HEALTH AND AMBULANCE SERVICES COMMITTEE

Members present:

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

Staff present:
Ms K Dalladay (Principal Research Officer)

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

TRANSCRIPT OF PROCEEDINGS

MONDAY, 23 NOVEMBER 2015

Brisbane

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Committee met at 12.06 pm

McCONNELL, Professor Harry Waldron, Professor of Neuropsychiatry and Neurodisability

CHAIR: Good morning. Ladies and gentlemen, thank you for your attendance today. Before we start I ask that all phones be switched off or to silent. I now declare this public hearing of the Health and Ambulance Services Committee open. I would like to acknowledge the traditional owners of the land upon which we are meeting today and pay my respects to elders part and present. I am Leanne Linard, the member for Nudgee and chair of the committee. The other committee members who are with me today are Ms Ros Bates, the deputy chair, the member for Mudgeeraba; Mr Steve Dickson, the member for Buderim; Dr Christian Rowan, the member Moggill; and Mr Aaron Harper, the member for Thuringowa, may teleconference in.

Today, we are hearing evidence on the two mental health bills are that currently being considered by the committee, the Mental Health (Recovery Model) Bill 2015 and the Mental Health Bill 2015. Given the similar purpose of the bills, the committee is considering both bills at the same time and is aiming to present a combined report to the Legislative Assembly tomorrow. The bills have a common aim to improve and maintain the health and wellbeing of persons with a mental illness who lack the capacity to consent to treatment. The purpose of the hearing today is for the committee to seek further information on the use of electroconvulsive therapy and deep brain stimulation on minors. As I mentioned earlier, the committee is due to report to parliament on both bills by tomorrow.

There are a few procedural matters before we start. The committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee that takes a non-partisan approach to inquiries. The proceedings today are governed by the standing rules and orders of the Legislative Assembly. Hansard will transcribe the proceedings and a transcript will be available as soon as practicable. The hearing is also being broadcast live on the parliament's website.

I would now like to welcome our first witness, Professor Harry McConnell. Welcome. Professor McConnell is a professor of neuropsychiatry and neurodisability. Professor McConnell, thank you for your submission to the committee. As I have just mentioned, the committee has invited you today to hear your views on the use of ECT and DBS on minors. Would you like to make a brief opening statement before we open up for questions?

Prof. McConnell: Yes. I think I understood a broader remit than ECT and DBS on minors, because I would like to preface this by saying that I am not a child psychiatrist; I am an adult neuropsychiatrist. My background is that I have trained in neurology and psychiatry, so I have some particular expertise with respect to DBS but not with respect to child psychiatry per se.

CHAIR: No trouble. Those views will be very helpful either way. Thank you. More broadly?

Prof. McConnell: More broadly? Okay. I think that both of these bills have their merits but they also have their drawbacks. At the moment we have also under review the guardianship act. Clinically, there is a lot of confusion about when to use the guardianship act and when to use the Mental Health Act. You also have different definitions for forensic situations, for guardianship and for mental health patients even in the concept of capacity. So I think you have to have an alignment between the Mental Health Act and the guardianship act and you have to use the same definitions. Capacity needs to be defined the same way, because already you see lots of situations clinically where one act is used where the other act should be used or vice versa or sometimes neither act is used or one act is used inappropriately. There is a lot of confusion clinically, because it is not always clear when people present if they have a mental illness, which is a prerequisite for the Mental Health Act, or if it is due to medications, or due to a medical condition—a neurological condition—or an underlying disability. You do not really have that benefit when you see somebody acutely, particularly in an emergency setting, of knowing without further evaluation if that person does indeed have a mental health illness or if there is one of those other factors in play. All you can determine clearly is that there is a diminished capacity.

So what we are really looking at is setting in place alternative mechanisms for decision-making in people who do not have the capacity to make decisions with respect to their own clinical care. This is the key concept. There is a lot of discussion out there about the fusion of acts. You may or may not be familiar with it as a committee, but there is lots of discussion. Clearly, this is a direction that it is going in in Victoria, in the UK, and I think, looking at a fusion of the act—

CHAIR: Sorry to interrupt you, but I just let you know that Aaron Harper, the member for Thuringowa, has also joined us on the teleconference if you hear a voice coming through.

Prof. McConnell: Okay. That is great. Thanks.

Mr HARPER: Thank you very much. I did not want to interrupt. Is that Professor McConnell?

CHAIR: Yes, he is just making an opening statement.

Mr HARPER: Thank you very much.

Prof. McConnell: I think that is an important factor, because I think that, with any Mental Health Act, you are really looking at the potential for discrimination against people on the basis of a mental illness. You really need to look at a uniform definition of 'capacity'. You can do that either by aligning the two bills and having the subcommittees meeting to align them so that your definitions are correct and things are applied uniformly to people with and without a disability, with and without a mental condition, with and without a mental illness or, ideally, you could have an integrated health and disability act where you have the main issue being capacity.

An example of this would be the Mental Capacity Act in the UK, where the emphasis is on capacity. Of course, 'capacity' is defined very specifically for specific situations. You can have capacity for finances, capacity for health decisions, capacity for treatment decisions. So it is a very specific definition that is given and it is relative to very specific situations and it is completely independent of whether or not they have a psychiatric illness. I think that is a direction that I personally would like to see the state moving, because I think that is less discriminatory towards people with mental illness, particularly when you are looking at things like restrictive practices. Those are applied unequally, even on the same individual. For example, when they are in the care of the department of communities and they have restrictive practices, you have the whole Carter legislation, which has tried to address this, but it has not been hugely successful. That, of course, is under review as well at the moment.

