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Systems Advocacy

Submission to the Health and Ambulance Services Committee

Mental Health Bill 2015

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Queensland Government

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Introduction

Interest of the Public Advocate

The Public Advocate was established by the *Guardianship and Administration Act 2000* (Qld) to undertake systems advocacy on behalf of adults with impaired decision-making capacity in Queensland. The primary role of the Public Advocate is to promote and protect the rights, autonomy and participation of Queensland adults with impaired decision-making capacity (the adults) in all aspects of community life.

More specifically, the functions of the Public Advocate are:

- promoting and protecting the rights of the adults with impaired capacity for a matter;
- promoting the protection of the adults from neglect, exploitation or abuse;
- encouraging the development of programs to help the adults reach the greatest practicable degree of autonomy;
- promoting the provision of services and facilities for the adults; and
- monitoring and reviewing the delivery of services and facilities to the adults.[1]

In 2015, the Office of the Public Advocate estimates that there are approximately 115,745 Queensland adults with impaired decision-making capacity (or 1 in 42 adults).[2] Of these vulnerable people, most have a mental illness (54 per cent) or intellectual disability (26 per cent). In addition to these factors, other conditions that can impact decision-making capacity include (but are not limited to) acquired brain injuries arising from catastrophic accidents, ageing conditions such as dementia, and conditions associated with problematic alcohol and drug use.

While not all people with these conditions will have impaired decision-making capacity, it is likely that many people with these conditions may, at some point in their lives if not on a regular and ongoing basis, experience impaired decision-making capacity in respect of a matter.

Engagement of the Public Advocate in the review

Since the review of the *Mental Health Act 2000* (the Act) commenced in 2013, the Public Advocate has been closely engaged in the review process.

The regulation of mental health treatment falls squarely within the Public Advocate's purview, particularly from the perspectives of promoting and protecting the rights of adults with impaired decision-making capacity and monitoring and reviewing services to adults with impaired decision-making capacity.

More importantly, the Act, both currently and in respect of its future directions, is a significant piece of legislation. Apart from the fact that it affects the rights of people with mental illness, it also sets the tone and aspirations for the future care and treatment of people with mental illness in Queensland.

This was a point made by Dr Ian Freckleton QC in the public lecture he gave at the Queensland University of Technology (QUT) in May 2014. The Public Advocate joined with the Australian Centre for Health Law Research and the Queensland Mental Health Commission to invite Dr Freckleton QC to give a public lecture on a human rights approach to mental health regulation due to his extensive expertise in relation to this field[3] and as part of a general strategy undertaken by the Public Advocate to become informed, and inform others in the course of engaging with the review of the Act.

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[1] *Guardianship and Administration Act 2000* (Qld) s 209.

[2] Office of the Public Advocate, The potential population for systems advocacy (Fact Sheet, Office of the Public Advocate (Queensland), April 2015).

[3] Dr Freckleton is a Queen's Counsel and member of both the Victorian and Tasmanian Bars. He is also a Professorial Fellow of Law & Psychiatry at the University of Melbourne, an Adjunct Professor of Law at Monash University, and a member of both the Mental Health Review Board of Victoria and

As part of this strategy, the Public Advocate also held a Roundtable with legal professionals and relevant statutory officers who work with the Act to consider the proposed changes in the Discussion Paper that was developed by the Queensland Government for the purpose of consulting on the review of the Act in 2014.[4] The Public Advocate also attended the forum facilitated by Dr Penny Weller, hosted by the Queensland Mental Health Commission with a variety of both government and community stakeholders in attendance.

In addition to the Office's own research and experience, this engagement strategy informed the Public Advocate's consideration of the previous review, and has influenced this submission.

The view of the Public Advocate is that a new *Mental Health Bill 2015* (the Bill) represents an opportunity for a legislative framework that is consistent with a contemporary understanding of mental health treatment and Australia's human rights obligations under the United Nations *Convention on the Rights of Persons with Disabilities*.[5]

Mental Health Bill 2015

Overall comments

The Bill provides a legislative framework for both the treatment and care of people with mental illness (mental health treatment provisions) as well as the detention and involuntary treatment and care of people who have been found unfit to plead or unsound of mind in relation to an alleged criminal offence due to a mental illness or intellectual disability (forensic provisions).

Overall, the Public Advocate supports the main principles listed in clause 5 in the Bill to achieve its objects, in particular the promotion of recovery-oriented services and the least restrictive approach to treatment provided for in clause 13.

There are particular aspects of the Bill that are also consistent with a rights-based approach to the treatment of mental illness including:

- a capacity-based approach to the involuntary treatment of mental illness;
- the explicit recognition of the importance of seeking a person's views and preferences about their treatment; and
- a focus on the reduction and elimination of restraint and seclusion.

The Public Advocate also welcomes the inclusion of procedural provisions for Magistrates to follow when dealing with issues of unsoundness and unfitness of both people with mental illness and people with intellectual disability in the Magistrates Courts.

