# Submission

## Mental Health Review Tribunal Submission on *Mental Health Amendment Bill 2016*

**13 January 2017**

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# 1. Executive Summary

It appears that a number of changes directed to improving a person's right to make choices about their progress through the criminal justice system may also result in less use of the beneficial intervention of the forensic mental health system established to date. A reduction of the demands on clinicians to prepare reports may also result in a significant number of people not being in a position to receive their right to a mental health defence because they lack the understanding of the benefit of treatment due to being untreated and unwell.

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# 2. Submission re *Mental Health Amendment Bill 2016*

## 2.1 Need for Amendment to section 721(4) about Tribunal Examination Orders

Section 721(4) of the *Mental Health Act 2016* (*MHA 2016)* provides for the Mental Health Review Tribunal (the Tribunal) being able to direct persons in relation to the carrying out of Examination Orders. It is noted that this sub-section mirrors the provisions in section 177.

The availability of qualified psychiatrists is limited and as such it has been the Tribunal's experience that obtaining appointments so that Tribunal Examination Orders may be conducted is difficult. Often psychiatrists only have available appointments some months in the future. Thus it would be impossible to direct a person to attend at the examining practitioner within a time of not more than 28 days as appointments cannot be arranged in that timeframe due to the lack of availability of reputable/qualified psychiatrists.

The Tribunal submits that section 721(4)(b) is impractical and that a further amendment should be made to the *Mental Health Act 2016* which omits section 721(4) altogether. Alternatively, "of not more than 28 days" should be omitted from section 721(4)(b).

## 2.2 Need for Amendment as to who may approve Limited Community Treatment attached to Treatment Authorities

The Tribunal strongly advocates for a further amendment to allow a patient's treating psychiatrist to approve Limited Community Treatment (LCT) for those patients subject to Treatment Authorities (TA). The current system where the Tribunal has jurisdiction to change a patient's Involuntary Treatment Order (ITO) category and if the category is inpatient, approve LCT, works in conjunction with section 129 of the *Mental Health Act 2000 (MHA 2000)* - Authorising LCT - is most effective and no change is required.

It is current Tribunal practice not to determine, on an Involuntary Treatment Order (ITO) review, a patient's LCT except in the most unusual circumstances as the treating psychiatrist is in the best position to assess whether LCT is appropriate. The appropriate level of LCT for an ITO or TA patient is best assessed on a short term basis as the patient's health may fluctuate within a day and/or on a daily basis. It is the treating psychiatrist who is most able to assess an inpatient's state of mind as they are able to be in constant contact with the patient. This advantage is not open to the Tribunal who can only approve LCT at the 28 day mark and then each 6 months at a hearing.

Section 425(3) states that in deciding whether to approve or extend LCT the Tribunal must have regard to the purpose of LCT but it is submitted that it is the treating psychiatrist who is best placed to have regard to the purpose of LCT and the patient's state of mind at the time of approving LCT.

As the provisions of the *MHA 2016* are currently, it is the Tribunal's view that if the Tribunal has not approved LCT up to discharge into the community and the patient becomes well enough for a change of category to community and discharge to the community, there will be a need for a further Tribunal hearing to enable a change of category and discharge to the community, causing substantial delay. This would be unnecessary if the provision mirrored the current situation under the *MHA 2000.* Another possible, but difficult, solution to the hypothetical situation created by the provisions of the *MHA 2016*, is that when a patient is ready for discharge, the treating psychiatrist

may choose to revoke the TA which has insufficient LCT and make a new TA Community Category. Both the proposed solutions seem unnecessary when the current system regarding LCT and ITOs works efficiently to facilitate the least restrictive options.

The Tribunal's position is that there should be an amendment to the *MHA 2016* to mirror the existing section 129 of the *MHA 2000* which will mean a less cumbersome and more efficient authorisation of LCT, changes of category and discharge of TA patients to the community to achieve the least restrictive option without the need to wait for a Tribunal hearing.