I think that the Carter legislation review has to be taken into consideration with the Mental Health Act review, because you should really be looking at the same laws for restrictive practices applying, whether or not somebody has an intellectual disability, or a psychiatric illness, or another condition. Those are my thoughts.

CHAIR: Thank you very much for that opening statement, Professor McConnell. I will open it up to the committee. Do you have any specific questions?

Ms BATES: Thank you, Professor McConnell, for appearing today and thank you for your expertise. I want to talk a little bit about seclusion and chemical restraints and code blacks. You just mentioned the confusion in the guardianship act and the Mental Health Act, particularly in emergency situations. I know that nurses have said to me that they are not sure which act a patient should be under. Obviously, their main thrust is to make sure that the patient does not harm themselves or harm anyone else. Some of the comments that we have had is that seclusion is being phased out. There were some comments from the Mental Health Commissioner about it being an offence to chemically restrain patients. Can you give me an overview of where you see seclusion and chemical restraints fit in, particularly in relation to code blacks?

Prof. McConnell: They play a very important role and I think it is done completely differently in every hospital across Queensland, certainly every hospital that I have had anything to do with in Queensland. There is no standard format that occurs in each of the hospitals in Queensland. I think that is a shame. It needs to be standardised.

In terms of excellence, if you look at what is done overseas you will see that they have frequently dedicated code black teams. These are clinicians, usually nurses, who are highly skilled and highly trained specifically in dealing with code black. We are not talking about security people, we are not talking about big bulky guys taught to sit on top of people; we are talking about people who are highly skilled at bringing the situation under control very quickly. They do it usually with a combination of medication, with different types of holds, with de-escalating techniques and they are able to do that amazingly within a period of minutes. So when it escalates and gets out of control, that is when it becomes difficult.

Clearly, in an emergency situation there is a very important role for the use of seclusion, for the use of medication, and there are very clear international guidelines that have been developed to do that that we do not currently follow in Queensland, it should be said. I think there is a really strong role here for looking at what is done overseas and how we can implement that in Queensland, because there is a potential risk both to the patient and to others, including staff, when you have an emergency situation. That needs to be differentiated from the use of restrictive practices in somebody who has a chronic illness, particularly in the community, because that also occurs. You do have chemical restraints and seclusion occurring in people in the community in nonemergency situations. I do not think there is a role for that in that situation. The Carter legislation did try to address those issues, but I think that has not really been totally successful, which is why that legislation is under review again already. I think that started in the right direction, but aligning with that review would be very important, so you get a standardised approach to restrictive practices and, particularly, to emergency situations and the use of chemical restraints and seclusion.

Ms BATES: As a follow-up question, you do work at the Robina Hospital and see patients there; is that right?

Prof. McConnell: I do, yes. I work at quite a few hospitals. St Vincent's is the main hospital where I work, but I have seen patients at most of the Brisbane and Gold Coast hospitals.

Ms BATES: When I shadowed at Robina Hospital, five of the code blacks were in the mental health unit. One of the code blacks was actually a MET call, but the nurse in charge at the time did not know what to call so she called a code black. I think that is indicative of the fact that a lot of nursing staff do not actually know what to do or which one to call and, when they do, they are not prepared, as you say, to help a patient in that acute period in a very short space of time. Have you had any experiences such as that at Robina?

Prof. McConnell: No. It changes, not only from hospital to hospital but also from shift to shift. That is the problem. There are no really good standardised protocols. There are guidelines which are very general. There is a lot of training. In Queensland Health there is mandatory training that goes on for days, which is really fairly useless, I have to say, for these situations. I think what you really need is good training for a small number of people. It needs to be treated just like in surgery patients and medical patients. When you have a code blue, you have people who are experts. They are trained in advanced cardiac life support, they are trained in using all the medications. They are there within seconds and they are onto it, and somebody's life is either saved or not. A person with mental health issues deserves no less a standard of care than a surgical or medical patient. They need people with expertise; a small number of people, perhaps four or five people, who have been trained and are on call constantly. Certainly there are enough code blacks in any hospital in Queensland to justify their existence and to justify their training. They need to get there within seconds or minutes and de-escalate the situation and bring it under control before the patient gets hurt or the staff get hurt.

Ms BATES: What are your thoughts about GPS tracking and using the Chief Psychiatrist? In the legislation, one bill says no for the Chief Psychiatrist and the other one says yes.

Prof. McConnell: GPS tracking can be a very useful tool clinically. Here we have to differentiate between GPS tracking that is mandated by a court and GPS tracking that can actually be a clinical decision that the patient and/or their decision maker agrees with, in combination with the treatment team, as the least restrictive practice. It should be said that GPS tracking is often the least restrictive practice, so patients are actually not that opposed to it when they see what the alternatives are. People do like to have freedom to be able to move about. I think that is an important thing.

When it comes to GPS tracking mandated by a court, then I think that is a still a clinical decision. In my mind, a clinical decision needs to be made by a clinician and the Chief Psychiatrist is clearly, by definition, an experienced clinician, so I would have faith that the Chief Psychiatrist would be the appropriate person to make that call. You can have the Mental Health Review Tribunal agree with that decision or disagree with that decision, but at the end of the day the Mental Health Review Tribunal is a committee and committees are not really ideal at making clinical decisions; individual experienced clinicians are the best people for making clinical decisions. You can get second and third opinions, but individual clinicians make clinical decisions on a daily basis. In my mind, GPS tracking is a clinical decision. At the end of the day, if a patient wants to appeal that, the Mental Health Review Tribunal can agree or disagree with the Chief Psychiatrist's decision, but it is a clinical decision and an experienced clinician should make it, such as the Chief Psychiatrist.

Mr DICKSON: Professor Harry, thank you so much for coming along. I would like to ask you about ECTs and deep brain stimulation. Earlier you said that you do not specialise in children, but I would like your considered opinion relating to the different rules and regulations throughout the country on ages for people to be treated with this particular product. What are your feelings on this?

Prof. McConnell: They are very different treatments, it should be said. First of all, ECT and deep brain stimulation are completely different treatments and should not be confused or even really, I think, considered along the same lines. The clinician uses a completely different set of expertise for deciding whether ECT is appropriate or DBS is appropriate, because they are very different procedures. ECT is a well-established therapy. It has a very important role in psychiatry. It can be a lifesaving treatment. When it is done as an involuntary treatment, I think it is appropriate that the Chief Psychiatrist and/or the Mental Health Review Tribunal act on that. Each one needs to be on an individual basis. It has a really prominent role in the elderly, so certainly there should be no discrimination against the elderly by not allowing them. In terms of children, that is a much more precarious area. I would suggest that the Mental Health Review Tribunal would be able to look at that on an individual basis with the benefit of specific experts who are child psychiatrists looking at that, because I think that should be considered differently to an adult situation. Again, I am not a child psychiatrist. I do not have expertise specifically in child psychiatry to comment on that.

I think DBS is an experimental procedure, whereas ECT is a well-established chemical procedure that has been in existence for decades. DBS is still experimental, so personally I feel it should be done under research protocols with informed consent and with health research ethics committees involved in making those decisions. I think when you are looking at new treatments in psychiatry or medicine, usually you do not start with children, so personally I feel that DBS should not be extended to children unless a very compelling argument is made. There may be situations that I am not aware of that could be made as exceptions for children, but when you are looking at experimental procedures children need to be treated a little bit differently to adults. You will see most new procedures and techniques will have age limits and will exclude children when they are still in the very experimental phase.

DBS has a reasonable track record in movement disorders, but its use in psychiatry is still very new. I think making it widely available as a clinical treatment is problematic in many ways. I think it does have a role, but it is a very select role for a very small number of patients. You will see in Victoria, where this is done, they have their own Psychosurgery Review Board. I have heard a lot of comments from my colleagues in Victoria who look at it as an unnecessary administrative burden to have to go through that review board. I can see the point that they are making there, because when you have somebody who is really ill and has actually been refractory to any treatment that they have been offered, you want the best for your patient and you do not want to have to go through months and months of paperwork in order to do that.

What I have proposed in my written submission is a neuroscience advisory penal that can consult to the Mental Health Review Tribunal for these types of decisions, and not just on DBS—I think DBS is a very select procedure that is going to be done on a very small number of patients—but for advances in neurosciences in general, because there are a lot more advances in neuroscience that have implications for the treatment of psychiatric disorders that the Mental Health Review Tribal does not have the expertise to address. DBS is clearly one of those situations. They do not have the expertise to address DBS, in my opinion. You need input from ethicists, from the community, from consumers, from neurosurgeons, from neurologists, from pharmacists. You need a wide multidisciplinary approach to look at using any type of psychosurgery, including DBS. But I think a neuroscience advisory panel for the Mental Health Review Tribunal could advise on lots of things besides DBS, because there are a lot of treatments out there that are new and revolutionary and life changing, that are neuroscience based and that already have a role in psychiatry. These treatments are increasing exponentially at the moment.

The interface between neuroscience and psychiatry is rapidly increasing. For example, a whole new area is different psychoses, so conditions that look like schizophrenia but are actually related to autoimmune disorders. That is a whole new class of schizophrenia, if you will—a whole new class of psychoses—and there is very little going on either in terms of diagnosing or treating that within psychiatry, yet it is a very real entity and a very real problem. How do you make decisions based on whether or not you are going to offer somebody with a potentially curable type of schizophrenia immunotherapies, for example? This is the type of thing that I am talking about. That is just one example, but there is a huge number of examples and that number of examples will increase every year. You could have a neuroscience advisory panel that would not necessarily have the bureaucracy that the Victorian review board has, but actually would have a wider remit so that you can look at new treatments applicable to different aspects of psychiatry as they come up. There is a whole new range of different stimulation therapies, for example, apart from ECT and DBS. Nobody is looking at that and the appropriateness of that in involuntary patients at this stage.

Mr DICKSON: Thank you very much.

Dr ROWAN: Thank you very much, Professor McConnell, for your presentation today. I want to tease that out a little more, because I have some concerns around this. DBS is experimental, as you outlined before, particularly in relation to mental health disorders. From a governance perspective, a number of institutions could look to have randomised trials, let us say, in relation not only to DBS as a form of non-ablative psychosurgery but also to some of the other newer technologies that you outlined. Would it be appropriate, in relation to the neuroscience advisory board that you have outlined or some other entity, to really standardise the approach to that, as opposed to different academic institutions with different ethics committees and people with a variance of opinion on how they do that, but that is capsulated? I have a concern around these new technologies, whether it be DBS non-ablative psychosurgery or some of the newer ones. From a legislative perspective, should there be some sort of control there, not only to manage DBS in clinical practice but also the other emerging technologies, given that mental health legislation will be reviewed only approximately every 15 years or so?

