classified patient, forensic patient or a person subject to a judicial order—200 penalty units or 2 years imprisonment; or (b) otherwise—100 penalty units.
Government Bill 621(1)	(a) Inducing or knowingly helping a patient of an authorised mental health service or public sector health service facility to unlawfully absent themselves from the service or facility; or (b) knowingly harbouring a patient who is unlawfully absent from an authorised mental health service or public sector health service facility.	(a) for a classified patient, forensic patient or a person subject to a judicial order— 200 penalty units or 2 years imprisonment (b) otherwise—200 penalty units

Bill and clause	Offence	Proposed maximum penalty
Private Member's Bill 580(3)	An employee of an authorised mental health service or public sector health service facility wilfully allowing a patient detained in the service/facility to unlawfully absent themselves from the service/facility.	(a) for a classified patient, forensic patient or person subject to a judicial order—200 penalty units or 2 years imprisonment; or (b) otherwise—100 penalty units.
Government Bill 621(3)	An employee of an authorised mental health service or public sector health service facility wilfully allowing a patient detained in that service or facility to unlawfully absent themselve's from the service or facility.	(a) for a classified patient, forensic patient or a person subject to a judicial order-200 penalty units or 2 years imprisonment; or (b) otherwise-200 penalty units.
Private Member's Bill 582	Obstructing, without reasonable excuse, an official exercising a power, or someone helping an official exercising a power.	100 penalty units
Government Bill 623(1)	Obstructing, without reasonable excuse, an official exercising a power, or someone helping an official exercising a power.	100 penalty units
Private Member's Bill 583	Impersonating an official.	100 penalty units
Government Bill 624	Impersonating an official.	100 penalty units
Private Member's Bill 584(1)	Giving, in relation to the administration of this Act, an official information, or a document containing information, that the person knows is false or misleading in a material particular.	100 penalty units
Government Bill 625(1)	Giving official information, or a document containing information, that a person knows is false or misleading in a material particular.	100 penalty units
Government Bill 678(3)	Failure (without reasonable excuse) to answer an appointed person's questions	100 penalty units

Bill and clause	Offence	Proposed maximum penalty
Private Member's Bill 613(5)	Contravening a confidentiality order without reasonable excuse.	100 penalty units
Government Bill 694(5)	Contravening, without reasonable excuse, a confidentiality order.	200 penalty units
Government Bill 720(5)	Contravening, without reasonable excuse, a confidentiality order.	200 penalty units
Government Bill 741(3)	Disclosing, without reasonable excuse, a victim impact statement in breach of the restrictions in section 741.	200 penalty units
Government Bill 741(6)	Disclosure, by a person's lawyer, without reasonable excuse, of a victim impact statement in contravention of section 741(5).	200 penalty units
Private Member's Bill 650(1)	Failure, without reasonable excuse, of a person given an attendance notice to— (a) attend as required by the notice; or (b) continue to attend as required by the presiding member until excused from further attendance; or (c) produce a document or other thing the person is required to produce by the attendance notice.	100 penalty units
Government Bill 758(1)	Failure, without reasonable excuse, of a person given an attendance notice to— (d) attend as required by the notice; or (e) continue to attend as required by the tribunal until excused from further attendance; or (f) produce a document or other thing the person is required to produce by the attendance notice.	100 penalty units
Private Member's Bill 650(2)	Failure, without reasonable excuse, of a person appearing as a witness at a hearing of a proceeding to, when required by the presiding member— (a) take an oath or make an affirmation; or (b) answer a question the person is required to answer.	100 penalty units
Government Bill 758(2)	Failure of a person appearing as a witness at a hearing of a proceeding to, when required by the tribunal— (c) take an oath or make an affirmation; or (d) answer a question the person is required to answer, without reasonable excuse.	100 penalty units

Bill and clause	Offence	Proposed maximum penalty
Private Member's Bill 651(1)	Stating to the tribunal or its staff anything a person knows is false or misleading in a material particular.	100 penalty units
Private Member's Bill 651(2)	Giving the tribunal or its staff a document containing information a person knows is false or misleading in a material particular.	100 penalty units
Government Bill 759(1)	Stating to the tribunal or a staff member of the tribunal anything a person knows is false or misleading in a material particular.	100 penalty units
Government 759(2)	Giving to the tribunal or a staff member of the tribunal a document containing information a person knows is false or misleading in a material particular.	100 penalty units
Private Member's Bill 707(3)	Failure, without reasonable excuse, to answer a question about a person's detention in a relevant service, when asked by a MHC appointee tasked with reviewing the person's detention.	100 penalty units
Private Member's Bill 723(5)	Contravening a confidentiality order without reasonable excuse.	100 penalty units
Private Member's Bill 733(2)	Using or disclosing personal information.	100 penalty units
Government Bill 777(2)	Using or disclosing personal information.	100 penalty units
Private Member's Bill 738(5)	Contravening a confidentiality undertaking.	100 penalty units
Government Bill 781(5)	Contravening an undertaking about the disclosure of particular information relating to a classified patient.	200 penalty units
Government Bill 785(3)	Contravening an undertaking given under section 785(1)(c) or 785(2)(c).	200 penalty units
Private Member's Bill 743(1)	Publishing a report of a proceeding, or a decision on a proceeding, in the Mental Health Court or Court of Appeal for a reference before the end of the prescribed day after the decision on the proceeding.	200 penalty units or 2 years imprisonment