### 2.3 Need for Amendment regarding Change of Category to Inpatient hearings

On notice of a change of category to inpatient pursuant to sections 210, 213 and 217, the Tribunal must review the change. This creates the potential for many additional hearings which must be organised at relatively short notice (14 days for TSO/TA and 21 Days for FOs), most of which will not proceed to hearing when the patient is discharged prior to review. For example, a change of category may occur for a TA patient if there is difficulty with housing arrangements or there is a change of treatment to clozapine.

It is submitted that patients whose category is changed to inpatient be allowed to choose whether or not they require a review of the change of category. When they are admitted to hospital under sections 210, 213 and 217, the patient should be handed an application for review along with a statement of patient rights. If the patient requires a review, they make an application for review and for those patients who lack the capacity to make this assessment, the Tribunal may initiate a review. A review the patient chooses to have by making an application review or a review initiated by the Tribunal at this time, should go ahead regardless of whether the patient is discharged within the scheduled timeframe for review.

It is the Tribunal's position that this review should always proceed within the statutory timeframe regardless of whether the patient is discharged prior to the review date. Ensuring the review goes ahead upon application or Tribunal initiation allows patients to present their views as to the need for involuntary treatment and proceeding regardless of whether the patient remains an inpatient ensures that patients are not disappointed when their review is cancelled, sometimes at very short notice. Patients are often frustrated that their voice is not heard or that they do not have "their day in court". In addition, notice must also be given to nominated support persons and, potentially, legal representatives. Should these automatic reviews be cancelled at the last moment (due to the discharge of the patient), those who have notice of the hearing may not receive notice of its cancellation and this could lead to disgruntled participants attending for a hearing.

In addition, it is submitted that as the *MHA 2016* is currently, the Tribunal will regularly not be able to notify patients of the cancellation of their hearing as discharge or revocation of the TA often occurs the day before the hearing. By legislating that the review will always proceed, the treating team will not feel the need to revoke TAs and/or discharge patients just before their review. This will promote better clinical practice and avoid wasting valuable preparation for a hearing that does not take place.

Amendments will require deleting sections 416, 433(4), 437, 465(4) and 469.

### 2.4 Need for Amendment to section 55 - Notice of making Treatment Authority

Section 413(1)(a) of the *MHA 2016* requires the Tribunal to conduct the first review of a TA "within 28 days after the authority is made". Section 55 requires that the notice of the making of the TA be provided to the Tribunal within 7 days. Given that the Tribunal has only 28 days after the authority is made to conduct the first review, the Tribunal submits that notice of making the authority should be provided the next working day after the authority is made. This would provide the Tribunal with more time to organise a hearing in what is already a tight deadline and it also reinforces patient rights to be notified immediately they are placed on a TA. Modern technology provides for notice in writing to occur by email which makes it entirely feasible that the treating health service can notify the Tribunal in writing on the next working day

It is the Tribunal's submission that section 55(2) be amended by omitting "7 days" and inserting "within 1 working day".

## 2.5 Need for Amendment to section 728 re Adjournment of Hearing of particular periodic reviews

The Tribunal submits that the timeframe of 7 days before a hearing in section 728(1)(b) be amended to 28 days and the timeframe of 14 days in section 728(2(b) also be amended to 28 days. This provides for consistency of timeframes and also will prevent adjournment of hearings at short notice meaning that organisation of the hearing is wasted and there is better use of resources.

All parties to a hearing are notified of a hearing at least 14 days prior to a review for a FO periodic review and at least 7 days prior to a TSO or TA periodic review. As patients and their support network are notified of a hearing, there is the potential or them to attend same. Apart from this notification, in some cases, interpreters are arranged, legal representatives are engaged (for some forensic matters), nominated support persons and guardians are notified of the time and place of the hearing. In addition, with the existing timeframe, the treating team will have prepared a clinical report (at least seven days prior to the hearing) and provided a copy to the relevant parties and the Tribunal.

Thus, it is submitted that the Tribunal should be notified of a patient's absence earlier – at 28 days for all periodic reviews and it only when there is notice 28 days before the hearing that there is an adjournment.

## 2.6 Need for amendment to clauses 45 and 46 regarding Tribunal's discretion whether to adjourn

The Tribunal submits that a hearing should take place when a patient is Absent without Authorisation (AWA) less than 28 days before the hearing. The Tribunal notes that when a patient is AWA, a hearing should be conducted and all treatment in the community be reviewed as this is the best way of protecting the community until the patient is located and back in treatment. It is submitted that the word "may" be changed to "must".

The Tribunal submits that the section 731 ensures that a patient is reviewed within a reasonable time on their return and allows for the administrative process to ensure that engagement of all relevant entities can occur.

## 2.7 Need to insert provision to allow notification of child safety risk to Department of Child Safety

The Tribunal submits that a further provision be inserted in Chapter 17 of the *MHA 2016* – Confidentiality – providing for the Tribunal to disclose child risk issues to the Department of Child Safety. It is envisaged that this may be necessary when the treating team does not recognise the risk to children. An example of when it would be prudent for the Tribunal to notify the Department of Child Safety would include when an unwell patient was travelling interstate to collect their child for a holiday and it was unclear if the child's mother was in a position to judge whether it was safe for the child to go with their father.

## 2.8 Need for Amendment to section 740(4) about patients waiving their right to Legal Representation

Section 740(4) of the *MHA 2016* provides that a person with capacity may waive, in writing, the right to be represented by an appointed representative. The Tribunal submits that it is likely patients may seek to orally waive their right to legal representation on the day of the hearing. As the *MHA 2016* is currently worded, what will happen when a patient tells the appointed legal representative that they are not required on the day of the hearing? What is the legal representative to do in this situation? Are they to assess the patient's capacity to make this decision in order to decide whether to represent the patient or otherwise?

Further, if only a waiver in writing is sufficient, is it intended that the legal representative continue to represent the patient when there is only an oral statement to waiver the right to legal representation?

It is submitted that the section 740(4) is insufficient to deal with the most likely situation and that patients should be able to waive representation either orally or in writing with a reliance on the professionalism of the legal representative to only withdraw when there is in fact oral or written waiver of a patient's right to legal representation.

## 2.9 Need for Amendment to Chapter 16 allowing for Tribunal to provide information required to support Information Notice processes

### 2.9.1 Requirement of the Chief Psychiatrist to provide brief explanation for increases in the extent of treatment in the community to victims with Information Notices in their favour

Schedule 1, 3(2) of *MHA 2016* requires the Chief Psychiatrist to provide a brief explanation for any increase in the extent of treatment in the community to relevant victims with Information Notices in their favour. In order for the Chief Psychiatrist to fulfil this requirement, the Chief Psychiatrist will need a brief explanation from the Tribunal.

The *MHA 2016* does not make any provision for the Tribunal to provide the brief explanation for increases in the extent of treatment in the community to the Chief Psychiatrist.

The Tribunal submits that to give efficacy to Schedule 1, 3, there is a need to add a provision to Chapter 16 – Establishment and administration of court and tribunal – which provides for the Tribunal to give the explanation to the Chief Psychiatrist.

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### 2.9.2 Need for provision requiring the Tribunal to respond to Victim Impact Statements

The Queensland Health Victim Support Service have informed the Tribunal that victims will continue to want feedback about their Victim Impact Statements when the *MHA 2016* comes into force. However, there is no provision requiring feedback to the victim about their statements.

The Tribunal supports meeting victims' needs where possible and notes, and supports, the inclusion of section 6 – Principles for victims and others in the *MHA 2016.* It is the Tribunal's submission that the continued provision of feedback to victims about their Victim Impact Statements is consistent with section 6 and indeed this is currently the practice due to section 465 of the *MHA 2000*. It would be a retrograde step to cease providing feedback to victims but currently there is no requirement in the *MHA 2016* to continue to do so.