Prof. McConnell: Exactly, and that is my point about having a neuroscience advisory panel. That actually gives the opportunity to do that. You can have experts in the field who can keep up with the literature, which is rapidly changing. For example, with the DBS you can look at the trials and they all have very similar inclusion and exclusion criteria. You would be very hard pressed to argue against going outside of the inclusion and exclusion criteria that exist in the trials that have already been performed internationally and do that clinically. You would be very hard pressed to open that up to a wider base than has already been done experimentally overseas.

That is the type of thing that keeps changing for DBS, for any type of psychosurgery or for any type of neuroscience based treatment. You need to have experts in the field. The Mental Health Tribunal does not have that expertise. They need assistance. That is why I am suggesting that a neuroscience advisory panel could play a huge role. That will be an increasing role that I think will be very important.

There are also things like issues relating to epilepsy and automatisms. I presented a few years ago to the Mental Health Review Tribunal on behalf of a patient who had epileptic automatisms. It was very difficult because it was very clear that the tribunal does not have expertise in epilepsy, but yet under Queensland law that is where that remit occurs. Similarly, things like driving and issues to do with neurodisability—those sorts of issues are done very haphazardly at different institutions and by different clinicians.

It would be better if you had one board that said, ‘This is the standard for the state. This is what we expect for people with neuropsychiatric disorders for driving. This is what we expect for their experimental treatments. This is what we expect for A, B and C.’ That would be continually changing. As you say, the Mental Health Act changes every 15 years so this is an opportunity to keep it up to date. The science is going to keep progressing even if the legislation does not.

Dr ROWAN: In your view would the entity that you are talking about—however it is so termed; the neuroscience board—have the legislative ability cascaded down to be able to set that out? Is that what you mean?

Prof. McConnell: I think so. I think that would be an important thing to do really. I think that the health research ethics committee play a very important role, but, as you say, even that is different in different institutions. You can get one study passing an ethics committee in one institution but not passing in another. You do need to have, particularly for these experimental psychiatric treatments, a standard that can be applied, ideally across the country but certainly across the state. That is how I see that you do it. You get the right people in the room to discuss the clinical issues and the ethical issues all at once. You set down very specific guidelines that are in line with international guidelines. That is an easily achievable thing to do.

Dr ROWAN: I know you mentioned Victoria before, but are there any other jurisdictions internationally or anywhere else that you are aware of that have this in relation to these emerging technologies?

Prof. McConnell: I am not aware of that, but I could get back to you on that. I am aware of some colleagues who have researched that recently. I can certainly get back to you on that.

Dr ROWAN: You can take that on notice. That would be great.

Mr HARPER: I did not get all of Professor McConnell's opening statement, unfortunately. Reading through his submission, I think he has answered some of my questions. In terms of checks and balances for any clinical care, I wanted to gauge whether he is opposed to certain people sitting on the Mental Health Tribunal? To my mind, I think there are enough checks and balances without creating yet another board. Professor McConnell has made his position clear in answering the previous question. He does not think there is expertise on the Mental Health Tribunal. Am I correct in saying that?

Prof. McConnell: Yes, that is correct. For experimental treatments I think it is important to have checks and balances. Having a chief psychiatrist and a mental health review tribunal as well as an advisory panel that actually has the expertise is appropriate. You really want to approach it logically. If you look at the history of neurosurgery and psychiatry, it is not that pretty really. We want to learn from history. That is not to say that DBS does not have an important role. I think it has a very important role, but I think that we need to be making those decisions on an individual basis very responsibly.

Mr HARPER: In your submission you state—

> The use of chemical restraint for an individual with a chronic illness and without a diagnosis for which that restraint is clinically indicated cannot be justified.

Can you expand on that? I will pass on my experience. In my previous role as an intensive care paramedic I had to chemically restrain many patients be it due to a psychotic disorder, schizophrenia, acute depression, bipolar, severe anxiety, drugs and alcohol, overdose or an underlying medical condition. You state in your submission—

> The restrictive practice regulations also need to make a clear distinction on the use of chemical restrictive practices or seclusion on an emergency basis where the individual represents a potential danger to themselves ...

I wanted to make sure that you were talking about those in the acute setting as opposed to those who are undergoing long-term treatment.

Prof. McConnell: That is a very important point. I am very glad you asked that question. The critical thing to do here is to clarify an acute emergency. When someone is a risk to themselves or others that is the code black situation. That can occur in the community. That can occur in a hospital. That is, you have somebody who is acutely agitated, who does not have the capacity, who is a potential risk to themselves or others as result of their behaviour.

To my mind, you should have the same legislation with respect to the capacity to be able to deal with that situation appropriately irrespective of whether that person has a mental illness or not. Where I say that it is not appropriate to use with people who have a chronic illness is—and this is the legislation that is currently being looked at in the Carter review of the guardianship act—people with an intellectual disability who, on a mass scale, are given chemical restraints on a chronic, ongoing basis as well as often times seclusion. In my mind, that is really not appropriate.

The Carter review brought out a lot of faults with the system. The legislation has tried to address that, but it has not been successful. I think we do need to look at what is happening with respect to restrictive practices with the Carter review of the legislation at the same time as the Mental Health Act.

You should have the same rules applying in terms of restrictive practices, including chemical restraint or seclusion, where there is no emergency. That is not justified if there is not an underlying diagnosis. You should not be giving people who do not have an acute psychotic disorder, for example, ongoing, long-term antipsychotics on a regular basis. That should not be the standard of practice.

When that does occur it needs to be very clearly justified. The clinician needs to make a case for why that particular choice is being made. We all know that they do have long-term consequences. If that is being used on a long-term basis then that needs to be looked at. I think it is appropriate to have statewide guidelines that address that.

Dr ROWAN: I want to pick up on the point about the alignment of the nomenclature or terminology between the Mental Health Act and the guardianship act. Are there other jurisdictions around Australia or internationally where that has been done well—there are shades of grey?

Prof. McConnell: They are aligned in the UK and in South Australia and in Victoria to some extent. There is no jurisdiction, to my knowledge, where there has been a complete fusion of the acts. There is lots of discussion about this. I believe that it is very likely that the next round of mental health act in Victoria and in the UK will likely be a fusion of the acts.

I think it is widely seen from a human rights perspective as going against the human rights of people with a mental illness to be discriminated against because of their mental illness—that is, for the ultimate freedom to be taken from them of making their own decisions. The issue there should be their capacity and their capacity alone to make their own decisions and not whether or not they have a mental illness. The vast majority of people—99-plus per cent of people—with a mental illness do have the capacity to make their own decisions.

That should not be the determinant. I think the determinants are really well presented in the UK Mental Capacity Act 2005. They have actually outlined it very beautifully. They say, 'This is what needs to happen. These are the determinants of capacity and whether or not somebody is able to make their own decisions. If they are not, then the decisions are made on their behalf. These are the mechanisms by which that can occur.'

I think it is a really good start to look at that act. Here we have completely different legislation. Clinicians are confused. I see both acts being used wrongly and poorly on a regular basis because clinicians are confused. There is a lot of grey area in the actual presentations. When somebody presents you do not know whether they have a mental illness.

I see people who are released from hospital when they are clearly a danger to themselves or others because people did not think that they actually met the criteria for the Mental Health Act. That is really wrong. People who do not have a mental illness also have a role to keep them safe and keep the public safe. There is an important role for these acts. It needs to be done in a responsible manner. That responsible manner is looking at the issue of capacity not whether or not they have a mental illness because that is just discrimination.

The restrictive practices are very important as well. In this state we currently have the situation whereby different rules for restrictive practices apply if they are in the community and receiving disability services funding. The moment they enter hospital those rules go out the window. They no longer apply while they are in hospital. You have people who are then subject to completely different legislation and completely different restrictive practice procedures.

You have a situation where people who do not have an acute psychotic illness are being given lots of antipsychotics, for example—lots of chemical restraints—that they are then discharged on. If they are given those medications in the hospital, in an emergency situation, that is really important because you have to protect the patients and protect the staff. I want to be very clear on this. I am very much in favour of dealing with code blacks appropriately, dealing with emergency situations appropriately, keeping patients safe, keeping staff safe. That is important. Chemical restraint and seclusion all play an important role. Once they are discharged and they are discharged on chemical restraint and discharged with seclusion being used in the community that needs to be regulated.

I have a patient who was admitted to a Queensland Health hospital with no psychiatric diagnosis and they are on massive amounts of antipsychotic. Now they are in a situation because they do not meet the Carter legislation requirements for restrictive practices. Those all have to be taken off. This case has been to the tribunal many times. It has taken about 18 months to take them off all these medications. It is a lot of effort. There are a lot of lawyers involved and a lot of clinicians involved who would not have to be if there was an alignment of the act.

Obviously, the simplest way is to align the acts and to have the people working on both the revision of the guardianship act and the restrictive practices legislation working with the Mental Health Act people. They should get together in the same room and iron it out. That is the simplest way. The ideal way is to have a single fusion of the acts—that is, one act.

Dr ROWAN: What you are saying is that that is occurring in the United Kingdom and South Australia and possibly Victoria?

Prof. McConnell: There is an alignment. There is not yet a complete fusion. There is a strong movement amongst human rights advocates and consumer advocates to have a fusion because I think it does become a human rights issue for people with a mental illness. They are discriminated upon on the basis of mental health acts not just in Queensland but in most jurisdictions.

CHAIR: I wanted to come back to the second point that you made in response to my colleagues question around code blacks. It seems that what is coming through very strongly in your comments today is that you certainly support regulated, standardised procedures for dealing with the use of physical restraint, particularly that it should be overseen by clinicians such as nurses and not security guards. I totally support that. The bill that the government has put forward would essentially ensure that the Chief Psychiatrist made the decision in that regard and had standardised procedures. It seems that you are supportive of that and supportive of making sure that we have appropriate clinicians. Is that fair to say?

Prof. McConnell: Yes. I am very supportive of having a statewide approach. But there need to be clinical guidelines developed. Currently there are no statewide guidelines that exist for this. There are international guidelines that we can amend and make relevant to Queensland. We have the expertise in Queensland to make those relevant to Queensland. That is what I am proposing we should do here.

CHAIR: Thank you and that is what is proposed under the government bill. You mentioned Victoria—and I apologise if I have confused the reference; it was a little while ago. You said that Victoria have a psychosurgery board.

Prof. McConnell: That is right.

CHAIR: It is my understanding that in Victoria they had a health review board and a psychosurgery board but they were discharged in 2014 and that they now have a similar tribunal structure to Queensland. Is that your understanding?

Prof. McConnell: That may be the case. The last I heard—the last I had a discussion with anyone—it was in place, but it may have been discarded. That is possible. I do not know.

CHAIR: Just coming back to your comments around the expertise on the tribunal, everyone here would agree that you need to have appropriate expertise given the nature of the decisions they are making. I think that tribunal, with regard to DBS and being a special tribunal, includes a neurosurgeon. You do not feel that that is adequate? You still think that an ethics review level is required?

Prof. McConnell: I think it needs a higher level of review than just a neurosurgeon. I think you need a neurologist. I think you need an ethicist. I think you need consumer advocates. I think you also need to make it broader—so not just DBS. The number of patients who are going to be getting DBS is going to be very, very small. What you need to do is set up a board that actually future proofs the legislation. You need to be future proofing legislation so that when there are new treatments—not just DBS but any type of psychosurgery, any type of neurological based treatment, immunotherapy or any type of treatment—you have experts who are at hand that the Mental Health Review Tribunal can talk to.

CHAIR: Professor McConnell, thank you very much for the time that you took to provide a written submission and also for the time that you took to come here today. I appreciate that you would be very busy. Thank you very much

Prof. McConnell: There was one other point that was made in my written submission that we have not talked about, and that is the issue of advance care directives. I really think that if those could be given more prominence in the act that would be very good. I know they are there and that is good. We have recently started a clinic that routinely gives advance care directives to neuropsychiatric patients at St Vincent's. It has been a tremendous success. Having advance care directives in place for psychiatric patients from very early on is a key thing, particularly because, if you anticipate that there will be times in the future when they may not have capacity to make their own decisions and that decision-making capacity will be taken away from them, having an advance care directive and perhaps having that readily available at the time of their first admission to hospital, for example, would be of huge benefit to the patients.

CHAIR: Thank you very much. I could not agree more. I know that that is one of the key platforms of the current government bill as well—to raise the profile of them. Thank you very much. As Professor McConnell leaves the table, I invite Dr Michelle Fryer to come forward.

FRYER, Dr Michelle, Child and Adolescent Psychiatrist, Chair, Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists

CHAIR: Dr Fryer, welcome and thank you for coming. I understand that you are a child and adolescent psychiatrist and Chair of the Queensland Branch of the Faculty of Child and Adolescent Psychiatry with the Royal Australian and New Zealand College of Psychiatrists. Thank you very much for attending today. I also appreciate that you are attending at late notice. Dr Stathis had hoped to be here. I appreciate you coming before us. You have been invited specifically so that we could ask questions around the use of ECT and DBS on minors. I know some of my colleagues have questions around that. Did you want to make an opening statement or will I just open it up to questions?

Dr Fryer: What I would like to do is give a couple of key points and then draw an analogy for you to consider and then endeavour to answer your questions to the best of my ability. My key points are that ECT is a safe and effective treatment for children and adolescents and a safe and effective treatment across the life span. It is often a treatment of choice in the elderly because it is so safe and because it has a rapid onset of action that we do not get from antipsychotics, antidepressants and other medications. People are very cautious about using it in children and adolescents, and I think there is an argument that we are in fact too cautious given the evidence base supporting its safety and effectiveness. That is predominantly due to the stigma that there is around ECT, and I am going to talk a bit more about that.

I think we need to remember that it is reasonable and important that there are safeguards in place to make sure that ECT is used appropriately and that there are things that are proposed such as a second opinion from a child and adolescent psychiatrist as to the appropriate treatment, especially if the treating psychiatrist is not a child and adolescent psychiatrist—which sometimes occurs in regional areas with some of the older adolescents, 16 or 17 year olds—and also reviews such as the Mental Health Review Tribunal. In caution I would say this is often an emergency treatment, so it important that those safeguards are there but they are not so onerous as to delay effective treatment that might be lifesaving. So the key points are that it is a safe and effective treatment and that there need to be appropriate safeguards in place.

The analogy I want to draw is with pre-anaesthetic surgery. I think we would all agree that the early days of surgery could be called pretty barbaric. Surgery pre anaesthetic was always traumatic—sometimes lifesaving and sometimes fatal. We now consider surgery a very safe and effective intervention. Our public perceptions and professional perceptions of surgery reflect what we see around us. We often know people who have had surgery. We might have had surgery ourselves. People talk about having had surgery quite freely. Our media depictions of surgery are very positive and balanced and generally show good outcomes.

ECT has undergone a similar evolution. It was misused in the early days. In context there was very little else that worked, but it did have a history of misuse and pre-anaesthetic ECT had severe side effects, and no-one would contemplate doing that now. Unfortunately, there is very little in the way of accurate depiction or balanced depiction of ECT in the media. Public perceptions are still very negative, and people do not talk about it because of the stigma. It is a very rare to hear someone talking about the ECT that they had that cured their mental illness or that really helped them. An exception to that was an *Insight* program a few months ago that did show ECT and patients who had been successfully treated with ECT talking very positively about their experiences. But that sort of presentation is rare. I use that analogy to say I think it is very important that we do not deny an effective treatment to anybody of any age because of the history of that treatment. I will take your questions now.

CHAIR: Dr Fryer, I mentioned that you were here to represent Dr Stathis, but it was remiss of me not to mention that you work with Queensland Health as well.

Dr Fryer: I worked with Queensland Health from 2001 until February this year—I worked with Gold Coast health. Since February this year I have been working for the Children's Hospital Queensland.

CHAIR: I will open it up to questions.

Dr ROWAN: Thanks, Dr Fryer, for your submission. Just to clarify, as far as ECT is concerned, you said it is a safe and effective treatment across the life span including children but there need to be safeguards as you have outlined. We have had some submissions from peers in relation to their views around no role at all for ECT, and that was part of the reason that we wanted to clarify this, particularly around paediatrics. In some jurisdictions they have put some age limits in place and there need to be further checks and balances and other processes. For me particularly I wanted to get a view as to why that does exist in other jurisdictions and whether it was based on clinical opinion or evidence, because obviously inconsistency in legislation is fraught with dangers and risks for people who may be either denied the treatment or inappropriately given the treatment.

Dr Fryer: I understand that Western Australia is the only place that has put in place an age limit and they have not given any rationale for their choice of age. Clinically there is no rationale for a choice of age. The frequency of severe mental illness such that ECT would be indicated in children is extremely rare. The frequency increases during adolescence and into adulthood. That is the predominant reason that it is very rarely used in children and rarely used in adolescents. We do not see the type and severity of mental illness that is an indication for ECT. However, I think we should not preclude an effective treatment even from a child who may benefit, especially when the evidence is that it is safe and that it is effective.

I am aware briefly of the WHO statement. Again, I would come back to my analogy that that seems to be looking at developing worlds and the misuse of ECT. Clearly there need to be safeguards in place to make sure ECT is used appropriately. I think there are a lot of surgical procedures done in a way in the developing countries that would not happen in Australia and in the developed world, and similarly with ECT there are practices that just would not be considered or acceptable here. There is no rationale that I know of for an age limit, as long as there is suitable review that the indications are there for ECT and that other alternatives have either been exhausted or that the risks of leaving the child untreated for a longer period of time or waiting for treatment to take effect outweigh the risks of ECT.

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

Dr ROWAN: In relation to deep brain stimulation and other non-ablative psychosurgery and other emerging technologies that we are seeing, can you outline the clinical efficacy or otherwise in relation to those that you are aware of and what is emerging in the literature or overseas in other jurisdictions?

Dr Fryer: I have to say my knowledge is limited, but I had some input into and helped review the college's submission in regard to DBS. I think Dr McConnell put it very well in saying there is a real difference between ECT, which is an established intervention with an evidence base, with known risks, side effects and benefits, and new treatments such as DBS, which are experimental and for which we do not yet have that evidence base both in support of and to give us knowledge of the risks that those treatments incur. I think the protections in regard to new treatments for children and adolescents do need to be of a very high standard and that such an intervention would only be considered as part of a clinical trial that has been through an ethical approval basis. As Dr McConnell said, it is general practice in medicine that treatments are established in adults first and then those treatments are extended to adolescents and then to child populations where that is appropriate, unless we are looking at a disorder that is specific to that age group or has a high frequency in that age group where the situation is different.

Dr ROWAN: So there are not any other sufficient safeguards or legislative requirements in your view that need to be included in relation to ECT for paediatric patients as a part of the review of this legislation?

Dr Fryer: I have not had an opportunity to look at the proposed legislation. I understand it includes review, a second opinion, from a child and adolescent psychiatrist and the Mental Health Review Tribunal. I believe that is an appropriate level of safeguard.

Mr DICKSON: Thank you so much for coming along today. Do you see a role for the Chief Psychiatrist in collusion with the Mental Health Review Tribunal? Do you think it would be appropriate to have a person with those qualifications on that committee or in communication with that committee?

Dr Fryer: I think the role of the Chief Psychiatrist might be in monitoring the overall use of ECT across the state, including across age bands and whether there are patterns of high rates, low rates, increasing rates or decreasing rights that might warrant further investigation or review as to why that is happening in a particular area. The Chief Psychiatrist is not a child and adolescent psychiatrist, so although he is very knowledgeable I am not sure what additional expertise he would bring.

Mr DICKSON: Do you think the expertise that is on the committee would be on an even benchmark with the Chief Psychiatrist?

Dr Fryer: Yes, because the Mental Health Review Tribunal has a psychiatrist and sitting with the expertise of an independent second opinion from a child and adolescent psychiatrist, I think those two things together, along with the other expertise on the Mental Health Review Tribunal, should give a safeguard to ensuring that the use of ECT in young people is appropriate.

Mr DICKSON: You would say that you do not require the Chief Psychiatrist, or you do?

Dr Fryer: I do not see what the chief psychiatrist would add to that. Are we are talking about ECT or DBS?

Mr DICKSON: I think I would cover both, to be brutally honest. I know they are separate.

Dr Fryer: I do not think you can consider them both together because—

Mr DICKSON: I understand that they are different processes, but what I am saying is for both of those situations broadly speaking do you think it would be of benefit for the tribunal to have the knowledge that the Chief Psychiatrist has to assist them in their operation that will affect this bill?

Dr Fryer: I think they should be able to call on the Chief Psychiatrist if there are difficulties in making a decision. I think the situation is different for an established treatment with known risks and benefits to that of an experimental treatment where the risks and benefits are not as well known.

CHAIR: Member for Thuringowa and member for Greenslopes, do you have any questions before we conclude?

Mr HARPER: Dr Fryer, I believe you are saying that the Mental Health Tribunal, with the oversight of the Chief Psychiatrist, gives those checks and balances in these processes?

Dr Fryer: Yes.

Mr HARPER: I am entirely happy with your opening statement and those answers, so thank you very much.

CHAIR: Member for Greenslopes, I know you joined us late.

Mr KELLY: I am fine, thank you.

CHAIR: Every member on the committee is a parent. Can you just briefly give us an example of a minor that would require ECT? What situation are they in that is so significant that they would need ECT, given the emotive concerns and fears that people have about the treatment itself?

