HEALTH AND AMBULANCE SERVICES COMMITTEE

Members present:

Ms L Linard MP (Chair)
Ms RM Bates MP
Mr SL Dickson MP
Mr AD Harper MP
Mr JP Kelly MP
Dr CAC Rowan MP

Staff present:

Ms K Dalladay (Acting Research Director)
Ms C Keyes (Executive Assistant)

PUBLIC BRIEFING—MENTAL HEALTH (RECOVERY MODEL) BILL 2015 AND MENTAL HEALTH BILL 2015 (QUEENSLAND HEALTH)

TRANSCRIPT OF PROCEEDINGS

MONDAY, 9 NOVEMBER 2015

Brisbane

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Committee met at 9.03 am

KINGSWELL, Dr William, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Department of Health

SHEEHY, Mr Paul, Director, Mental Health Review, Department of Health

CHAIR: Welcome, ladies and gentlemen. Thank you for your attendance today. Before we start I ask that all phones be switched off or to silent. I now declare this public briefing of the Health and Ambulance Services Committee open. I would like to acknowledge the traditional owners of the land on which we meet and pay my respects to elders past and present. The other committee members with me here today are: Mr Aaron Harper, the member for Thuringowa; Mr Joe Kelly, the member for Greenslopes; and Dr Christian Rowan, the member for Moggill. Ms Ros Bates, the Deputy Chair and member for Mudgeeraba and Mr Steve Dickson, the member for Buderim, are joining us via teleconference.

The purpose of today is to inform the committee's inquiry into the Mental Health (Recovery Model) Bill 2015 and the Mental Health Bill 2015. The committee is considering both bills at the same time and will present a combined report to the Legislative Assembly by 24 November 2015. The bills have a common aim, which 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. They 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. The bills also aim to protect the community if people diverted from the criminal justice system may be at risk of harming others.

The committee recently held a public hearing and heard evidence from a number of invited witnesses who made submissions on either or both bills. Following the hearing the committee requested that officials from the Department of Health brief the committee to provide further clarification on issues raised during the hearing. I acknowledge that the department has previously briefed the committee on the bills, and I thank the officials attending today for again making themselves available.

I would like to mention a few procedural matters before we hear from the invited witnesses. The committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee which takes a nonpartisan approach to inquiries. Committee proceedings are subject to the Legislative Assembly's standing rules and orders. Hansard is making a transcript of proceedings which will become available as soon as practicable, and the proceedings are also being broadcast live on the parliament's website.

I would now like to welcome witnesses from the Department of Health who have briefed us previously on the two mental health bills currently before the committee. Thank you for attending today and thank you for the fulsome answers that you provided to a letter we sent you recently with questions from the committee arising from our public hearing at the last sitting. Please note that members of the committee will direct additional questions to you, but if you are not able to answer a question you can take it on notice. Would you like to make any opening comments about the letter we wrote to you or the information that you provided?

Dr Kingswell: Thank you for the opportunity to address some of the issues that were raised with you. There were a number that we highlighted: the treatment of minors, GPS devices, advance health directives and the recovery oriented model. In relation to the treatment of minors, I believe the parliamentary committee has received a number of submissions expressing concern about the use of ECT on persons under the age of 18, so we wanted to try and put that into some perspective for you.

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. It is used in particularly serious situations and the procedure can be highly effective. 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. More generally, in relation to minors being treated under involuntary treatment orders again the numbers are very low. 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.

The committee has received submissions and sought advice on the use of GPS tracking devices on forensic patients. Again these devices need to be put into perspective. 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 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. The authorisations related to the West Moreton and Townsville secure units, and as indicated in the department's written response to the committee, the use of these devices will be beneficial in a very small number of cases.