Bill and clause	Offence	Proposed maximum penalty
Government Bill 787(1)	Publishing a report of a proceeding in the Mental Health Court or the Court of Appeal on a reference in relation to a person, or a decision on the proceeding, before the end of the prescribed day for the decision on the proceeding.	200 penalty units or 2 years imprisonment
Private Member's Bill 744(1)	Publishing a report of a proceeding of— (a) the tribunal; or (b) the Mental Health Court relating to an appeal against a decision of the tribunal; or (c) the Mental Health Court relating to an inquiry by the court.	200 penalty units or 2 years imprisonment
Government Bill 788(1)	Publishing a report of a proceeding of— (a) the tribunal; or (b) the Mental Health Court relating to an appeal against a decision of the tribunal; or (c) the Mental Health Court relating to a review under section 671.	200 penalty units or 2 years imprisonment
Private Member's Bill 745(1)	Publishing information that identifies, or is likely to lead to the identification of, a minor who is or has been a party to any proceeding under this Act in the tribunal, Mental Health Court or Court of Appeal.	200 penalty units or 2 years imprisonment
Government Bill 789(1)	Publishing information that identifies, or is likely to lead to the identification of, a minor who is or has been a party to a proceeding under this Act in the tribunal, Mental Health Court or Court of Appeal.	200 penalty units or 2 years imprisonment
Private Member's Bill 745(2)	Publishing information that identifies, or is likely to lead to the identification of, a person other than a minor who is or has been a party to a proceeding mentioned in section 744(1).	200 penalty units or 2 years imprisonment
Government Bill 789(2)	Publishing information that identifies, or is likely to lead to the identification of, a person other than a minor who is or has been a party to a proceeding mentioned in section 788(1).	200 penalty units or 2 years imprisonment

Appendix A – List of Submissions

Sub #	Submitter
001	Maddie Jones
002	Kathy Fairweather
003	Glen Stewart
004	Troy Johnston
005	John Favaro
006	Stephen Barber
007	Julieannne Hupalo
008	Kerry Larkman
009	Dr Reddington
010	Australian Association of Social Workers Qld
011	Anthony Parker
012	Jay Lawrence
013	Joy Rizzo
014	Queensland Mental Health Commission
015	Quentin Chen
016	Faye Lan
017	Nicky Flynn
018	Julie Lawrence
019	Manfred Franz Schirnhofer
020	Peter Davies
021	Bart Nettle
022	Dr McLaren
023	Rob Ovenden
024	Amanda Hickman
025	Darryl Burnside
026	Narelle Ladd
027	Queensland Nurses Union
028	Rights in Action Incorporated
029	James Davey
030	Claudette Woodley
031	Pinchung Pan
032	Office of the Public Advocate

033	Royal Australian and New Zealand College of Psychiatrists (QLD Branch)
034	Meng-Lung Yang
035	Sung Ming-Yen
036	Eli Lee
037	Tsai Linda
038	Baiyen Tsai
039	Ivonne Fang
040	Wen Lin
041	Douglas Hsu
042	Ann Lu
043	Evelyn Wang
044	May Liu
045	Jen Chou
046	Allyssa Lin
047	Monique Wright
048	Randi Lin
049	Name suppressed
050	Sasa Gason
051	Linda Vij
052	Rebecca Sferco
053	Queensland Law Society
054	Bryan Hu
055	Royee Tung
056	AMA Queensland
057	Renee Fang
058	Tania Lee
059	Qld Section of the Australian Psychological Society's (APS) College of Forensic Psychologists.
060	Judith Williams
061	Kevin Lin
062	Heidi Ross
063	Archee Riddell
064	Ken Yao
065	Nai Chiao Chen
066	Wenda Moore

067	Lin Yu-sho
068	I-Horng Tsay
069	Iona Kentwell – Peta Fowler
070	Karen (No Surname Identified)
071	Albert (No Surname Identifeid)
072	Janelle Bonato
073	Office of the Public Guardian
074	Dennis Denning
075	Janssen-Cilag Pty Ltd
076	Colin and Colleen Marsh
077	Professor H.W. McConnell, Professor of Neuropsychiatry and Neurodisability

Appendix B – List of Witnesses

Witnesses – Public Briefing held Wednesday 9 November 2015	
1	Dr William Kingswell, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Queensland Health.
2	Mr Paul Sheehy, Director, Mental Health Review, Queensland Health.
Witnesses – Public Hearing held Wednesday 28 October 2015	
1	Ms Karen Williams, Chairperson, Health and Disability Committee, Queensland Law Society.
2	Mr Michael Fitzgerald, President, Queensland Law Society.
3	Ms Beth Mohle, State Secretary, Queensland Nurses Union.
4	Ms Sharyn Hopkins, Professional Officer, Queensland Nurses Union.
5	Mr Jamie Shepherd, Professional Officer, Queensland Nurses Union.
6	Dr Steve Kisely, Queensland Councillor, Australian Medical Association.
7	Dr Vikas Moudgil, Royal Australian and New Zealand College of Psychiatrists.
8	Mrs Judith Johnston, Policy Officer, Royal Australian and New Zealand College of Psychiatrists.
9	Ms Gail Corrigan, Forensic Psychologist, Secretary of the Queensland Section of the College of Forensic Psychologists.
10	Ms Kim Chandler, Acting Public Advocate, Office of the Public Advocate.
11	Ms Julie Duffy, Public Guardian, Office of the Public Guardian.
12	Dr Niall McLaren, Consultant Psychiatrist.
Witnesses – Public Briefing held Wednesday 14 October 2015	
1	Dr Bill Kingswell, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Queensland Health.
2	Mr Paul Sheehy, Director, Mental Health Review, Queensland Health.
3	Mr Mark McArdle MP, Member for Caloundra.
Witnesses – Public Briefing held Monday 23 October 2015	
1	Professor H.W. McConnell, Professor of Neuropsychiatry and Neurodisability
2	Dr Michelle Fryer, Child and Adolescent Psychiatrist and Chair, Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists