HEALTH AND AMBULANCE SERVICES COMMITTEE

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Mr SL Dickson MP
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Mr JP Kelly MP
Dr CAC Rowan MP

Staff present:

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Ms K Dalladay (Principal Research Officer)
Ms E Booth (Principal Research Officer)

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

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 14 OCTOBER 2015

Brisbane

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Committee met at 10.02 am

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

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

CHAIR: I welcome our witnesses from the Department of Health who will brief us on the two mental health bills currently before the committee. Dr Bill Kingswell and Mr Paul Sheehy, welcome and thank you for attending today. I invite you to commence your briefing on the two bills. We have a number of questions to ask you this morning which I will invite after your briefing. Please note that if you are not able to answer a question you may take it on notice and the secretariat will be in touch about timing for providing responses after the briefing.

Dr Kingswell: Good morning. I wanted to address you in two sections: firstly, an overview of the existing Mental Health Act and, secondly, the reasons for the need for reform of the legislation. The current Act commenced in February 2002, and the main purpose of that Act is to provide for the involuntary treatment of persons with a mental illness in two contexts—the first where a person is so unwell that intervention is required to ensure the person receives appropriate treatment and care and the second where a person has committed an unlawful act and the risks to the community need to be managed through appropriate treatment and care. In the first scenario the Act enables authorised doctors to make an involuntary treatment order for the person; in the second the Act enables the Mental Health Court to make a forensic order for the person.

Involuntary treatment orders may be made for a person if the treatment criteria apply. Making an order involves a two-step process whereby the examination of a person may result in a recommendation for assessment followed by an assessment which may result in the making of an involuntary treatment order. An examination may be undertaken without the person's consent under a justices examination order. These orders are made primarily by justices of the peace or magistrates on the application by members of the public. In emergency circumstances, an examination may be undertaken without the person's consent under an emergency examination order. These orders are made by police and ambulance officers but can also be made by private psychiatrists who consider that persons are at risk due to a mental illness.

Involuntary treatment orders are made by authorised doctors who are psychiatrists and, in some cases, psychiatric registrars. As at 30 June 2015 there were 4,100 persons on involuntary treatment orders in Queensland. Persons on involuntary treatment orders may be detained in authorised mental health services on an inpatient category with or without limited community treatment or live in the community on an ongoing basis under a community category involuntary treatment order.

Authorised mental health services and mental health services are designated under the Act to provide treatment and care to persons under orders. Nearly all of the authorised mental health services are in the public sector, although some of the larger private hospitals are also authorised. Most persons on involuntary treatment orders live in the community on an ongoing basis. Authorised doctors are responsible for the appropriate treatment and care of these persons. When a person's health improves to the extent that the treatment criteria no longer apply, the involuntary treatment order must be revoked.

Forensic orders may be made by the Mental Health Court on a reference to the court by the Director of Mental Health or a lawyer representing the person. A reference may be made if the person appears to have a mental illness, an intellectual disability or another mental condition. References by the Director of Mental Health to the court follow the preparation of a psychiatrist's report for the person. Under the Act, any person who is subject to an involuntary treatment order or forensic order and is charged with an offence, either simple or indictable, must have a report prepared.

The Mental Health Court consists of a single Supreme Court judge assisted by two psychiatrists. The court is a specialised court established for the purpose of deciding whether a person was of unsound mind at the time of an alleged offence or is unfit for trial. Where the court

decides the person is unfit for trial, it must also decide whether the unfitness is of a permanent or temporary nature. Persons on forensic orders may be detained in an authorised mental health service or live in the community on a full-time or part-time basis in what is referred to as limited community treatment. As at 30 June 2015, there were 780 persons on forensic orders in Queensland. Most persons on forensic orders live in the community on an ongoing basis. Authorised doctors are responsible for the appropriate treatment and care of persons on forensic orders.

Victims of unlawful acts by a person who has or may have a mental illness are given specific rights under the Act. Victims may make submissions to the Mental Health Court and the tribunal on the impact of the unlawful act. Victims may also be approved by the tribunal to receive specific information about the relevant forensic patient, such as decisions about the treatment of the person in the community.

The Mental Health Review Tribunal is established under the Act with the main role of reviewing involuntary treatment orders and forensic orders. Involuntary treatment orders and forensic orders must be reviewed regularly by the tribunal to decide whether the order should continue and, if so, the extent of treatment in the community under the order. The tribunal also reviews persons who are found temporarily unfit for trial to decide whether the person becomes fit for trial. The Act also enables persons with a mental illness who are in custody to be transferred to an authorised mental health service for treatment and care, and these persons are referred to as classified patients.

The Act regulates the use of mechanical restraint and seclusion on involuntary patients. The Act outlines the steps that must be followed when mechanical restraint and seclusion are used and requires reporting to the Director of Mental Health on the use of mechanical restraint and seclusion. The Act regulates the use of electroconvulsive therapy and psychosurgery. When a person does not have the capacity to consent to treatment, the use of electroconvulsive therapy requires the approval of the Mental Health Review Tribunal. Psychosurgery may only take place with the consent of both the relevant person and the approval of the Mental Health Review Tribunal.

The Act establishes the position of the Director of Mental Health. The main role of the director is to protect the rights of involuntary patients under the Act. The director may undertake an investigation into a matter if there are concerns about compliance with the Act or the rights of involuntary patients. The director also issues policies which are binding on authorised doctors and other persons in authorised mental health services. The director has other functions under the Act such as approving temporary absences and limited community treatment for certain patients.

I now move to the reasons for reforming the legislation. The current Act is 15 years old and was developed over many years, so the underpinning policy goes back to the early 1990s. There were problems evident with the current Act at the commencement of the review. In addition, when the review commenced, the department sought stakeholders' views on areas for improvement in the Act. The process identified major areas for improvement in most areas of the Act. There have been increasing community expectations over the years to strengthen the rights of persons with a mental illness. Wherever possible, individuals should have the right to make decisions about their own health care. This expectation resulted in the review closely examining how involuntary treatment orders were made and how alternative mechanisms such as advanced health directives may be strengthened. The current Act has limited provisions dealing with the rights of support persons. It is well recognised that family and support persons can play a major role in a person's recovery. The most significant provisions for support persons in the current Act are the allied person provisions, which have been largely viewed as ineffective.

Forensic orders may be made under the current Act for minor indictable offences such as common assault. This led to many stakeholders being of the view that there are too many forensic orders in place in Queensland. This has been exacerbated by the length of time persons have been on forensic orders for minor offences, due in part to the lack of any step-down order from a forensic order. Under the current Act, psychiatrists' reports are mandated where a person on an order commits an offence, whether indictable or simple. This has resulted in large numbers of psychiatric reports being prepared for nuisance offences such as fare evasion, urinating in public and begging. The mandatory nature of these reports is contrary to human rights principles where a person should be able to make decisions about their own legal defence. It has also subsumed a significant amount of mental health resources given that about 50 per cent of the reports are done for simple offences.

The current Act is unnecessarily complex and contains inconsistencies and gaps which have created difficulties in practice. This includes in areas such as the transport of patients, search provisions, the classified patient provisions and providing notices to persons. The provisions in relation to the interstate transfer of patients have been largely ineffective. It was also important in the review to ensure that the legislation aligned with good clinical practice to ensure best possible patient

outcomes. Examples of areas that required attention were the restrictions on the use of audiovisual technology in the current Act and the requirement to keep treatment plans separate from normal health records.

The Mental Health Court is generally very well regarded. However, the review identified opportunities to improve aspects of its operations. It is also evident that there are inadequate legislative provisions dealing with persons who may be of unsound mind or unfit for trial who appear before magistrates. The provisions in relation to the victims of unlawful acts are generally seen to be working well, but the review identified opportunities for further improvement.

The way in which community treatment is authorised for forensic patients was also an important area for the review, to ensure there is the correct balance between a patient's rights and managing risks to the community. There was a further concern with the justices examination orders under the current Act which are primarily made by justices of the peace on an application of a member of the public. These orders are effectively a warrant enabling entry to a person's home where an involuntary examination can take place. These orders have been widely criticised for being vulnerable to inappropriate use—for example, in family law disputes.

Concerns were also identified in relation to the use of emergency examination orders under the Mental Health Act, as most uses of the orders do not relate to an underlying mental illness that requires emergency treatment. Deficiencies were also identified with the Mental Health Review Tribunal such as the very low level of legal representation for patients at hearings. There have been efforts in recent times to reduce, and if possible eliminate, the use of seclusion and mechanical restraint on patients. It was therefore important in the review to assess whether the legislative mechanisms in place were adequate for this reform direction to be taken forward. There are also concerns about the use of physical restraint and the inappropriate use of medications such as sedation on involuntary patients which needed to be considered. There are concerns in some areas of the community around the use of electroconvulsive therapy and psychosurgery. The review provided the opportunity to assess whether adequate safeguards were in place in these areas. Thank you.

CHAIR: Thank you very much for your presentation. You have outlined for the committee the reasons for reform. I think it is great timing. I think there are many important developments in the bill to move forward. It would be important for this committee to clearly outline the differences between the two bills that are before the committee, both the private member's bill and the government bill. Are you able to talk to that?

Dr Kingswell: I could do that now or I could lead you to Paul Sheehy's presentation, as he was going to talk to that.

CHAIR: Sorry, I was not aware. You are making a presentation?

Mr Sheehy: Yes. I was going to address that.

Dr Kingswell: Mr Sheehy was going to address the technical aspects of the bill and specifically outline the differences between the private member's bill and this one.

CHAIR: Perfect. Thank you.

Mr Sheehy: I propose to address two issues: first, the main differences between the bill and the current Mental Health Act; and then, as requested, the differences between the two bills. In terms of the main changes in the bill, the objects of the bill have been updated. They are to be achieved in a way that safeguards the rights of persons, is the least restrictive of the rights and liberties a person who has a mental illness, and promotes patient recovery. Clearly those elements set the scene for the whole Act.

The principles in the Act have been updated. The bill includes principles in relation to the role of support persons. There are many areas of the bill where the roles of support persons are strengthened. Principles have also been updated to recognise the needs of Aboriginal people and Torres Strait Islanders, the needs of people from culturally and linguistically diverse backgrounds, and the specific needs of minors—persons under the age of 18—and to emphasise the importance of recovery oriented services. The bill also includes principles in relation to the victims of unlawful acts for the first time.

In relation to what are currently involuntary treatment orders, under this bill they will be referred to as treatment authorities. The view is that this is the more appreciate terminology to emphasise that the bill requires a legal authority to treat a person who does not have capacity, rather than placing a person on an order.

Two key changes to the current arrangements relate to the criteria on which a person can be placed on a treatment authority. Under the current Act, an involuntary treatment order can be made if a person unreasonably refuses treatment. That is quite a subjective test and does provide an opportunity for treatment to be made contrary to a person's consent. That has been removed from the bill. There is also a much more expanded and appropriate definition of capacity to consent to treatment given its critical nature in the making of treatment authorities. That includes the ability for people to have a capacity with the support of another person. This is referred to as supported decision-making.

An important reform in the bill is to strengthen the use of advance health directives. If a person does have an advance health directive in place and if that directive is adequate to meet the person's treatment needs then the person must be treated under the advance health directive rather than under a treatment authority. Similar arrangements also apply if the person has appointed a personal attorney or if QCAT has appointed a guardian for the person. This is a very important element of treating a person in a less restrictive way.

As Bill Kingswell referred to, there has been a deal of criticism about justices examination orders. Under this bill they are to be replaced with examination authorities. These authorities are to be made on application to the Mental Health Review Tribunal, which has the expertise in dealing with these types of matters. Prior to a person making an application, they must seek clinical advice about the behaviour of the person who is subject to the application. Alternatively, an application can be made by a mental health service—for example, if a person has previously been treated by the service.

Under the bill, emergency examination orders will be replaced by emergency examination authorities. These provisions will be transferred to the Public Health Act in recognition that a person may be brought in for a variety of circumstances. It could relate to intoxication, drug or alcohol abuse. It could relate to an underlying mental illness or possibly to an injury. So the provisions have been moved across into the Public Health Act. If on examination it is found that a person does have a mental illness, the various provisions in the Mental Health Act can then be brought in. A person brought in by police or ambulance under an emergency examination authority can be detained for up to six hours. Under the bill, that is being extended for a further six hours if that is necessary.

Some variations have been put in place to deal with particular circumstances in rural and remote communities. There is a requirement under the bill that if an authorised doctor who is not a psychiatrist makes a treatment authority it must be confirmed by a psychiatrist. The usual time period for that is three days. Under the bill that can be extended up to seven days in a rural or remote area. I should have indicated that the rural and remote areas will be designated by the Chief Psychiatrist. It is also possible in a rural and remote area for an authorised psychiatrist to make a recommendation for assessment and do an actual assessment if there is no other doctor available at the time. Just to be clear, for a person to be on a treatment authority, there is an initial examination of a person which results in a recommendation for assessment. The person is then assessed which may result in a treatment authority. So it is a two-stage process. Restrictions on the use of audiovisual technology have been removed, so it will be up to clinicians to decide what is appropriate in the circumstances.

Consistent with taking the least restrictive approach, persons on treatment authorities are to be treated under a community category wherever possible. That is, in effect, the default category. It will only be in circumstances where the person's treatment needs cannot be met that way that they will be an inpatient. In all cases where a treatment authority is made it is then reviewed by the independent Mental Health Review Tribunal to see whether it is necessary to continue that authority. Currently under the Act that happens in six weeks. That has been brought forward to 28 days.

I will now talk about classified patients. As Dr Kingswell indicated, in circumstances where a person who is in a prison or a watch house becomes acutely unwell, the current act enables that person to be transferred to an authorised mental health service for treatment. These provisions are being retained. They will be improved in terms of their clarity and presentation. The most important change will be that if a person is not transferred within 72 hours of a recommendation being made for a transfer then an authorised doctor must notify the Chief Psychiatrist. The Chief Psychiatrist can then become involved in negotiation or mediation to ensure the person gets timely treatment.

I will move on to psychiatrist reports. The model under the current Act will be changed in two areas. The bill changes the approach to psychiatrist reports and also strengthens what happens in magistrates courts, which I will refer to shortly. In relation to psychiatrist reports, if a person is on an order or an authority, if they are charged with a serious offence they can request a report. This is different to the current Act, where various reports are mandated. In this case a person may request a report. A report may also be requested by a lawyer or another representative of the person.

The concept of a serious offence is a new concept in the bill. The model there is to mirror the Criminal Code. A serious offence is an indictable offence other than an offence that must be heard by a magistrate. Under the Criminal Code, certain indictable offences are always heard by a magistrate. There is the capacity to refer it up to a higher court if needed, but otherwise it must always be heard by a magistrate. An example of this is the offence of common assault. For serious offences, as I say, a psychiatrist report can be requested. There is a reserve power for the Chief Psychiatrist to also direct the psychiatrist report, and in either case this may result in a reference to the Mental Health Court.

The jurisdiction of the Mental Health Court will be modified slightly. Its jurisdiction will be for serious offences. There will also be a capacity for magistrates to refer other indictable offences. References may be made to the Mental Health Court for any mental condition, so it covers a mental illness, intellectual disability or perhaps another mental condition. The legal concept of 'unsound mind' follows the Criminal Code. The term 'fitness for trial' is not defined, which is the case in the criminal jurisdiction. In those cases the common law precedent for the meaning of `fitness for trial' does apply.

Under the bill there is a new type of order that is being introduced. It is called a treatment support order. The intention of this is that it is an order that can be made by the Mental Health Court or by the Mental Health Review Tribunal which is of less intensive nature than a forensic order. A forensic order will be reserved for the more serious offences. A treatment support order can be made in circumstances where a person needs less oversight.

The distinction is twofold between a forensic order and a treatment support order. Firstly, under a forensic order the court and the tribunal set the boundaries for treatment in the community. That is very important in terms of managing risk to the community. For a treatment support order, it is akin to a treatment authority where an authorised doctor can make the decisions about the extent to which the person is well enough to have access to the community. Under the bill, the Chief Psychiatrist is required to make binding policies on the treatment of persons on forensic orders and treatment support orders. It is anticipated that there will be a lower level of oversight for treatment support orders. One of the outcomes of this will be that appropriate resources can be focused on forensic orders where the risks to the community are greater.

For forensic orders we have introduced categories. As with treatment authorities, there will be an inpatient category and a community category. The bill introduces the concept of a non-revocation period for a forensic order. This applies to the most serious violent offences such as murder and grievous bodily harm. The Mental Health Court has the discretion to set a non-revocation period of up to 10 years for those orders. There also have been some procedural improvements identified in the court, such as the court can be assisted by a single assisting clinician rather than two where it is appropriate.

For magistrates, as Dr Kingswell indicated, there was significant deficiency identified in the current arrangements. The bill now explicitly enables a magistrate to discharge a person if satisfied on the balance of probabilities that the person was or appears to have been of unsound mind when the alleged offence was committed or is unfit for trial. This applies to a person with a mental condition, so it could be a mental illness or it could be an intellectual disability or perhaps another mental condition. If a person appears to have a mental illness, a magistrate may also refer a person to a mental health service for an examination. That could result in a treatment authority being made for the person or it could result in the person engaging in voluntary treatment under the recommendation of a doctor.

If exceptional circumstances arise and a magistrate believes that a matter should go to a Mental Health Court, for any indictable offence a magistrate could refer a matter to the court. For example, if there were repeat offences that have not been resolved through the arrangements I have just mentioned then the matter could be referred to the Mental Health Court.

The bill clarifies a number of areas in terms of the treatment and care of patients. The bill outlines responsibilities for administrators and authorised doctors to ensure that patients receive appropriate treatment and care for their illness. The requirement to put in place treatment plans has been replaced by a statutory requirement to record planned and actual treatment, and that can be done in the usual patient records.

The position of Chief Psychiatrist under the current Act is referred to as the Director of Mental Health, so that will become the Chief Psychiatrist. The ability of the Chief Psychiatrist to impose a condition that a forensic patient wear a GPS tracking device will be removed. That authority will be with the Mental Health Court and the tribunal only.

With regard to limited community treatment for classified patients and patients subject to various court orders, that will be limited to on-ground escorted leave. It is at the discretion of the court for individuals in some of these circumstances to be granted bail. That is outside this Act.

Provisions in relation to electroconvulsive therapy were looked at closely. 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.

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.

The bill introduces the concept of nominated support persons, so when an individual is well they can appoint a family member or a friend to support the person when they become an involuntary patient. Nominated support persons have particular rights. They have a right to receive notices under the Act, they can discuss confidential information with the treating team and they can support the patient or represent the patient in tribunal hearings.

As Bill Kingswell indicated, there are moves to reduce and eliminate the use of mechanical restraint, seclusion and other practices, so the bill takes a number of steps to strengthen the safeguard there. In the case of mechanical restraint, the Chief Psychiatrist must approve all uses of mechanical restraint. The criteria for applying mechanical restraint have been strengthened. It is seen very much as a last resort, if there is no other alternative. When mechanical restraint is being used, the patient must be continuously observed.

In relation to both mechanical restraint and seclusion, the Chief Psychiatrist can require approvals to be made by way of a reduction in elimination plan. This is a plan that authorises the use of restraint and seclusion but within the context of reducing and eliminating it for that patient. In the case of both mechanical restraint and seclusion, it must be removed if it is no longer required, so there is a statutory obligation on an authorised doctor to remove it if that situation arises. The Chief Psychiatrist can also issue written directions about seclusion, so that could relate to individual patients or classes of patients or more generally. The bill introduces the regulation of physical restraint, so physical restraint must be authorised by an authorised doctor in the circumstances stated in the bill. There are exceptions in emergency circumstances or if it is otherwise lawful.

There is also an offence in the bill in relation to the use of medication. The bill states that medication may only be used on a patient if it is clinically necessary for the patient's treatment and care. In the case of physical restraint, medication and mechanical restraint or seclusion more generally, the Chief Psychiatrist will be required to develop policies on all those matters. Policies are binding on authorised doctors and other persons in authorised mental health services. Policies must be published on the internet, so there is a public accountability there for those policies.

The bill strengthens the rights of patients and other support persons in a range of ways. There is a particular chapter dealing with certain aspects of the rights of patients. A patient has the right to be visited by family members, carers and other support persons and has the right to communicate by phone and mail. There are some exceptions in the bill in particular circumstances such as if there is a non-contact condition attached to a forensic order, for example, but otherwise an individual has the right to communicate. The bill also requires that oral information is explained to persons in an appropriate way—

CHAIR: Sorry to interrupt you, but I know they are both large bills and we have a lot to get across. I know we have another hour to go, but can I just check how much further you have to go in your presentation, because I know that everyone will have many questions and we will not be able to get to everything in this briefing?

Mr Sheehy: Yes, sure. I can just skim through the rest, but there are two aspects: the bill and then the differences between the two.

CHAIR: If you do not mind, can we go to the differences between them, just to make sure that everyone on the committee can ask questions. Thank you.

Mr Sheehy: Yes, sure; that is fine. I have covered a lot of information, but I am happy to answer any questions.

CHAIR: You are also certainly welcome to provide in written form any information that you have prepared that you did not get to present today.

Mr Sheehy: In relation to the key differences between the two bills, we have provided the committee with the documents. I will just run through the key highlights. In terms of examinations, assessments and treatment authorities, the bill amends the criteria for placing a person on an emergency examination authority to emphasise its focus on high-risk individuals who need urgent treatment. It is intended there will be a similar cohort of persons brought in under a better legislative arrangement, so that has been clarified in this bill. There are circumstances where a doctor may decide to make a recommendation for assessment. In some cases the individual may abscond while the assessment is being made, so this bill enables the person to be detained for up to one hour purely to enable the documentation to be prepared.

In support of the advance health directive provisions, a doctor must explain to a patient and record in the patient's records why an advance health directive has not been followed. We have also clarified the relationship between treating people in a less restrictive way and the Chief Psychiatrist's policies, so the Chief Psychiatrist's policy will assist doctors and patients to understand how treatment in a less restrictive way will apply.

For the Mental Health Court, this bill has a non-revocation period of up to 10 years. The previous bill has a period of seven years. This bill explicitly states how the confidentiality of victim impact statements is to be dealt with in the Mental Health Court in a similar way that applies to the tribunal. The Mental Health Court may have a hearing with one assisting clinician where it is appropriate. The previous bill, as per the current Act, has two. This bill removes the two-term limit on the appointment of assistant clinicians and this bill also clarifies that the advice given by an assistant clinician need not be disclosed to the parties if it relates to a purely procedural matter in the court.

For the Magistrates Court this bill removes the ability of magistrates to set conditions that were seen to be unnecessary, noting that there is an express power for a magistrate to refer a person for examination. This bill enables a person to appoint up to two nominated support persons—the previous bill had one—and enables the nominated support person to withdraw from the role. This bill regulates the use of physical restraint, which was not in the previous bill, and also regulates the appropriate use of medication, so they are two quite significant policy differences.

The bill also clarifies that the offence related to mechanical restraint, seclusion and physical restraint applies to any patient in an authorised mental health service, so that includes inpatients being treated under an advance health directive. This bill has made more consistent the provisions related to advising support persons, so there is a requirement in the bill that if a matter is told or explained or discussed with a patient it must also be explained with a nominated support person. That is a significant improvement from the current bill. The bill is also explicit on circumstances where an obligation to communicate with a support person is not required. The previous bill had the qualification of `wherever practicable', which is quite broad, so this bill has a more specific statement.

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. There are also some additional functions for independent patient rights advisers, including to consult with community visitors. This bill removes the ability of the Chief Psychiatrist to require a forensic patient to wear a GPS tracking device. There is also a requirement for the Chief Psychiatrist to develop a policy in relation to the treatment of persons charged with prescribed offences, which are the more serious offences. Under the previous bill, that was a discretion. This bill has them mandatory.

With regard to the Mental Health Review Tribunal the bill includes a regulation-making power in terms of mandatory legal representation, so that provides an opportunity at a future time to expand the types of hearings where legal representation is required and enables the tribunal president to refer questions of law to the Mental Health Court. There are also a significant number of drafting changes identified by the department and also by Parliamentary Counsel as a result of the consultation process and the further time to analyse the bill. Thank you.

CHAIR: Thank you both very much. Given your presentation, is it fair to say that the government bill has significantly strengthened the rights of those with a mental illness and the capacity of their families and carers to support and advocate on their behalf?

Mr Sheehy: Yes, there have been improvements identified. We did have an opportunity to have a further round of consultation on the bill, so as I indicated examples are such as a person being able to appoint two nominated persons and to strengthen the provisions where if a matter is explained

to a patient it must also be explained to a nominated support person. That has been clarified and made more consistent. So, yes, there have been opportunities to improve areas of the bill in relation to patient rights.

CHAIR: Thank you. Given the significant consultation that has occurred on the bill and mental health reforms, what were some of the key issues and themes that came through in the submissions that you received? I understand there would have been many, because you had many submissions, but were there any consistent issues?

Dr Kingswell: 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.

CHAIR: Which is what the government bill has addressed. They did not want them used at all or they wanted to make sure that they were—

Dr Kingswell: They would prefer that they were not used at all, but if they were to be used to be applied by a competent authority with appealable rights.

CHAIR: Thank you.

Mr Sheehy: I can elaborate on that. I think overall in the consultation there was very strong support for the bill across a range of stakeholders. Particularly for patients interested in individual rights, they saw the bill as being very positive and, as I say, there have been opportunities to strengthen that. The issue around treating persons under an advance health directive as an alternative to a treatment authority was strongly supported. There was, however, a perceived need in policy and implementation to ensure that it can all work in practice, so that is about ensuring that doctors and individuals and the support persons understand how it all works and about having good documentation for an advance health directive—that is, more in line of having a good implementation of what is seen to be a very important way forward.

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.

Dr Kingswell has referred to the GPS tracking devices. There are some stakeholders who do not support non-revocation periods for forensic orders. However, there are other stakeholders, particularly victims, who would indicate that it does not go far enough. I think the bill seeks to strike a middle ground. It does relate to the most serious offences. It is a discretion of the court. We think that strikes a middle ground. There are groups in the community that oppose the use of ECT, electroconvulsive therapy, under any circumstances or for particular groups. The bill does go a significant way to strengthen how that works, but it is still permitted under circumstances in the bill. A further implementation issue relates to the Magistrates Court and the court liaison service. Again, generally, there is very strong support for giving the magistrates powers. It needs to be supported by a strengthened court liaison service. Everyone recognises that that requires a lot of training, education, collaborative work and the relevant players to make it work.

CHAIR: Can you elaborate on your earlier comments about the safeguards that have been placed around the treatment of minors?

Mr Sheehy: In relation to electroconvulsive therapy?

CHAIR: Just the treatment of minors generally and how their families are involved in that process. Most particularly I am interested, obviously, in that they are even more vulnerable than adults with mental illness. What safeguards are in place for them?

Mr Sheehy: I can touch on a couple of areas. The bill does state explicitly, in terms of treating a person in a less restrictive way, that if a minor can be treated with a parent's consent then the minor must be treated that way. 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. There are provisions in relation to electroconvulsive therapy. I appreciate that does get a great deal of attention. It is used very, very infrequently on persons under 18. However, the bill does require, in all instances, that the tribunal must consider and demonstrate that it is in the individual's best interests. There are principles in the bill about recognising the

particular needs of minors in terms of communication where possible and in terms of how they are treated in relation to adults. That does bring in some implementation issues for the bill. Those are probably the main ones.

Dr Kingswell: There is probably one additional area in the bill. This bill determines that free legal representation will be provided for persons being reviewed by the Mental Health Review Tribunal under certain circumstances and those circumstances include all minors.

Ms BATES: My question is probably to Dr Bill. On this committee we have a range of nurses, doctors and ambulance officers. We all firmly believe that the nurses, doctors, police and ambos who work for us in Queensland have the right to expect that they can come to work and then go home safely each and every day after their job. My questions are really about seclusion and restraint. I am a little concerned about that. I understand that we have to have a legislative principle, but I do not want to see government taking over a debate and putting things into law that can make it impractical in real life. For instance, we need to be able to trust staff, whether they are ambulance officers, police or nursing staff in an ED department, to use seclusion, restraints and those sorts of things as the only available action open to them, the last course of action. I understand that you are doing it at a legislative level with the Chief Psychiatrist, but my concern would be how it actually works and if it gets enveloped in red tape when it finally gets down to the coalface, where people need to actually use it. I would not want to see three people, for instance, needing to review and sign off before anything can be done. Situations can and do change, and people need to have the authority to act and make decisions really quickly. One of my concerns is that at the coalface they are not going to be caught up in red tape but will be able to use seclusion and restraint as a last resort when it is absolutely necessary without having to be bogged down with red tape. That is my little preamble. From the legislation, can you outline when it would be an offence to use mechanical restraints, if you are an ambulance officer or a nurse in an emergency department?

Dr Kingswell: An ambulance officer or a nurse in an emergency department will not be able to rely on the Mental Health Act to do those things; they will have to rely on the Guardianship and Administration Act that is available to them now. The Mental Health Act will regulate the use of seclusion and restraint in authorised mental health services. The current Act does so now. It is important to understand the driver for the policy decision behind this. There is a hundredfold variation in the use of seclusion and restraint around the state. That cannot be the result of real differences in populations; that has to be a difference in clinical practice and culture in organisations. This picks up on the national agenda that we intend to reduce or eliminate seclusion and restraint wherever possible. There have been very significant improvements over recent years in driving that agenda and we would like to continue that. I do not think this Act will be such a burden that staff will not be able to respond appropriately when they need to.

Ms BATES: Seclusion rooms are in EDs, so I imagine that is part of guardianship as well, because they do have them in there. They would come under the same rules and regulations as a seclusion room in a designated mental health unit inside a hospital?

Dr Kingswell: That is not quite correct. Yes, an emergency department seclusion room will be in the footprint of an authorised mental health service. For instance, an authorised mental health service would refer to the Royal Brisbane Hospital and everything except the canteens and things like that get captured by the footprint or the envelope of the authorised mental health service. You cannot use that seclusion room in the ED under the Mental Health Act unless you have made an involuntary treatment order for that person. You would be able to use it relying on the Guardianship and Administration Act. There is nothing that would prevent people from responding appropriately in an emergency.

Ms BATES: So they do not need to get caught up in two different acts to actually use the seclusion rooms or use restraints, whether it is in an ED seclusion room or a mental health—

Dr Kingswell: That is a really important question. It is an area of great confusion for clinicians. There is a body of work that we anticipate taking forward to do a broader review of the legislative frameworks that can govern activities like that and try to get some clarity for clinicians and simplify the legislation where possible.

Ms BATES: I think, too, there are patients who come into emergency departments who are affected by medication where they are psychotic, but they may have a medical or surgical problem at the same time. My understanding from nursing staff is that they cannot put them into the mental health unit out of the mainstream medical/surgical part of the emergency department until they have dealt with the surgical problem. If they came in with a laceration or whatever, even though they are psychotic and should be in a mental health unit the staff from the emergency department cannot move

them on to the mental health unit until they have dealt with whatever the surgical thing is. That causes a lot of concerns for nurses, because they have patients who do not have mental health problems with serious surgical or medical complications side by side in an emergency department.

Dr Kingswell: That touches on the policy direction behind removing emergency examination orders from the Mental Health Act and putting them into the Public Health Act. That then means that a positive decision will need to be made within the ED that this is a mental health problem and not some alternative problem. Again, the driver is that there are a number of appalling health outcomes for people who have mistakenly been thought to have a mental health issue when it was clearly a physical problem. Very recently there was a death from a ruptured spleen, where somebody had made the mistaken diagnosis of delusional shoulder pain. We really would prefer that that sort of thing does not happen. This Act will emphasise the need to make a positive decision that this is, in fact, a mental health problem and we are not missing any physical issues. The existing emergency examination order encourages a view that this is a mental health problem and the person goes straight to a mental health team to wait for that assessment and then, of course, their significant physical illness is missed.

Ms BATES: In the estimates hearing I raised the number of code blacks in the hospitals in my area. There are mental health units at the Gold Coast University Hospital and Robina Hospital. I know that at Robina Hospital, for instance, the number of code blacks has escalated to something like 90 in a month, primarily because of code blacks being called in mental health facilities. They can even just be an escalation from verbal aggression and those sorts of things. I have been really concerned about the security of staff and patients when they do have a mental health problem in a major facility and they have to call a code black. I will give you an example.

About three weeks ago I worked a night-duty shift at the Gold Coast University Hospital. A gentleman came in who had overdosed on fantasy. There were six security guards on duty for the hospital that night. Five of them were in the resuscitation room. There were two police officers and four nurses. That patient took up nearly four hours in the emergency department with almost every security person in the hospital having to deal with him. That was just one code black. There were two others that went off at the same time in the emergency department.

This is why I am concerned about seclusion and restraint. Whilst that patient was not restrained with shackles or anything like that, he was physically restrained as he was trying to jump off the trolley. And they did use drugs to settle him, because he was absolutely psychotic. They gave him enough to knock out two elephants, effectively, and he was still psychotic. How does this Act then deal with those sorts of patients? I understand that you do not want to use drugs to zonk patients out, but in cases like those with MDMA, MDA and ice where they are absolutely psychotic, sometimes part of the treatment regime is to use drugs to be able to deal with them.

Dr Kingswell: It is a vexed issue. I am not sure legislation can address this problem. If there was a positive diagnosis of amphetamine intoxication then it would be beyond the reach of this Act in any case. Again, you would be dependent on the Guardianship and Administration Act. We now live in a federated system where hospital and health services are all statutory health agencies and make their own decisions about how these issues get resolved locally. Code black is a difficult space. As you say, it will be applied to the person who abuses a member of staff and to the person who takes a gun from the police officer, and there are no shades of grey in between. I am a psychiatrist by background and, personally, I believe that these problems should be approached in the same way as medical emergencies. So in every hospital in the country you have MET teams and they respond to critical incidents. I am not sure why we do not have that for acute behavioural disturbance as well.

Ms BATES: They do. At the Gold Coast University Hospital the CTC team deals with that.

Dr Kingswell: That is not a uniform process across the state. We get a number of deaths in our hospitals every year from restraint procedures and sedation procedures that have not worked well. Again, it is a matter for the HHSs, but in my view there should be a much more standardised approach and team based approach to those sorts of incidents.

Ms BATES: The CTC position is effectively an eight-on position on night duty who liaises with every ward, responds to every code black and is there for every MET call, and they are the only people who can actually stand down a code black if it is a false alarm. I saw that work brilliantly at Gold Coast University Hospital, but I will tell you what: they absolutely need more than one person on night duty for an 850-bed hospital.

Just quickly on searches, I want to know whether staff are able to search patients and their belongings, if they are voluntary and/or involuntary, if the staff believe that the patient might have possession of a harmful thing like a weapon or drugs or is harmful to themselves.

Dr Kingswell: I can tell you the position under the current Act and Paul might be able to tell you what the position will be under the future Act. Under the current Act an involuntary patient can be searched on admission and their belongings can be searched for contraband and weapons and things if there is reasonable concern. A voluntary cannot be, but the voluntary patient will need to leave.

Ms BATES: There have been reports of voluntary patients who can go out on day leave, for instance, who go out and score ice or whatever and then come back to the unit and maybe even bring it back with them. It is my understanding that, because they are voluntary, the staff cannot search their belongings even if they suspect it.

Dr Kingswell: They can ask and, if the person refuses, they can ask them to pack their bags and leave.

Ms BATES: But they do not necessarily have to comply.

Dr Kingswell: They can pack their bags and leave if it is an unacceptable risk to the hospital.

Mr KELLY: I am interested in the role of the support person. A number of people have approached me over the last few months with concerns about relatives and friends who are under mental health care and they cannot seem to get adequate information to, in their view, assist that individual to comply with their treatment. I was interested in this role of the support person. If one or two support persons are appointed under this Act, do other members of the community have a right to ask who those support people are and would they be allowed to be given that information?

Mr Sheehy: Generally not. The nominated support person is appointed by an individual, and we would not generally see that as being something in the public domain. The individual could appoint a wife or husband for that particular purpose, and under the bill that individual is given a whole range of additional rights.

In terms of providing information around the patient, wherever the Act indicates that a doctor must explain something to a patient—so that could be on an examination or assessment on a review of a treatment authority—the doctor is also required to explain it to a nominated support person or, if a nominated support person is not available, another family member or carer. There are specific exceptions. If the person does have capacity and asks for it not to happen, that individual has the right to privacy. If for some reason a family member is not in the hospital and does not want to come to the hospital then we cannot place that obligation on a doctor. Thirdly, there would be some cases where there is a dysfunctional family arrangement so the treating team might say, `We are not going to advise the family in this case because it will be detrimental to the patient.' With those three specific exceptions there is an obligation to talk to nominated support persons and family members.

Mr KELLY: That is interesting. I am more used to a rehabilitation setting where often the involvement of family and a support person is much easier because you are dealing with people who have the capacity to say, `Yes, this is who I want you to talk to and this is who I do not want you to talk to.' What is really common in that setting is that we find ourselves in situations where there is nobody to talk to. There is nobody in the community; there is no family; there are no friends—people have absolutely nobody. Given the patient also has a right to refuse to have any support person, is that when the independent patient advocate is automatically involved or are they only involved upon request? How does that process work?

Mr Sheehy: The independent patient rights adviser is appointed by the hospital itself. That person is always there and is always available to talk to patients and support persons. So there is some overlapping of roles, but the appointment is quite different. In terms of supporting the individual, the patient rights adviser would be there to talk to the patient about their rights—so the fact that a person has been on a treatment authority and what that means, for example, 'A tribunal hearing is coming up and you have a right to apply to the tribunal.' That person is generally available to all patients in the mental health service.

Mr KELLY: Is it a proactive sort of thing? If I am placed on an involuntary order, will that person be made available to me within a period of time and explain my rights or advocate on my behalf if I am unable to do so?

Mr Sheehy: The exact mechanisms will be worked out as part of implementation, but certainly the Act requires the independent patient rights advisers to be appointed. The Chief Psychiatrist must have policies in place in terms of how that works in practice, and it is certainly envisaged that wherever practical a patient will be able to be given the advice that they need to understand the situation they are in.

Mr KELLY: Something else I am interested in is the use of the advance health directives as opposed to the authority; is that correct?

Mr Sheehy: Instead of the treatment authority, yes.

Mr KELLY: Are they established by a person when they are well or in a relapse situation?

Dr Kingswell: The expectation is that an advance health directive would be drafted when the person was well and, providing it is not contrary to good clinical practice, it would need to be followed by a doctor on that person's subsequent admission to hospital. It would only be when the person could not be safely managed on that advance health directive that an involuntary treatment authority would need to be put in place. Again, the policy background to this is that there are 7,000 or thereabouts involuntary treatment orders established each year in Queensland. About 3½ thousand of them end, but, as you heard, 4,000 of them do not. So they are being used as an enduring mechanism for substitute decision-making. Everyone else in the community has access to other assisted and substitute decision-making mechanisms, and we could not see any reason we would single out the mental health population for something other than what everybody else has access to.

Mr KELLY: What sorts of things do those advance health directives direct doctors to do?

Dr Kingswell: For instance, a person might have a particular preference for a type of treatment. There are a number of different treatments available, for instance, for very severe depressive illnesses. One of those would be ECT. There are a number of patients who think ECT is very beneficial to them. They might put that in their advance health directive. Alternatively, they might have had an unpleasant experience with ECT and they would prefer to be treated with lithium and antipsychotic or lithium and antidepressants. They can make those sorts of decisions. What they will not be able to do is make an advance health directive that would be contrary to good clinical practice or kind of constitute an assault, like, `I consent to seclusion,' or, `I consent to restraint'—that sort of thing. It is somewhat limited, but I think the person will be able to have a significant contribution to their own health care through that mechanism.

Mr KELLY: The support person is really just there in a supporting role rather than a clinical decision-making role, so they would not be able to override something that is in an advance health directive; is that correct?

Dr Kingswell: No, they would not.

Mr KELLY: That would be where you would be getting into the enduring power of attorney.

Dr Kingswell: That would be an enduring power of attorney, yes.

Dr ROWAN: I would like to acknowledge Dr Kingswell and Mr Sheehy for the presentation today on behalf of the Department of Health. My first question to you, Dr Kingswell, is: which entity should take the lead role with regard to education and training, the implementation plan, of this new mental health legislation when enacted, given that there is a significant change as far as process changes, forms, changes to terminology and definitions around emergency examination orders and justices examination orders and given that it affects not only psychiatrists but also GPs, other health professionals, ambulance officers, police officers and the community generally? My question really is: should that be a shared responsibility between the Department of Health and the Queensland Mental Health Commission, or should the Queensland Mental Health Commission take that role? And how does that articulate with primary care as well, given that the operational aspects of this are a significant transformational and cultural change?

Dr Kingswell: We are yet to establish but have given consideration to a governance committee. That governance committee will have interdepartmental representation. The obvious players are police, ambulance, JAG and ourselves. DPC would normally be involved in a committee such as that, and the commission will be at the table. Would the commission be driving the implementation? I suspect they would say no, that that is an operational issue that is the responsibility of the department. We have certainly seen it as an obligation of the department, and we have commissioned the Queensland Centre for Mental Health Learning to assist us in developing a whole lot of learning materials that we will be able to roadshow, if you like, over the implementation period.

The proposal at the moment is that, if this legislation were to pass the House, we would press the go button in November 2016, which gives us a lead-in time of 12 months or thereabouts. That is our plan. Obviously we are subject to whatever decisions parliament makes, but that was our proposal, and that would give us enough time to get to all of the HHSs and all of our government partners and community partners. I think we will need to use the `see one, do one, teach one' model. We will leave learning materials and have a clear expectation of HHSs that they can continue with that.

You are right: there is an enormous amount of work. We rely on the client integrated mental health application as a single electronic record for mental health patients in Queensland that hinges on a unique identifier. The whole thing needs to be rebuilt to accommodate this Act. We have not missed the complexities of implementing an entirely new Act.

Dr ROWAN: Just coming back to your earlier evidence around acute behavioural disturbance, it sounds like there is not a standardised approach to that across the state. Does that put patients, staff and the community at risk that there is not a standardised approach?

Dr Kingswell: It concerns me that we do not have a standardised approach, and it concerns me that every year we get injuries and deaths.

Dr ROWAN: So a standardised approach would be—

Dr Kingswell: It may not change the outcome, but at least you could put your hand on your heart and say, `Best practice was applied and a bad outcome occurred.'

Dr ROWAN: My next question relates to the current approval process for non-ablative psychosurgery, so deep brain stimulation, of mental health patients in Queensland. At this stage, from what I understand from the earlier evidence, patients have to give consent and it goes to the Mental Health Review Tribunal. At this stage involuntary patients are ineligible for deep brain stimulation?

Dr Kingswell: That is right.

Dr ROWAN: Should there be any additional requirements in relation to this legislation prior to approval being given for deep brain stimulation for voluntary patients, or are the current parameters sufficient around patient consent and people going before the Mental Health Review Tribunal?

Dr Kingswell: I might just talk to the policy decision behind this. 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.

Deep brain stimulation is used outside the Mental Health Act for conditions like Parkinson's disease and Tourette syndrome, so there is no requirement at all for those people to go anywhere near a Mental Health Review Tribunal; they can just consent to the procedure and have it done. It consists of having an electrode placed into the brain and there is a pacemaker type device, if you like, in your chest and it can be turned on, it can be turned off, it can be turned up and it can be turned down. The treatment itself has remarkable outcomes in some Parkinson's patients—not all, but it can be very effective.

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.

Dr ROWAN: My final question relates to the increasing penalties for unauthorised mechanical restraints, seclusion, medication, administration or ECT treatment that is provided within this legislation within authorised mental health services. I want to ask about the implications for individual registered health practitioners who are involved in providing any such unauthorised treatment and also for those who may be involved in oversight or administering the system—so either additional penalties that will be applied for people inappropriately using such restraints or providing such treatments. This relates to not only the individual clinicians but also the administrators of those systems.

Dr Kingswell: I think Paul might be best placed to address that.

Mr Sheehy: From the current Act, I acknowledge that the penalties have gone up. If an individual breaches the Act, there is an offence created, particularly for an individual doctor authorised procedure. As always, in these situations there may be alternative actions that can be taken and it would be up to the Chief Psychiatrist to decide what action to take. So an offence provision is one avenue. There can be disciplinary action within the portfolio or the matter could be referred to the Medical Board. There are a variety of options, depending on the particular circumstances. In terms of administrators being responsible, I think you are getting into complex legal areas. I think there would have to be some involvement of the administrator in that decision. Any offence in the Act would have to be investigated and looked at from a legal perspective.

Dr ROWAN: I know that we have come a long way since Ward 10B in Townsville many years ago, but obviously over the years there have been numbers of scenarios where inappropriate treatments and services have been provided that have been in breach of the relevant legislation. Is there sufficient strengthening around that within the current legislation to ensure those sorts of things are prevented from occurring?

Mr Sheehy: The penalty has been increased. I would also point out that under this bill there are enforcement powers for the offences which are not in the current Act. Under this Act, an inspector can be authorised to investigate an offence and take action, which could lead to prosecutions. Those provisions are not in the current Act, but this bill puts those powers in place. So the matter can be taken seriously as necessary.

Dr ROWAN: That is what I was asking. Thank you.

Mr HARPER: Mr Sheehy and Dr Kingswell, thank you very much for all of the content that you have provided. I think there are some very good movements going forward in patient safety. At the end of the day, that is about ensuring patient safety. From my experience, particularly with the ambulance, I am glad there is some work in the EEO space. You might be able to expand a little bit. Quite often, when you have put an emergency examination order on someone they have a particular psychiatric history of being bipolar, having schizophrenia or being clinically depressed. Often I think we are seeing, particularly with our students, more drug related issues. I know that we touched on it earlier, but people who are affected by drugs or alcohol do not fit into that. They might have a history of some mental illness, but you are right and I congratulate you on the work that is being done. We do not want to miss those patients who belong in the emergency department for an underlying or medical reason.

The other thing that I really congratulate you on moving forward is our hold on those absconding patients. There is nothing more challenging. They are all complex and challenging cases. Last year the Queensland Ambulance Service had over one million interactions with patients throughout Queensland. That is a lot of people. There is nothing more frustrating than when you take somebody into a hospital environment, to an emergency department, and they abscond and they are down the street. They put themselves at risk or the public at risk by putting themselves in front of cars. I do not know if you can expand on those particular EEOs and the holding for that one hour, but I congratulate you on the work being done in that space. I think it is outstanding. That is a comment only. Do you have any good data in relation to that? You mentioned that particular case with the unfortunate death with the spleen. Are you seeing any other numbers? Is there good quantitative data?

Dr Kingswell: I think the number of EEOs is in the order of 14,000 to 15,000 a year. It is a huge number of people who are caught up in them. Every time it occurs you run the risk of diagnostic masking. If the default position is, 'This is a mental health patient,' there is a risk that clinicians will not think beyond the mental health issue that is in front of them. We have had a number of outcomes that have not been good.

Mr HARPER: Thank you.

Mr DICKSON: Paul and Bill, welcome. I am sorry I missed the first part of the meeting. My first question relates to children being placed into psychiatric wards with adults. Is that still occurring today or do we have better practices in place?

Dr Kingswell: I guess the short answer is yes, it is still occurring. Is it desirable? No, it is not, but it probably does not happen very frequently. We now have dedicated child and youth units in Townsville, Toowoomba, Logan, Gold Coast, Lady Cilento—about 62 beds across the state. But in those areas that do not have child and youth beds, they would tend to admit to a paediatric ward. There are situations where that does not work because the minor's behaviour is just too difficult to manage in a paediatric ward. That person will end up in an adult mental health unit, usually for a very short period of time while we try to access a child and youth specialist unit.

Mr DICKSON: That probably flows on to the other statement that I heard when I first came in. Earlier you spoke about the legal support for minors after the event. Are these events are occurring because children are being put in with adults or is that the flow-on effect? Is that why we are giving free legal services to minors?

Dr Kingswell: 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.

Mr DICKSON: Fantastic. Mr Sheehy, you had oversight of the review of the Mental Health Act since it was announced by Lawrence Springborg on 22 May 2014. Your department provided briefing notes before and after the consultation period to the minister. In May 2015 Cameron Dick stated that the bill was `riddled with technical errors and drafting mistakes'. Given that the department had the oversight of this bill, do you agree with what the minister said?

Mr Sheehy: It is up to the minister to express it in the way that he chooses. I would say that the previous bill that went into parliament was a good bill. As happens at times when bills go to parliament, the time frames were tight. That is not unusual; I have been involved in legislation over many years. Since that time we have had more time to consider the bill. It is a large bill and, of necessity, bills get read, reread and reread. Also there is a further round of consultation. That has identified areas for improvements in the bill. I will not speak about policy matters; that is a matter for the parliament. But in terms of technical drafting issues we were able to identify inconsistencies and areas for improvements. Some people might say that they are extremely minor—using plural versus the singular—but there are also other areas for ensuring the bill is consistent throughout. It is quite a large bill, so with the additional time we were able to identify areas for improvement in the draft bill.

Mr DICKSON: So we will not be coming back and asking that same question in six months time—that the bill that is going forward this time was riddled with errors? We have it right; is that what you are telling me?

Mr Sheehy: Given the further time we have had, I believe that from a technical drafting perspective it is much better. There may be some minor technical areas that we identify. We will see what happens as part of this committee process or anything that happens prior to debate. I think from now on any technical issues would be relatively few in number.

Mr DICKSON: Just to take that a little bit further, is it the same people who drafted this bill or is it a new set of people who have done the work this time around?

Mr Sheehy: A similar set of people, yes.

CHAIR: When we were talking about advance health directives—and I have certainly seen their utility in practice and how important they are when they are applied properly—you mentioned `as long as they are not contrary to good clinical practice'. Could you just clarify for me what would be an example? Recently I spoke to a patient who has had ECT. She does not want to, but it has a significant positive impact on her outcome. If she had indicated that she does not want to have that, where is that threshold?

Dr Kingswell: That would be okay, because there are alternatives. ECT is a remarkably effective treatment in a small number of conditions. It is quick and it has a very limited side-effect profile. Personally, I would probably take the ECT but not everybody would, and there are alternatives—very effective alternatives. You can use a combination of antidepressants and antipsychotics. So if that were a legitimate concern of that person, you would have to adhere to it.

CHAIR: So that threshold about the advance health directive would be followed as long as it is not contrary to good clinical practice. What would be an example of meeting that threshold where it would be contrary?

Dr Kingswell: It could be in the mental health space. For instance, if you put in your advance health directive that you wish to be treated with St John's wort instead of ECT or effective antidepressants, that would not be consistent with good clinical practice.

CHAIR: Thank you. That concludes the questioning on behalf of the committee. Dr Kingswell and Mr Sheehy, I thank you both for coming before the committee and for bringing your significant expertise to assist us with our understanding of both bills. We may call upon you at a future time to appear again at our subsequent public hearings. Thank you very much.

Dr Kingswell: Thank you.

Mr Sheehy: Thank you.

Proceedings suspended from 11.28 am to 11.52 am

McARDLE, Mr Mark, Member for Caloundra, Parliament of Queensland

CHAIR: Member for Caloundra, for your benefit, this morning we have heard from Dr van Schoubroeck, Mental Health Commissioner, and also from the Department of Health in regard to the two bills before the parliament, drawing out both the differences between the two and also the need for reform of the Mental Health Bill. I now invite you to commence with opening remarks and then I will open up to the committee for questions.

Mr McArdle: Do you wish to hear me on the harmonisation letter that the minister has responded to?

CHAIR: If you would like to, yes.

Mr McArdle: I will not go through the details of both letters. I received the response from the minister roughly an hour to an hour and a half ago. I have read it through very quickly, but I have been in a second meeting as well. I intend to reply to that letter to the minister. I will not elaborate for the committee on what I intend to say. It is really a matter for the minister and me to take on board. At this point in time I am not relinquishing the issue of harmonisation.

Let us talk about the history of the bill prepared by the LNP, which derives from the then minister for health back in—

CHAIR: I am sorry, member for Caloundra. Just before you move on to your bill, for the benefit of the committee do you mind expanding on your letter and what you meant by 'harmonisation'?

Mr McArdle: My apologies. I thought it had been disseminated across the committee.

CHAIR: We all have it. We were just a bit unsure about what you meant.

Mr McArdle: The idea was this: both bills had gone through a lengthy process of assessment. They had gone out to consultation with the community on two separate occasions. They had come back with the submissions that I understand informed the preparation of both bills back in 2014 and 2015. Both bills had been prepared by the same department and also had the same intent of reviewing and, in essence, rewriting the Mental Health Act 2000. The minister, in his commentary when putting the bill into the House, made a suggestion that the issues were similar and, with my paraphrase, that the directional change was similar.

I consider mental health to be a very important issue in the community. I have some figures here that I will go into shortly. I believe that a bipartisan approach in relation to this issue is in the interests of all Queenslanders, whether you are a consumer of the service or a public observer of the service. My proposal was that, given there is very similar direction in where we are headed, we would harmonise—that is, jointly prepare a bill that (1) covers those issues that are the same and (2) harmonises where issues are different to form a consensus opinion so that one bill goes through the House.

The reason I say that is: the parliament is of a combative nature. I do not believe that mental health should be, at this level, of a combative nature. These bills do not deal with the service of clinical provisions; they deal with the protection of those who use the services and those who, in fact, are in the public arena. So the idea was very simple: we would have one bill as opposed to two bills, thereby showing consensus and showing that the government and the opposition are of the same general intent moving forward.

The money involved in mental health is very high, the cost to the community is very high and, equally, so is the cost to the parliament, so spending time on what could be a consensus bill is a better way to go. I think the public are fairly tired of parliamentarians battling over issues that we could sit down and work through. I find that parliamentarians are going to be better perceived and received if we adopt an approach of saying, 'How do we work together for the better outcome?' I think mental health sticks out significantly as an issue on which this approach should be adopted.

CHAIR: Member for Caloundra, with regard to the differences between the two bills, they would obviously form the normal discussion in the second reading debate and also the consideration in detail of the bill. For the benefit of the committee's understanding, can you explain your intent in following a different process and what that would look like to you?

Mr McArdle: It would be a three-tier step (1) you would have a meeting of minds as to the provisions in the bills that are the same and therefore no change would occur; (2) identify the provisions in the bills that are at odds or different or that do not apply or appear in each bill and determine how we derive new provisions with consensus; and (3) prepare a new bill that draws those together in the one document. The parliament and the members have the right to withdraw a bill from the parliament and then put in place a new bill. It sends the message to the public that we are genuine

in what we are saying and that we do want to work together in a consensus fashion to achieve an outcome that is of benefit to the public. It also shows the intent of both the government and the opposition that this is an important issue and bipartisanship is a strong element of how we approach these things.

CHAIR: Member for Caloundra, you do not feel that normal parliamentary process can achieve that?

Mr McArdle: No, it can certainly achieve it. What I am trying to say is: if we believe that mental health is an issue that is of concern to the public, the first step the parliament can take is to pass a bill that is of consensus. If the committee is saying to me now that that consensus can be reached from what you have heard today, that would put a different slant on things. If you are saying to me that this process cannot reach a consensus on what you have heard today, it is difficult to understand how we can achieve the one bill I am talking about.

CHAIR: From your point of view, can you outline for the committee the issues in the government bill that you feel require further consideration and that you would want to change? For the purposes of the committee, there is a government bill before the House. The government is happy with it and feels that the appropriate policy positions are represented in it. You have brought a bill to parliament that you are obviously happy with and you feel best represents the issues. What are the key aspects you are referring to?

Mr McArdle: Can I elaborate first of all on what I said earlier. Both bills deal with a process that was of length, with submissions received from across the public, prepared by the Department of Health and, in my opinion, prepared with the ultimate goal of a new bill being put into the House. I will have to come back to the committee as to what are the critical issues between the two bills, but what I am simply saying is this: the minister makes it quite clear in his address that he sees these bills as being of very similar direction in regard to changes within the Act. If the committee is saying to me that there is a potential to get a consensus in this process, well and good. But I am quite concerned that the minister dismissed out of hand any conversation or any suggestion of consensus and I want to go back to him with a proposal that can keep the process alive. As I said, my concern has always been that politicians are seen as being combative in nature and this is an area where I think we can get consensus. If that consensus lays the platform for the development of future policy, well and good.

CHAIR: Thank you, member for Caloundra. Just for the benefit of the committee, and I am reading from the minister's letter here, he similarly agrees with you that a bipartisan approach to mental health is of great importance. He makes the point that the Mental Health Bill 2015 resolves some of the issues that were present in the private member's bill and has benefited from an extensive exposure draft process—you yourself have commented that there was further consultation—and that he also looks forward to support from both sides of the House. Deputy Chair, you have a question?

Ms BATES: I am assuming with this harmonisation process that you mean there would be only one bill that would be presented to the House which would be the government bill which would have bipartisan support from everyone. Is that what you mean?

Mr McArdle: It does not matter who puts the bill into the House. If the government wants to put a bill into the House that joins the bills together as one bill, as I said, we can withdraw the bills with the consent of the House and put the one bill in. If the government puts in a bill that dovetails the issues, that is fine. I do not mind who puts the bill in, but I think it would be good if we could get a bill that is actually put together by both sides of the chamber and then agreed to by the chamber.

Ms BATES: Can we achieve the same aim by amendments put by you, where there are differences in the government's bill, that the minister would accept and then that makes the government bill harmonised and then the private member's bill is withdrawn? Would that not have the same effect?

Mr McArdle: If you are saying to me that there is a statement from the department and/or the minister that the amendments would be put in place that reflect the differences in the bills to a consensus point of view, of course. But that is not what I am getting from the letter. The letter seems to be quite blank that there will be no approach by way of consensus.

CHAIR: I think the letter outlines that the parliamentary process allows for what is being suggested, which was my earlier question about what those critical issues are so the committee understands what they are.

Mr McArdle: My proposal was, Chair, that we would sit down and go through those. These are very big bills and they would take some time to go through. I outlined a three-tier process: we would sit down and we would work through what is agreed to, what is not agreed to and how we would get those issues together and then, thirdly, a new bill.

Ms BATES: Could we not still achieve that by you sitting down with the department? From our briefing this morning there are only three or four very minor differences that I could see that had been changed.

Mr McArdle: If that had been contained in that letter to me today that would have given me a lot of solace walking into this room, but it was not contained in the letter. With all due respect to the minister, if he had said to me that he could get his department to sit down with me and my policy advisers on only three or four issues to be dealt with, that could resolve the matter, but it does not say that. This is the first occasion I have heard of the department saying there are only three or four issues because I have a document here of about six pages.

CHAIR: The department did not say that.

Mr McArdle: Somebody did.

Ms BATES: From my understanding from when they went through it today, there were not absolutely major, major differences. It is not even like ideological differences. There were things like having monitoring for seven years instead of 10 years and those sorts of things. If you wrote back to the minister and picked out the things that are of difference and then had amendments made that are agreed to, would that not achieve the same aim?

Mr McArdle: Yes, it could. Madam Chair, can I ask for clarification? I am slightly confused as to what the department said today. I am getting two messages here. The research director indicated probably not quite as clear cut as the member is saying, so I need to get a better understanding. That might be a way forward.

CHAIR: Member for Caloundra, I will make a few comments and please let me know if I have not answered your question. The deputy chair and I have perhaps a different perception of what was said this morning. I agree with the member for Mudgeeraba in that there was not a list of 40 or 50 things that are different, but I would say that there are some significant improvements and evolution in consideration, in regard to the protection of patient safety and advocacy around their wellbeing, that are of significant benefit in the government bill. That is one of the key differences. Also the member for Mudgeeraba is correct: there is a briefing, which I think would be public and would have been uploaded, about the key differences between the two bills which I am sure you and your team would have access to which draw out those differences.

Mr McArdle: On the website?

CHAIR: Yes. The other thing I would say in regard to your letter is that the remit of this committee is such that we have been given two bills—the private member's bill and the government bill—to consider and we will do so through a public submissions process. We do not have the capacity to extend our reporting time. We are required to report by that date. That would be a decision of the House. I appreciate that you are having discussions direct with the government through the Minister for Health, and that would be the appropriate forum. We are required to report and will continue along that line unless the House advises us otherwise.

The only other comment I would make—I know that your discussions will continue direct with the Minister for Health and I know that you have made comments about your disappointment at the response—is that, as I mentioned here, there is no question about whether the government is fully committed to the mental health reform before us and that a bipartisan approach is what is wished, but your request for a harmonisation process, I would argue—I know that it has been reflected here—would be a matter for consideration in the House in that the government has put a bill forward and may not wish to change elements of that bill. But it is your right to revisit those in the House, if you wish, in the second reading debate and consideration in detail. That is obviously a conversation you may continue with the Minister for Health. We will be required to continue in our submissions process.

I know that the member for Moggill has a question, but then I think it only fair that you have the opportunity to brief the committee on your private member's bill—I know that is what you came here today to do—so that we can reflect that in our report. You can speak to the provisions in that and why they have been chosen and how they differ from government's and why that was obviously important from your point of view.

Dr ROWAN: If legislative harmonisation does not occur via the process you have outlined, what are the risks or potential unintended outcomes or consequences for mental health patients and the community? I clearly understood the legislative harmonisation process that you are outlining. If that does not occur in the method you have outlined, are there potential or actual risks to mental health patients in the community?

Mr McArdle: I might come to that when I discuss the bill.

Mr DICKSON: Madam Chair, I seek clarification from you if possible. What I am hearing from the gentleman sitting opposite us today is that he is looking to take part in some bipartisanship. Since I have been in this House I have not heard of this type of process happening. It excites me just a little bit. Do we still have the time available to us so that the member can have that conversation with the Minister for Health to come to some sort of an agreement? Obviously he may say no, but on the other hand he may say yes.

CHAIR: Member for Buderim, in my comments earlier I was trying to get across that it is not a matter for us. We have been given two bills to consider and we have been given a reporting date.

Mr DICKSON: With respect, I understand that. I am asking you for clarification about whether the time lines available to us allow that to occur as the policy sits before the House?

CHAIR: My understanding of the three-step process the member for Caloundra has outlined is that it is a matter for the House to decide. This committee has a reporting time frame and we need to meet that reporting time frame, unless the House gives us a different reporting time frame. We need to report by that day. Part of that will be these public hearings and I think an important part of that will be allowing the member for Caloundra to speak to his bill and to allow members of this committee to ask questions to understand his intent around that bill and some of the key policy differences. There is obviously a process the member for Caloundra will pursue behind the scenes, but it is not a matter for us.

Mr DICKSON: I understand.

CHAIR: It is not that I am sitting here trying to say no. We do not have that right. We do not have that capacity. That is a different process for the member for Caloundra to pursue.

Ms BATES: Even when the report is tabled in parliament, we still have up to six months for the bill to be debated in the House; is that right?

CHAIR: The government could bring it on whenever it wanted. The private member's bill would sit on the table for three months.

Mr McArdle: Your point is absolutely valid: the committee is tied to the parliament. Any committee is at the whim of the parliament, put it that way. What I intend to do is write back to the minister and suggest that he and I and our advisers have a meeting next week to try to go through these points that have been raised here today. I was not aware of the conversation with the department or the Mental Health Commissioner. He may say yes; he may say no. It is a matter for him to make that determination. I accept that. I would not mind reading the transcript of today's conversation with the department to pick out where the major issues lie between my bill and the government's bill that would then inform a conversation next week.

CHAIR: Sure. The member for Mudgeeraba indicated three or four things. There is a five-page document outlining the key differences.

Mr McArdle: I have seen that.

CHAIR: That would answer that question.

Mr McArdle: I wonder if that document to a certain extent relates more to grammar and those sorts of things.

CHAIR: It is everything. Member for Caloundra, I am mindful that we have 15 minutes and definitely want to give you the opportunity to speak to your bill. I know that the committee will have questions for you. I know I have some. Would you mind giving an opening statement and then we will proceed to some questions about your bill.

Mr McArdle: Certainly. A document titled *Estimating the community prevalence and treatment rates for mental and substance use disorders in Queensland*, prepared for the Mental Health Commissioner in November 2013, said that in 2011-12 there were 897,000 Queenslanders who had a mental or substance use disorder. The larger portion of that were adults 55 to 64 years of age, with over 156,000 having a severe disorder, about 250,000 having a moderate disorder and about half a million having a mild disorder. What it does show is that 49 per cent of those with a disorder received treatment in Queensland in 2011-12. When one considers the National Mental Health Service Planning Framework, the overall treatment target should be 67 per cent. So we have in this state, based upon that data, a shortfall of 20 per cent of the population in this state who have a disorder who are not receiving treatment. That is a significant number of people.

It is estimated that one in two Queenslanders will report a mental disorder at some time in their life. This comes from the Chief Health Officer's report in 2014, *The health of Queenslanders*. Roughly speaking, one in seven Queenslanders self-reported a long-term mental or behavioural problem. The

prevalence of mental and behavioural disorders is 61 per cent higher in groups that are disadvantaged and three times higher for unemployed persons over those who are employed. The bill considers six areas of improvement: strengthened support for patients, improved health service delivery, strengthened community protection, a more transparent and fairer Act, improved legal processes and greater value in health services.

I will very quickly touch on those issues. The first is support for patients. A patient has a right to nominate a support person to support the person's treatment in care at a future date if they become unwell. Improved health service delivery includes widening where people can receive treatment and also removing barriers to interstate transfers, bearing in mind that treatment that occurs in a locality that is known to the person provides a better outcome.

Strengthening community protection is also a major issue. With the Mental Health Court there can be a non-revoke period for forensic orders of up to seven years. In addition, mental health services are required to give a risk assessment of persons to assist police in responding to people who abscond. Victims of serious crime will also receive information notices explaining why people are given community treatment. That is, a victim of a major crime will be notified if a person is to receive community treatment.

A more transparent and fairer act requires publication of the Chief Psychiatrist's policies and practice guidelines. The improved legal processes would enable a magistrate to discharge persons who appear to have been of unsound mind at the time of an offence. The magistrate may also refer people to the Mental Health Court. The bill also enables the Mental Health Court to consider the five disputed matters that affect a psychiatrist's opinion.

The costs of implementation are also dealt with in some detail. The initial cost is $5.2 million for education and training. There is an ongoing cost of $12.1 million that mainly relates to the cost of the judicial officers involved with implementing the terms of the bill.

The bill in a very short manner deals with those topics. The idea is to strengthen the protection of people who are consumers within the system and at the same time protect the public. I believe this bill is, in essence, one of the cornerstones of the mental health system but does not deal with the provision of clinical services. It deals with other matters that are of relevance.

I think historically there has been a concern in the public arena with regard to those who access these services. I hope this bill will give some solace to those in the community who are the victims of crime but also some solace to the families of those people who are consumers of mental health services.

CHAIR: Thank you, member for Caloundra, for your opening remarks. I note that section 217 of your private members' bill retains a role for the Chief Psychiatrist, who is a departmental employee, to impose GPS monitoring on a forensic patient. I know that many stakeholders find this controversial. For your benefit, this morning the Department of Health, in response to a question about the consultation process, indicated that it was one of the key issues of contention raised during the consultation process. The government's bill reallocates this power to the Mental Health Review Tribunal and Mental Health Court. Can you outline for the committee why you have adopted your approach to this issue?

Mr McArdle: 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.

If I recall correctly, there is a provision in the bill that allows an appeal of that person's determination to the Mental Health Review Tribunal. That must automatically occur within 21 days, if I am not mistaken. If I am wrong, please let me know. That is when the review of the determination is made. We have a qualified person, appointed by the government, to make that call. There is, if I recall correctly, a review approach that kicks in automatically within 21 days.

The bill also deals with an urgent application having to be made to a person who is ready and available to make that call as opposed to going through a process that may take longer. That length of time may not be in the best interests of either the consumer or the public.

CHAIR: I note that the government's bill at chapter 8 includes new provisions to regulate physical restraint.

Mr McArdle: Could you actually go to the section, if you do not mind, because the bill is exceptionally lengthy.

CHAIR: I can. If you want to refer to the actual bill I can get a copy for you.

Mr McArdle: I have the government's bill with me.

CHAIR: For your benefit, this morning Dr Kingswell spoke of the national agenda to further restrict the use of physical restraint. Your bill does not. Can you outline for the committee whether you support the regulation of physical restraint?

Mr McArdle: Issues of restraint must be looked at very carefully. The principle would be that physical restraint would only be used in the last set of circumstances that warrant it occurring. It would not be an initial issue that should be looked at. I do not like physical restraints. I think modern medicine would be a much better way to deal with these matters. I do not believe physical restraint should exist in a modern society, but I am not a psychiatrist either.

CHAIR: I am referring to section 269 at page 214 of the government's bill.

Mr McArdle: The issue of physical restraint is a matter that would need to be taken into account as a last resort. I would need to be guided by a psychiatrist's opinion or a qualified person's opinion. The public perception is that physical restraints are probably not in line or in sync with how we should treat patients of this nature. I understand that very clearly. That is why I am very guarded about the use of them.

CHAIR: The government bill obviously restricts them and your current bill does not. I just make that distinction.

Mr McArdle: I think my comments err on the side of the government's perspective in that regard.

Ms BATES: I made some comments today about restraints being used as a last resort. Whilst the government bill does have provisions to make sure they are not abused, I am still of the opinion that there is a place for restraints and seclusion until such time as there is some change to ensure not only the safety of patients but also the safety of staff. The other night in the emergency department I witnessed firsthand patients who needed to be restrained for their own safety but more so for the safety of those who were looking after them. I understand that you believe it is a last resort, but I still think there is a definite place for them.

Mr McArdle: I take the point. I also hold my own opinion about physical restraints. They would need to be used in circumstances where the medical evidence justifies it occurring. It would only be as a last resort, as I said earlier, to either protect the consumer or client or protect the staff. There is a sense, from what I have heard, having visited EDs across the state, that there are better ways to deal with things. As we go down the path of research trials in the medical arena, particularly in the neuroscience area, we will find that there are better methods of dealing with issues that were approached in a much more physical manner in the past.

Ms BATES: When there are psychotic patients who are on ice or MDMA in emergency departments, there is no rationalising with those patients at the time. Yes, they do use drugs to calm patients down, which hopefully means that they do not have to be restrained. There are some patients who have absolutely superhuman strength in those situations who do put themselves at risk of harm. They have no concept of their own bodies when they are under the influence of those sorts of drugs. I have seen people turn themselves inside out and back to front. I am pretty sure my ambulance colleague would be able to tell you the same thing. They have the propensity to really hurt themselves because they have no feeling when it comes to what is occurring. It is not only for their own safety but also for the safety of the staff who have to deal with them lashing out at them.

Mr McArdle: I think we are dealing here with a subset of patient, which I understand. I am taking the question as one across the spectrum. There are always going to be subsets of patients who are treated differently for various reasons. I am quite aware that ice users are a subset—a very dangerous subset. You would seek independent qualified medical advice before you restrained them.

I concur that there are circumstances where a patient is restrained for their own safety and/or the safety of other patients or the public. The ED is a prime example. A patient is taken in the front door of an ED. You do not have isolation wards or mental health wards. It could be a busy Saturday night and there are a massive number of patients coming through the doors consuming a lot of hours. In those circumstances, the call has to be made by a qualified medical practitioner—either an ED physician or, if need be, a psychiatrist engaged in the ED.

CHAIR: For the benefit of the member for Caloundra, Dr Kingswell drew the distinction this morning between an approved mental health facility and an ED. That does not come under the legislation. I appreciate the point you are making, Deputy Chair.

Mr KELLY: Member for Caloundra, you referred to a range of statistics. Unfortunately, I do not have time to ask you about those. I would appreciate it if a copy of those could be tabled or supplied.

Mr McArdle: What I have here comes from the health of consumers 2014 cover sheet and pages 48 to 51. I will table that now. I also have the report of the Mental Health Commission done in November 2013. They are available at the library.

Mr KELLY: My question is not specific to the bill; it is more to do with the technical aspects that we were discussing at the start of this session. I am one of those people who has a background in unions, which is much talked about in the House. It is not unusual—

Mr McArdle: You surprise me, Sir!

Mr KELLY: I am shocked! It is not uncommon in union negotiations and employer negotiations to have two very similar documents with some differences and find a way forward. Without interfering with your right to talk to the minister about anything you like, what I would be interested in is if you could simply produce a list of things from your bill that you would like to see added to or changed in the government bill or that you think would improve the government's bill and we can consider those as a committee.

Mr McArdle: I will do that, by all means. That is a good idea.

Dr ROWAN: Thank you very much, Mark. We all know that when there are circumstances of social, educational and health disadvantage they can often create the ideal conditions for mental health and substance dependency disorders to emerge. Do you think if the Labor government ensured all Queenslanders received care within clinically recommended time frames that could reduce the overall incidence of mental health disorders in the community?

Mr McArdle: There is no doubt it would. I think the three men on this committee are health professionals. You are a nurse, as I recall, member for Thuringowa.

Mr KELLY: That is me.

Mr HARPER: He hands them to me.

Mr McArdle: I did not mean to be disrespectful to anybody. Any clinician would say the delivery of health services in a timely manner is going to facilitate a recovery time line that is much shorter and also a lesser likelihood of a repeat performance occurring. What does worry me, however, is that there are a large number of people who do not get any help whatsoever because they do not know they have a problem or they are in an environment where they cannot get help.

I think the minister and I are at one when we talk about education and conversation as being part of the solution. If we could educate the public, but, more importantly, have a conversation around the kitchen table to inform people that it is all right to have a mental illness—you are not stigmatised or isolated—it would be useful. If we could get that out in the public arena as part of the process of informing people about what is available, what the risk signs are and where they can go, that would be a strong message. Getting care in a proper manner and in a timely manner is absolutely critical, there is no question about that. That is the case not just for mental health but right across the whole spectrum.

Dr ROWAN: Just to add to that, the difficulty for mental health patients is that there should be something in the final legislation in relation to mental healthcare patients not only getting their own mental health care within clinically recommended time frames but also if they need general medical care as well, surgery, medical type care. There should be some sort of element in there to ensure that their welfare is looked after and they get their care within clinically recommended time frames.

Mr McArdle: Are you talking about the bill or just in general?

Dr ROWAN: Both.

Mr McArdle: The bill would not deal with that issue, per se. I would have thought that admission to a hospital or a mental health service would also pick up the other areas of concern. Mental health also brings with it concerns about alcohol, drug addiction, housing, education, potentially domestic violence and the like. If they can be dealt with as a cohort at the one time, we will have a much better outcome. This bill would not deal with that, per se. It is more a delivery of service and quality of service matter. This bill deals with the protection of the community and the consumer. If we can get a broad spectrum of initiatives, that would be better.

Can I say, however, that we need to be careful that we are not always reactive. Reactive is actually coming in after the event. I prefer a mix of being reactive and proactive. In terms of how you can be proactive in this arena, I am not a qualified person to make the call. I do sense that by being

proactive we eliminate three things: the dollar expense at the end, the expense to the person involved at the end and the expense to the community at the end. People who are psychotic or schizophrenic pose a serious danger to the community.

Mr HARPER: Thank you very much, Mr McArdle, for coming in and giving us a briefing. It has been fantastic. I will make a comment very quickly on the physical restraint topic that has been spoken about before I ask a question. I was an intensive care paramedic for the last 25 years. There is a small cohort of us who would actually go in and actually sedate those patients. They are complex and challenging cases. Sometimes there is no time in the acute setting. We talk about the emergency departments but sometimes there is no time for us. There is not a sign saying, `I am on ice.' You have to work out the problem quickly. There is a role for physical restraint, but it has to be clinically appropriate. The ultimate aim here is patient safety. That is a comment only.

I notice that chapter 9, part 5 of your bill creates a role for patient rights advisers. I notice also that section 285 requires them to be employees of the mental health service. How will your bill achieve independence for the patient rights advisers if they are employed within the mental health service? Would it not be better to be external to the mental health service?

Mr McArdle: 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.

CHAIR: Thank you, member for Caloundra, for coming before the committee today. Our time has expired. Thank you to the Mental Health Commissioner and witnesses from the Department of Health for also attending today. The secretariat will be in touch in relation to providing any answers to questions taken on notice, although I do not believe we had any today. A transcript of the proceedings will be available on the committee's parliamentary web page as soon as practicable. Our final report will also be made available on our web page after it has been tabled in the parliament by 24 November 2015. I thank my fellow committee members, the secretariat and Hansard for their assistance.

Mr McArdle: Could I get a letter from the research director as to any information required of me?

CHAIR: We will write to you formally. I declare the briefing closed.

Committee adjourned at 12.35 pm