Dr Fryer: From my own practice I have rarely needed to consider ECT. One of the few times that I did was an almost 17-year-old who had autism and psychosis and presented with catatonia, so he was not interacting with us, he was not eating and he was not drinking. In that situation we were fortunate that he responded very quickly to some medication that was given intramuscularly because he was not taking anything orally, and he started to drink. But clearly if he had not responded to the medication we would have needed to move to an intervention to get him eating and drinking quickly, so that was why ECT was being considered.

CHAIR: So ECT when they are drug resistant or treatment resistant otherwise?

Dr Fryer: They may not be treatment resistant. The antipsychotic and antidepressant medications take six to eight weeks to take full effect and you do not always have that long.

Dr ROWAN: I wanted to ask one final question regarding the Chief Psychiatrist and whether there are any other additional roles or functions that you believed the Chief Psychiatrist should undertake in relation to child and adolescent psychiatry or generally?

Dr Fryer: At the risk of being cheeky, I think there should be a child and adolescent psychiatrist alongside the adult Chief Psychiatrist.

Dr ROWAN: As a formalised role?

Dr Fryer: Yes.

Dr ROWAN: As distinct from the current Chief Psychiatrist's role?

Dr Fryer: That is in place in other jurisdictions in Australia, I believe, and I would make that recommendation. I could be considered biased.

Dr ROWAN: Could I ask specifically what value would there be to the community in having that role?

Dr Fryer: There are particular issues around working with children and adolescents with mental illness. Child and adolescent psychiatrists would have experience in that field, such as in the disorders, frequency and type, and also in the complexity of working with families, working with schools, child safety and juvenile justice. I think child and adolescent psychiatrists bring an expertise that is not readily available to adult psychiatrists to the same depth and degree. That thinking can help inform other areas of psychiatry as well.

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

CHAIR: Thank you for appearing before the committee, Mr Sheehy. There have been comments made with regard to the expertise of the tribunal given the decisions that they make. Can you speak to that? For the benefit of the committee, who will sit on the tribunal and what is their expertise?

Mr Sheehy: There are a few different provisions in the bill. It does depend on the nature of the hearing. Generally the tribunal is constituted of between three and five members; one is a psychiatrist, one is a legal practitioner and one is essentially a layperson, somebody who is neither a lawyer nor a psychiatrist. In the context of what you have been talking about today, if the person before the tribunal is a child or a minor, a person under 18, then the psychiatrist must have expertise in child psychiatry. So that is relevant and mandatory to the discussions we have had today.

If it relates to neurosurgery, there are specific provisions in clause 716 and quite a different panel is set up: president, deputy president or another member of at least seven years' standing, two members who are psychiatrists, one member who is a neurosurgeon and a layperson. So a specific panel is set up for any hearings of neurosurgery.

Ms BATES: No offence to neurosurgeons, but neurosurgeons are interested in surgery. They really do not know anything much about the long-term management of chronic mental illness, and I think that is the point that Professor McConnell was making. Neurosurgeons do the surgery but, like all surgeons, they do the surgery and then a physician or someone follows up later on. I wanted to make that point. I know you mentioned about melding the guardianship and mental health bills, which is not what we are doing in this bill at the moment, but can you give the committee any advice on what your knowledge is of what is happening with the guardianship bill at the moment in relation to—

Mr Sheehy: I can certainly speak in general terms. If I could just respond to the first issue just so that I am clear. Yes, there is a neurosurgeon for neurosurgery, but there are also two psychiatrists. People with a greater clinical background could explain about the clinical team that has an interest in those sort of procedures. I will just make that observation.

Ms BATES: And there isn't a neuroscientist as well.

Mr Sheehy: Not specifically. In general in terms of some of the comments that have been made earlier, clearly this is an application made to the tribunal. Preceding that there would be all sorts of ethics considerations, research protocols. If you are a private health facility, you are licensed under the Private Health Facilities Act. The chief health officer has various requirements in terms of complying with ethical standards and research protocols. So all that information would be packaged up and presented to the tribunal, and the individuals on the tribunal assess the validity of that information, ensuring consent has been received properly and that everything has been properly complied with. So it is a whole package of information put to the tribunal, if I could say that.

In terms of the issue about the relationship with the Guardianship Act, in principle I can understand where the previous speaker is coming from. Essentially, I believe very strongly that that is the direction that this bill is going in. In terms of fusing legislation, some stakeholders would say that people with a mental illness should be treated as anyone else is, and therefore they should be treated under the guardianship legislation. If they do not have capacity, then they can be treated under an advance health directive or with the consent of an attorney or a guardian. That is the very strong direction that we are going in. Some people would advocate that ultimately you would not have involuntary treatment orders, and I think that was the point the previous speaker was talking about in terms of people with a mental illness being discriminated against or being treated differently, because historically mental health legislation and guardianship legislation has come up in different streams. I would say that this bill is very much around moving people with a mental illness who do not have the capacity more into the guardianship world and very strongly promoting the use of advance health directives and guardians. If that is successful over time, then there would be less reliance on what are now called involuntary treatment orders and there would be more persons with a mental illness who do not have a capacity being treated under guardianship legislation, as would other people in the community.

CHAIR: Member for Greenslopes or member for Thuringowa, was there anything you wanted to clarify?

Mr HARPER: No, I am entirely happy with that, thank you.

CHAIR: Ladies and gentlemen, that concludes our hearing today. Thank you for attending. A transcript of the proceedings will be available on the committee's parliamentary web page as soon as practicable. The committee's report on the bills will also be made available on our web page after it is tabled tomorrow. I declare the briefing closed.

Committee adjourned at 1.11 pm