The Tribunal submits that to better meet victim needs there needs to be a further amendment to the *MHA 2016* Chapter 16 which allows the Tribunal to give feedback on Victim Impact Statements similar to section 465 of the *MHA 2000*. Such feedback could continue to provide feedback about the relevance of the Victim Impact Statement and also on how the statement was taken into account.

## 2.10 Need to include provision for Submissions other than Victim Impact Statements

The Tribunal receives submissions from persons other than victims, most commonly from patient's family members, allied persons and, on occasion, members of the community. Under the *MHA 2000*, there was provision made for material submitted by a victim or concerned person. See section 464 of the *MHA 2000*. However, there is no provision made for material received from concerned persons in the *MHA 2016*.

The Tribunal submits that for completeness and to ensure consistency in decision making and the way in which concerned persons' submissions are dealt with, and whether they are taken into account, provision should be made for such submissions in the Chapter 16 of the *MHA 2016.*

[redacted]

# 3. Broader Concerns and need for Amendments to *Mental Health Act 2016*

## 3.1 Providing a Legislative Framework to Support the Step-down Process

The Tribunal supports the development of a step-down process to assist patients in their recovery and rehabilitation after episodes of illness leading to criminal charges.

It would be of great assistance to the Mental Health Court (MHC), the Tribunal, victims, the broader community and patients, if there was clear definition of the types of order that may be made and the relevant criteria in determining the appropriate order to be made. This would enable consistent decision-making and provide greater certainty and acceptance of Queensland's Mental Health forensic system.

Currently all patients on a Forensic Order (FO) or an ITO must have a treatment plan under the *MHA 2000*. Patients on a FO have a risk management plan and their management is subject to the Forensic Patient Management policy and procedures. There is also a Policy and Practice Guideline for the care of disability forensic patients, providing for the possibility of monitoring conditions and drug tests. If a forensic patient does not return from LCT, there are procedures to be followed. There are also different tests for the making of a FO and the making of an ITO.

However, it is submitted that an ITO patient may have significant treatment needs and in those circumstances the level of supervision required by the order may be as great as the level of supervision provided to a Special Notification Forensic Patient (SNFP). In order to have consistent decision making in relation to a step-down process, the MHC decisions, on appeal and references, need to be examined to understand why the MHC makes FOs when the patient may have committed relatively minor offences and then draft legislative provisions listing relevant criteria or considerations for the making of specific orders – FOs or Treatment Support Orders (TSOs). The tests for FOs and TSOs should be different.

There also needs to be a recognition of the gap between:

- the MHC's statements that a FO is not stigmatising or that it is not some sort of punishment and patients' perceptions of the opposite;
- the MHC's statements that FOs (and likely also TSOs) impose a higher level of supervision and follow up of treatment needs and the AMHS' priority of patients' treatment needs driving the degree of supervision and follow up.

Currently the *MHA 2016* relies on the differentiation between FOs and TSOs being broadly stated in section 130(2) and references to the Chief Psychiatrist Policy and Practice guidelines referred to in 134(2) and 305(1)(e) and (f) and the fact that the default category of a FO is inpatient while the default category of a TSO is community.

### 3.1.1 Legislative Guidelines for the Mental Health Court

Section 130 is noted however it is submitted that an example of when a FO will be made could be included and state that in all but the most exceptional circumstances, when a person is found of unsound mind, not fit for trial (of a permanent nature or not of a permanent nature) and the index offences include murder; attempted murder; rape; assault with intent to rape; attempted rape;

dangerous driving causing death, stalking or serious child sexual offences: the Mental Health Court will make a FO. Alternatively this might be included in section 138 – Making of FO.

The use of the phrase "in all but the most exceptional circumstances" provides the MHC with the discretion that is associated with Supreme Court jurisdiction.

Another example in section 130 might be that "in all but the most exceptional circumstances when the index offence is not one of the more serious offences, but the nature of the offence indicates that when unwell the patient may pose a risk to the safety of others, or a serious risk to property, the MHC will make a TSO".

In addition, if a FO is to operate in a way that is more restrictive of a person's rights and liberties than a TSO, then the legislation needs to include provisions which establish exactly how the FO will be more restrictive. The *MHA 2016* currently has the same test for the making of FOs and TSOs and the considerations in making these orders are also exactly the same. What is the difference between a FO and a TSO?

The Section 130(2) *Examples* seem to indicate that it is the category of the FO and the inpatient LCT that are the mechanisms through which a FO will operate to be more restrictive of patient's right and liberties. It is implied in *Example 1* that FOs will likely be inpatient but in what circumstances might the MHC make a FO community category? Is it intended that patients with the most serious offences as listed above, will be placed on a FO inpatient category, in all but the most unusual circumstances? If so, why is this not reflected in the legislation?

### 3.1.2 Legislative Guidelines of the step-down process for the Tribunal

The Tribunal is a legislative body and its powers are those defined by the provisions of the founding legislation, currently the *MHA 2000*. As such the *MHA 2016* should provide considerations and criteria to be applied when determining the type of order that should be made.

The *MHA 2016* requires that FOs be confirmed after:

a) consideration of the "relevant circumstances", victim impact statement and certain MHC recommendations;
b) the application of the test that the order is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property.

The same test is to be applied, following the revocation of the FO, when the Tribunal is to determine whether to make a TSO. The provision states "that the Tribunal must decide to make a TSO if the Tribunal considers that a TSO, but not a FO, is necessary because of the person's mental condition, to protect the safety of the community, including the risk of serious harm to other persons or property".

What is the difference between the nature of a FO and a TSO? The only guidance provided is in section 130 and this provision does not clearly state what it is about a FO that "operates in a way that is more restrictive of a person's rights or liberties than a TSO". As raised above, is the category of a FO intended to be inpatient and LCT more restrictive than that of a TSO? Is a TSO intended to be community category, but may be inpatient? If so, when should a TSO be made? Under what circumstances should a FO be community category and a TSO be inpatient category?

The step-down process needs to be clear, predictable and understandable to all parties. There needs to be clear criteria that focus on the significant difference in the level of risk management provided by a FO compared to the level of risk management that is provided under a TSO. There

needs to be a difference in the level of supervision which attaches to the type of the order, not the category of the order itself or the type of LCT conditions.

In addition, while the MHC, in making the choice between a FO and a TSO, is required to refer to the Chief Psychiatrist's guidelines, the Tribunal is not required to consider those guidelines. Therefore the basis on which the Tribunal would make the change or step down is even more unclear.

If there is no difference between the nature of FOs or TSOs, and there is no difference in the test to be applied to the Tribunal, the Tribunal will need to write guidelines for members to apply the very broad provisions, and provide for some degree of consistency in decision-making and certainty for the parties.

### 3.2 Change "amend" to "authorise" LCT within the limits last set by Mental Health Court or Tribunal regarding sections 23, 139, 140, 145, 212, 216, 445, 446 and 477

Throughout the *MHA 2016*, sections 23, 139, 140, 145, 212, 216, 445, 446 and 477 provide that an authorised doctor may "amend" LCT attached to an FO or TSO.

This provides an authorised doctor with considerable power, not subject to review or scrutiny. Indeed, under the current *MHA 2000,* a treating psychiatrist does not have this power in relation to FOs. The Tribunal submits that with respect to TAs, the power to amend the category of the TA should remain with the Tribunal and authorised psychiatrists. Regarding FOs and TSOs, only the Mental Health Court and the Mental Health Review Tribunal should be able to amend or change the category of the order and amend or change the LCT.