The department has responded in writing to the committee in relation to persons being treated under an advance health directive or with the consent of an attorney or guardian. These proposals are strongly supported by stakeholders and, if implemented effectively, will give persons greater control over their future health care. I would like to assure interested stakeholders that there are strong protections under the Mental Health Bill for persons being treated under an advance health directive or with the consent of an attorney or guardian. We have listed these protections in the letter to the committee, and I would encourage interested stakeholders to peruse this list if they have any concerns in this regard. We can read that list into the record if the committee requires.

CHAIR: If there is something specific that you wanted to mention you are welcome to do so. Otherwise, we are more than happy for you to table the list.

Dr Kingswell: There is nothing to add over and above what has been written in the letter, so if you are happy for that to be published we will move on. Many of these protections do not currently apply under the Mental Health Act 2000, and these protections are in addition to those that apply under the Guardianship and Administration Act and the Powers of Attorney Act. The department has agreed to enter into a memorandum of understanding with the Public Guardian to ensure effective oversight of the rights of patients in authorised mental health services, and the department will be working closely with mental health consumer and clinical stakeholders in implementing these provisions.

The bill does a great deal to support a recovery oriented model for patient treatment and care. The objects of the bill are to be achieved in a way that 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. This governs the administration of the whole bill. The bill emphasises the importance of involving family, carers and other support persons in decisions about the patient's treatment and care, including when the patient returns to the community. This includes enabling a person to appoint a nominated support person to support the person during the acute phase of an illness in alliance with good clinical practice and will improve health service delivery and lead to better patient outcomes. The bill will generally allow treatment and care to be provided in any place that is clinically appropriate, including in community settings, and the act will remove restrictions on the use of audiovisual technology in the current act.

The provisions in the Victorian legislation referred to by the Public Advocate related to recording and explaining when an advance health directive is not followed, and those provisions are included in the bill at clause 54.

The bill requires patients on treatment authorities to be treated in a community unless the patient must be admitted to an in-patient unit to meet the patient's treatment and care needs. The bill enables the Mental Health Review Tribunal to step down a patient on a forensic order to a less

restrictive treatment support order when it is appropriate to do so. The bill removes the barrier to interstate transfers which can assist a patient's recovery by being closer to family members and other support persons. The legislative provisions will be supported by appropriate clinical practice that supports patient recovery.

CHAIR: For the benefit of my fellow committee members, please ask questions at will rather than going member by member. We may have a number of different questions on the same issue and we can move a bit more informally.

Dr ROWAN: Thanks very much to the Department of Health for being here this morning. I wanted to ask about legislative inconsistencies particularly relating to deep brain stimulation, or ECT, for minors. As I understand it, the legislation in West Australia does not provide for the administration of ECT to minors under 14 years of age. Is the potential legislative inconsistency which could exist across jurisdictions in Australia the result of differing professional opinions or departmental advice? Do you have any information which could inform the committee about that?

Dr Kingswell: I suspect it is occurring at a state policy level and I am not sure what the drivers are. I did ask this question of Dr Stephen Stathis, who is the director of mental health at Children's Health Queensland, and he provided this response for me which I might just read into the record, if that is okay. He said—

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.

That was from Stephen Stathis, Medical Director, Child and Youth Mental Health Services, Children's Health Queensland. I am not sure how I can get that into your record. He did write a formal letter which I could forward to the committee, or you may have it.

CHAIR: If the letter you are referring to is with regard to queries that we had about ECT on minors, we do have it—thank you—and that is now in the transcript, so formally on the record. Thank you.

Dr ROWAN: On occasion there can be the placement of minors with mental health disorders into adult mental health wards and I just wanted to ask whether all staff in those mental health wards are required to have blue cards, whether they be clinical or operational staff.

Dr Kingswell: Can I take that on notice?

CHAIR: Yes.

Mr KELLY: I have a further question in relation to ECT. A number of submissions noted that the World Health Organization has stated that legislation should prohibit ECT use on minors. Are you aware of that and can you comment on that?

Dr Kingswell: I am aware that that claim was made in a letter that came from the scientologists—however named; I cannot remember what they call themselves, citizens for human rights or something—and I asked the question whether it was true or not and I cannot remember the answer, I am sorry. I can take that on notice as well.

Mr KELLY: I would appreciate that. There was reference in another submission and in Niall McLaren's submission as well in relation to the World Health Organization. I am not sure if you are familiar with Dr McLaren's submission, but he gave evidence that he discontinued ECT in a number of hospitals and had admission rates that had dropped by 50 per cent. There was no evidence supplied that I could see to back that claim. Are you aware of that submission and can you comment on that?

Dr Kingswell: I have not seen the submission. I think I have told the committee in the past that 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. So I tend to support Dr Stathis's view that to prevent minors from accessing this treatment would be to deny them potentially lifesaving intervention. I would be very surprised if the World Health Organization has made a categorical statement around particular age groups—we certainly will check that—but it does not ring true.

Mr KELLY: With regard to the advance health directives, you note in your response that they will be recorded on a statewide mental health information management system which is accessible to all mental health clinicians. Just for my understanding, will the advance health directives that deal with treatment for psychiatric illnesses be handled totally separately to, say, an advance health directive that would be used for, say, physical ailments and illnesses as people progress in life?

Dr Kingswell: My understanding of this piece of legislation is that the responsibility of the administrator of the authorised mental health service will be to keep on record mental health related advance health directives. They will not be required to keep all other health directives on record. Paul might have a fuller answer.

Mr Sheehy: Yes, that is correct. The statutory duties are established within the ambit of the Mental Health Act, so it is not intended to be a wider repository for advance health directives. It is for the specific purposes of persons with a mental illness.

Mr KELLY: Thank you.

Mr HARPER: Just on the ECT subject—and I think you are right: it does evoke some sometimes emotive responses—are you aware of any other medical procedures outside of mental health which have proven to be clinically useful which have legislative age restrictions?

Dr Kingswell: I think I would have to take that on notice. Nothing occurs to me.

Mr Sheehy: We can take it on notice. From my understanding of the health legislation I do not believe so, but I would like to take the opportunity—in fact, I am fairly certain that is the case—to check that.

CHAIR: Just moving on to a different topic, on behalf of the committee please thank Dr Stathis for his advice. He has provided a number of pieces of evidence or information to the committee to assist us.

Mr DICKSON: Madam Chair, just before we leave that topic, I have a couple of questions on that.

CHAIR: Sure.

Mr DICKSON: Bill, I just wanted to clarify a couple of things. You stated that you had four minors in 2014 and three in 2013. Did any of those young people get treated with ECT?

Dr Kingswell: Yes. So all of those applications were heard by the Mental Health Review Tribunal for the purposes of administering ECT, yes.

Mr DICKSON: The other point I want to raise relates to private health providers for mental health. Who is responsible for them? Who oversees them and how do we get some sort of a recording process in place, because I do not think private enterprise can just take people out there and do what they like when they like? I am sure that does not happen, but what are the process and procedures that are in place to cover transparency?

Dr Kingswell: Private hospitals are licensed by the Chief Health Officer under her legislation and private hospitals are a bit more strictly controlled than our public hospitals. They have to meet the clinical services capability framework that is set by the department. It is mandatory for them and they get audited on their performance against that. With respect to mental health, for those facilities that are authorised mental health services—and not all private hospitals are but some are such as New Farm and Toowong and Belmont; they are all authorised mental health services—they are subject to exactly the same safeguards as the public hospitals. However, patients admitted as voluntary patients to those facilities are invisible to us. We do not have any oversight of those patients.

Mr DICKSON: So realistically the legislation we are talking about at the moment does not really make a difference to those five facilities and they can all do what they like?

Dr Kingswell: It makes a huge difference in respect of ECT because it means that all applications for ECT, whether the minor consents or not, must come through the Mental Health Review Tribunal process and will be then visible to the department.

Mr DICKSON: Just to take that a little bit further, how can we get into a situation in Queensland where it is tracked, because I think there is a lot of controversy relating to this particular type of

program? The Queensland government needs to understand how many people are getting this done and what the outcomes are because that is the only way we can prove or disprove how wonderful this program is.

Dr Kingswell: This act will achieve that in relation to minors. It will not achieve that in relation to adults who have capacity. They will still be able to access ECT as voluntary patients and we will not necessarily have visibility over that.

Mr DICKSON: Bill, thank you very much for your time.

CHAIR: Thanks, Steve. Ros, did you have anything you wanted to ask on this topic before I ask an unrelated question?

Ms BATES: Are we just on ECT or on GPS tracking as well?

CHAIR: Ros, you should just ask whichever questions you like. I know that you are limited somewhat there.

Ms BATES: I am listening but it is sometimes a little bit difficult to hear, so I just wanted to make sure where we were up to.

CHAIR: No, you are fine. Go ahead.

Ms BATES: I do have a question. All of the submissions so far to the Health and Ambulance Services Committee recommended the use of GPS monitoring of forensic patients or state that it stigmatises patients. My concern still remains that public safety should be paramount in these deliberations. In terms of the difference between the two bills, the private member's bill includes the ability for the chief psychiatrist I believe in consultation with the Mental Health Court and the Mental Health Review Tribunal to be involved in decision making for the requirement for a forensic patient to wear a GPS tracking device and I am assuming the government from my reading of the government bill does not want the chief psychiatrist involved in this process as he is just a bureaucrat. Can I please have some clarification around why the recommendation is that we do not include someone like the chief psychiatrist, because I am assuming he actually has qualifications? I ask if someone would like to comment on that.

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.

Mr KELLY: I have a question in relation to electronic monitoring. A number of submissions suggested that the application of an electronic monitoring device could potentially stigmatise a person in the community. Are there less obvious options available, and I know that it is very small numbers of people who actually have these devices applied?

Dr Kingswell: The amendment to the existing act was made when the Queensland Mental Health Commission bill passed the House. It specifically put GPS monitoring as an example of a monitoring device. The legislative change was not required in that the Chief Psychiatrist has always had the capacity to authorise a monitoring device of almost any type. In fact, most of our involuntary treatment order patients are subject to all sorts of monitoring conditions, such as having to attend outpatient appointments, having to contact their case manager at particular intervals, or be available on a mobile phone or be available in some other way. So it is not new. We did not need the legislation to make it happen. It just made it overt that it was going to occur and it drove the department's need, of course, then to source the hardware to make it all happen.

Yes, there are much less obvious options. 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.

With the GPS monitoring device, having said that, they are unlikely to be used except in those circumstances where somebody has been responsible for a very serious offence. In that situation it might allow you the opportunity to provide greater freedom for somebody rather than less. I get the concern about the stigma, but if your option is to sit in a secure hospital for the rest of your life or to safely access some leave through a technological device, I think that is possibly the better option from the patient's point of view.

Mr KELLY: Thank you.

Dr ROWAN: Just to clarify then, so without the option of GPS monitoring devices being available for certain forensic patient cohorts, can the community be guaranteed their safety?

Dr Kingswell: Sorry, the GPS devices are available. We did purchase them through the department of corrections and they are there to be used as required.

Dr ROWAN: So into the future? Their place is appropriate to be an option for certain eligible patients despite the stigmatisation which may or may not exist?

Dr Kingswell: Yes. I am not here to state a policy position, but it would seem logical to me that this might allow some freedom to patients who might not otherwise be able to access leave. I am certainly aware of a number of patients who we have in our system who cannot leave a security hospital facility.

Mr HARPER: How many patients do you have currently wearing these monitoring devices?

Dr Kingswell: None.

CHAIR: You mentioned earlier, too, that there had been a number where decisions had been made that someone was to wear them but then it had been overturned or changed. What did you mean by that? What happened in that situation?

Dr Kingswell: I cannot remember the exact numbers, but I think I made a decision to put monitoring devices on at least two patients at the Park—Centre for Mental Health and both of those decisions were overturned by the Mental Health Court or the Mental Health Review Tribunal. I made a decision to place a device on a patient in Townsville who refused to wear the device and so was not able to access leave of any sort and I think that decision was also overturned at some point.

CHAIR: I take the point raised by my colleagues in that the stigma is a concern but I also take the balance in your response to that concern. It has the potential to contribute to stigma and portray mentally ill people as criminal offenders but, as you are saying, it is not just someone with a mental illness; it is someone with a mental illness who has committed a serious offence. So that balance is very important.

Dr Kingswell: The first devices that we purchased are pretty clunky. They are the heavy-duty devices that are used in the sex offender treatment program. I get the concerns of patients about those devices. We think there is a range of better technologies available to us and we have done some market sounding around that.

CHAIR: So that is the ankle box you are talking about—the GPSOS?

Dr Kingswell: The ones that the prisoners wear are an ankle bracelet and they are quite obvious.

CHAIR: Thank you. I have a question in regard to point 6 in your response, which was for psychiatrist reports for serious offences. The first statement you make is that the model proposed under the bill will substantially increase the number of persons diverted from the criminal justice system due to mental illness rather than a mental condition. I thought it would be beneficial if you would not mind stepping us through what happens currently and what is proposed under the bill to explain that statement if you could, please?

Mr Sheehy: I will kick it off and Bill can follow through. Essentially, there are different cohorts of individuals. If a person is currently on a forensic order or an involuntary treatment order and they are charged with any offence, then a psychiatrist's report is prepared. So for that group of patients, it would be a significant number and I think it is upward of about—

Dr Kingswell: Two thousand per year.

Mr Sheehy: Two thousand reports are done. As we indicated before, about half of them are for simple offences. So these would quite commonly be nuisance offences.

CHAIR: So public urination type of things.

Mr Sheehy: That is correct. So that group then mandatorily go through the process where a report is done by the Director of Mental Health and there are various processes under the act where it may go across to the Director of Public Prosecutions, who can discontinue the charges or, alternatively, they can be referred to the Mental Health Court.

The much bigger group of people are persons who are not on any order under the current act. They could routinely go through the Magistrates Court. It is difficult to get exact figures, but certainly the anecdotal advice would be that that would be many more times that persons would go through a Magistrates Court, possibly have a mental health defence but get no opportunity to present that to a court. So that group is missing out under the current act.

What this bill aims to do is have a more fair and equitable process. If the person is charged with a serious offence, which is defined in the bill and that is indictable offences other than offences that are heard by a magistrate, because a person is already on an order the bill takes the view that there is an obligation for the state to offer to assist these people—and it is an offer and we have plenty of safeguards in there to make sure that the individual or someone on their behalf can request a report. So they can request a full psychiatrist's report.

Where there will be a very big expansion will be in the other areas, so these people who go through the Magistrates Court with nuisance offences—common assault, drug charges; it will be a whole raft. So it will be that area where we anticipate that there will be a very significant expansion of assessments done. Those assessments will be done by the court liaison service that currently exists within Queensland Health. That role will be significantly expanded under the bill. There will be lots of training for duty lawyers. We will work with Legal Aid and magistrates to assist identifying these people. We will work with the justice department to try to automate systems so that we can identify these persons and then, through the duty lawyers or whomever it is appropriate, offer them an assessment.

Given that the offences are not as serious, the report does not need to be as rigorous as a full psychiatrist's report, but the system will be overseen by psychiatrists. Those reports can then be provided to the defence, the magistrate and, where appropriate, the charges can be dismissed. That is the area where we anticipate that there will be a very substantial increase in courts being better informed of a person's mental health defence.

CHAIR: And is the purpose essentially to connect people who may not otherwise have been accessing or able to access a service to assist them as well as, if they have repeated nuisance offences, to deal with the issue?

Dr Kingswell: The purpose is to divert them at the first opportunity into mental health care rather than having them go to prison and languish there.

CHAIR: You mentioned a psychiatrist. You would not necessarily need a report of that level. Who would do the report?

Mr KING: The court liaison services will be run as they are run now under the direction of the director of forensic mental health, who is a psychiatrist, but they will be clinical positions filled by psychologists, senior nurses—other allied health.

CHAIR: So there will be a significant amount of training given that that is not the first level. The first level is those duty lawyers or liaison officers who are coming into contact with these people. So the Department of Health will have a fairly involved implementation plan?

Dr Kingswell: Yes, yes.

CHAIR: And you also mentioned there and you have mentioned it verbally that you would likely see a substantial increase in the number of persons diverted, which is consistent with the information that police have always provided in regard to public nuisance offences and the nature of those people who are getting caught. Are the service there to support that significant increase?

Dr Kingswell: We believe so.

CHAIR: Thank you. Any further questions?

Mr KELLY: Yes, I have some more. I have a couple of questions in relation to the submission of the Royal Australian and New Zealand College of Psychiatrists. In the submission they refer to section 97 and request that strong guidelines about the role of the support person and restrictions on their actions during an examination be developed. Can you advise if Queensland Health has a view on this and how it might be dealt with?

Mr Sheehy: I can introduce that. The issue is here is that, if a person is requiring a report to be done and they are undergoing an examination, the bill simply states that the person is entitled to

have a support person with them. The bill does state explicitly that that person cannot interfere with the examination. We have put that in the bill as a right for an individual who is likely to be in a vulnerable situation. We think that it would assist and support that person having someone else in attendance. We do not want the examination to be compromised in any way, so we are happy to talk to the college about guidelines to ensure that the purpose of the examination is not affected in any way.

Mr KELLY: In relation to the patient rights advisers, what qualifications would they be required to have?

Mr Sheehy: 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.

Mr KELLY: Given that they are obviously advising someone who is in a somewhat vulnerable situation, do we have any systems for monitoring the advice that the advisers are giving?

Mr Sheehy: It is proposed, as part of the implementation, that there will be a statewide 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 statewide 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

Mr KELLY: Just going back to the College of Psychiatrists'' submission, they raised some concerns around section 135, particularly in relation to the Mental Health Court being able to impose conditions on people who have forensic orders in place. They contend that the treatment of a patient should remain the sole reserve of the treating psychiatrist. What is the department's view in relation to that part of the submission?

Mr Sheehy: Perhaps there is a misunderstanding there. The treating team will always have the say in the person's treatment. That is not something the court gets into. The Mental Health Court currently does have the power to set conditions. Quite often that is about matters such as treatment in the community. A condition might be not to drive a motor vehicle or to not engage in drugs or alcohol. They are the sort of conditions; they are not related to treatment. The court does not get involved in treatment decisions.

CHAIR: Can we suspend for just a moment. We have lost Ros and Steve due to a technical issue. We want them to have the benefit of hearing your questions.

Mr HARPER: If I could make a comment while we are waiting for that technical issue to be resolved. I think it is a very good thing to have the support person in there. Coming from an electorate office point of view, I think we will see a decrease in the various advocacy groups that contact us about these particular cases. Having those checks and balances in place I think is a great step forward and will reduce the interactions we are getting through our office with those advocacy groups.

Mr KELLY: I have one final question. In relation to the letter you sent to us regarding the fifth point you made around the patient rights adviser issue, you note that the department will review the operations of the advisers over time. Do you have a time frame when that will occur if and when the legislation is passed?

Mr Sheehy: We have not gone through that detail, but certainly that is something that would need to be done in conjunction with people like the Mental Health Commissioner and consumers. We would certainly want to have an independent robust—maybe 12 months 18 months time—we need a bit of time to sort of bed it down, but perhaps in 12 or 18 months time we can have a review, talk to actual consumers and, as I say, the Queensland Mental Health Commission and see how effective it is working.

Mr KELLY: Thank you.

Dr ROWAN: Just to come back to the statewide coordinator for the patient rights advisers, that will be, as I understand from the letter here, a position in the Office of the Chief Psychiatrist located in the corporate office?

Mr Sheehy: Yes, it would be in the mental health branch. I would think it would be in the Office of the Chief Psychiatrist.

Dr ROWAN: As you have alluded to before, there will be matters that potentially come through the patient rights advisers and other matters that might come via the Health Ombudsman around quality of mental health and health care. The coordination of that between the statewide coordinator and that network that is to be created along with the Mental Health Ombudsman and also the Mental Health Commissioner, is there any sort of thought to how all of those entities, from a government's perspective, will articulate together?

Mr Sheehy: I think that would be 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.

Dr ROWAN: So there could be an MOU between the department and the Health Ombudsman?

Mr Sheehy: It is possible. The Health Ombudsman, as you would understand, is in the complaints area and there is a requirement under the bill to have a Chief Psychiatrist policy about managing complaints and how all that works. So certainly part of that could be a process of escalating that to the Health Ombudsman.

CHAIR: Can I draw your attention to point seven in our letter to you and your response, section 32 to 35, powers of doctors or authorised mental health practitioners. As you would be aware, our letter and the submission received from the Queensland section of the Australian Psychological Society's College of Forensic Psychologists, submission 59, raised a point in regard to the increase in powers of doctors or authorised mental health practitioners under the bill and concerns in regard to individual rights. You have gone to that in your letter. You have obviously read that submission and their concerns.

Mr Sheehy: Yes.

CHAIR: If you would not mind speaking to that.

Mr Sheehy: I think there was a misunderstanding there. Essentially, the powers of entry, the actual powers, are the same. There will be more hoops to jump through to get the power. At the moment there is the justice examination order and a person can go to a Justice of the Peace. Over 90 per cent are done by a Justice of the Peace. They can get a justice examination order which is effectively a warrant and under that you can go into a person's home with the police. So that does give you the power of entry. That is currently in place. What we are replacing that with is a more robust system whereby a person would have to apply to the Mental Health Review Tribunal. That would have to include a lawyer on the tribunal. They need to get clinical advice that there is actually evidence of a problem and then an examination authority can be issued. Once the authority is issued it is the same powers; you do have a power of entry. So as I say, the powers are the same, but it is a much more robust system to have those powers exercised. There may have been a misunderstanding with the emergency examination provisions perhaps.

CHAIR: Thank you. Steve, do you have any further questions?

Mr DICKSON: No, I am at a loose end here. We only got reconnected a couple of moments ago so I am a little bit behind the 8-ball.

CHAIR: That is okay, Steve. Just in case you needed that opportunity. And Ros I do not think we have on the line. Are there any final statements you want to make in regard to any consideration or questions the committee has asked in relation to the bill or anything before we conclude? We are about 30-minutes ahead of schedule, but I would like to thank you on behalf of the committee for the further information you have provided in written form to further inform our consideration and deliberations on the bill. It has been very helpful. Also I thank Dr Stathis for the additional information he has provided. Thank you for your answers here today and for providing us the opportunity to further consider some of those matters. In relation to any matters taken on notice—I believe there were three—our secretariat will be in contact with you to get that further information. A transcript of the proceedings will be available on the committee's parliamentary web page as soon as practicable and our final report will also be made available on the web page after it has been tabled in the parliament by 24 November 2015. I thank the department of health as well for their assistance. I declare the briefing closed.

Committee adjourned at 9.52 am.