The current *MHA 2000* arrangement works very well. The MHC or the Tribunal approve LCT and there is usually a provision stating that the LCT is to be implemented subject to the assessment of the treating psychiatrist with regard to the patient's mental condition. It is clear that LCT cannot go beyond that which has been approved by the MHC or the Tribunal – whichever is the latest decision. The LCT sets the outer framework within which the clinician may decide on day to day absences and activities of the patient.

Under the current *MHA 2000*, if a treating team is in doubt about the limits of the LCT, they consult with the Tribunal office and the relevant Presiding Member explains the intention of the Tribunal. In this way, issues of interpretation are referred to the Tribunal and this is a safeguard. In addition, the treating team have the ability to restrict or revoke LCT as appropriate, within the limits of the LCT approved by the MHC or Tribunal.

In addition, the use of "amend" could lead to interpretations of LCT that suit the treating team, including those potentially outside the scope of the conditions made by the MHC and the Tribunal.

It is noted that the *MHA 2016* does include, later in these provisions listed in the first paragraph in this section, sub-sections that establish that the amendment must be in accordance with the decision of the Mental Health Court or the Tribunal. However, it would be much clearer, if the authorised doctor or senior practitioner's powers were limited to "authorising" LCT or change the category of the order within the limits last set by the MHC or the Tribunal. Sub-sections 3 and 4 of section 23 (and the like) should be removed and these provisions be amended as per the wording explained above.

This wording clearly requires that the authorisation of LCT is limited to the conditions of LCT approved by the MHC or the Tribunal, whichever is the latest. On the other hand, the use of the word "amend" or "change" suggests that the wording of LCT can be changed without limit,

especially on the first reading of these provisions. An authorised doctor may stop reading at the end of that sub-section and proceed to change the LCT without regard to what has been provided for by the MHC or the Tribunal. The entire provision is not necessarily read by those who apply it, especially by those who do not have legal training.

It is submitted that the term "amend" is misleading in the context of the whole provision and as such it may result in greater changes or amendments to LCT than is intended. Amendments may well be outside the scope of the latest decision of the MHC or the Tribunal, leading to adverse consequences.

### 3.3 Forensic Order (Disability) providing for Detention of People with Untreatable Mental Conditions in AMHSs

The Tribunal submits that the Bill or other legislation, perhaps the *Guardianship and Administration Act 2000,* be amended to provide alternative accommodation for the care and supervision of people with untreatable mental conditions (such as dementia, organic brain disease and intellectual disability) whose condition has resulted in offences for which they have been found permanently unfit for trial. Appropriate accommodation needs to be found to preclude their detention in an inappropriate environment.

FOs may be made when mental conditions or mental diseases such as dementia, organic brain disease and intellectual disability are the basis for a finding of unsoundness of mind or permanent unfitness for trial. For the most part, such findings result in patients, or clients, being detained in an AMHS with a condition or disease that causes some degree of risk (as defined in section 204(1) of *MHA 2000*) but cannot be treated. With an aging population, the cases, where dementia is found to constitute an unsoundness of mind, will continue to rise with it becoming a major issue over the next decade.

The prospects for such patients or clients are that they will remain subject to the Forensic Order (Disability) [FO (Dis)] indefinitely, if section 442 of the *MHA 2016* is implemented. This is consistent with the MHC acceptance of the submissions of the Director of Mental Health regarding the interplay of legislation in the reference of *Drennert* [2013] QMHC, unreported, 6 February 2013, Court Proceeding No 0071 of 2012.

In circumstances, when the mental condition of patients or clients does not require treatment, reviews are currently focused on the supervision or care of the patient/client, not their mental condition or treatment. There is nothing in the *MHA 2016* to indicate this will change.

It is submitted that the where treatment cannot be provided in an AMHS, it is inappropriate for the AMHS to be used as a place to detain patients with organic brain disease and clients with an intellectual disability.

It is submitted that provision be made for alternative accommodation in a safe environment for the care and supervision of people with these mental conditions as it is inappropriate, and at times unsafe, for them to share wards with patients suffering from acute psychosis and mania.

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