The Public Advocate does however retain a number of concerns (to be outlined in this submission) in particular:

- **The implementation of the 'less restrictive way'**: in terms of its reliance on guardians and attorneys to consent to mental health treatment without the safeguards and specific legislative authority to consent to such treatment (as is provided for in other jurisdictions);
- **The shortcomings in the implementation of the recovery-oriented model**: through the lack of specific provisions to engage a person in treatment planning (in particular the lack of provision for a treatment plan), the reliance on existing advance health directives and a lack of specificity in the

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the Psychosurgery Review Board of Victoria. He is an elected Fellow of the Australian Academy of Law, the Australian Academy of Social Sciences and the Australasian College of Legal Medicine, the editor of the Journal of Law and Medicine, and the Editor-in-Chief of Psychiatry, Psychology and Law.

[4] This Roundtable included representation from the Office of the Adult Guardian; the Director of Mental Health; the Office of the Director Forensic Disability; the Office of the Director of Public Prosecutions; Legal Aid Queensland; Crown Law; the Anti-Discrimination Commission; Department of Health; Queensland Advocacy Incorporated and Queensland Public Interest Law Clearing House Incorporated (QPILCH).

[5] *Convention on the Rights of Persons with Disabilities,* opened for signature 30 March 2007, [2008] ATS 12 (entered into force 3 May 2008).

circumstances in which the patient's wishes and preferences with regard to their treatment (as expressed in an advance health directive) will be overridden by the making of a treatment authority;

- **The lack of detail regarding the new register for advance health directives and enduring powers of attorney**: both in terms of the implementation of the register and access;
- **The lack of either an appropriate legislative or systemic response to people with intellectual disability**: who, by virtue of their contact with the criminal justice system, will come under the ambit of the forensic provisions of the Bill and thus the failure to adequately address the issues highlighted in *R v AAM exparte A-G (Qld) QCA*;[6] and
- **The introduction of non-revokable forensic orders:** that, for the first time, introduce a 'punitive' approach to the mental health legislative framework.

'Less restrictive way'

The Bill is premised upon the concept of the 'less restrictive way' to provide treatment to people with mental illness.[7] The least restrictive principle/doctrine is fully supported by the Public Advocate. In practice it means the least interference with a person's rights and liberties when providing treatment and care and as such also enables people with mental illness to better able to direct their own treatment.

In the Bill the less restrictive way predominately relates to the making and review of treatment authorities with the requirement that, where there exists a less restrictive way for a person to receive treatment and care for their mental illness, that way should generally be implemented in lieu of resorting to involuntary treatment.[8]

In the Bill, the less restrictive way to receive treatment and care for a person's mental illness will involve reliance on a person's parent (if the person is a minor); an advance health directive; a personal guardian; an attorney appointed under an enduring document; or a statutory health attorney.

With the way in which the Bill is currently drafted, the Public Advocate retains a number of concerns with this approach, in particular:

- The significant policy change represented by the reliance on Queensland's guardianship system without appropriate consideration of policy, practice and resource impacts;
- The unresolved question of the lawfulness of guardians' consent to treatment for mental illness where a person is objecting, enforcement of their decisions (or authorisation of others to enforce them) and authorisation of detention of a person in an Authorised Mental Health Service; and
- The possibility that guardianship could be used as a way to circumvent the safeguards that currently attach to involuntary treatment, such as satisfying the necessary criteria and independent overview by the Mental Health Review Tribunal;

Reliance on the guardianship system

Policy considerations

The 'less restrictive way' will rely heavily on Queensland's guardianship system. Apart from parental consent, the remaining 'less restrictive ways' are created by either the *Guardianship and Administration Act 2000* or the *Powers of Attorney Act 1998*.

The Bill in its current form would represent a significant policy change for the guardianship system of Queensland. Consistent with the *parens patriae* jurisdiction, the current guardianship system is focused on

[6] *R v AAM; ex parte A-G (Qld)* QCA 305.

[7] *Mental Health Bill 2015* (Qld) cl 13.

[8] Ibid cl 18; Chapter 2.

making decisions in the *best interests* of adults who lack capacity to make decisions about certain matters for themselves. The system was not designed to restrict the rights and liberties of those with mental illness who are objecting to treatment and/or require treatment and detention against their will to protect the community. The Bill will change this by providing a way in which *involuntary* treatment and detention for mental illness be made *voluntary* through the consent of guardians and attorneys and potentially put guardians and attorneys in a position of imposing treatment that (while it may provide for the community's safety) is not necessarily in the best interests of the person.

This degree of change would normally require a fulsome and holistic review of the policy behind such a shift, the other relevant legislative frameworks affected (i.e. guardianship legislation) and the roles and resources of public agencies that make up the guardianship system. The Public Advocate respectfully suggests that such a review may find, from a policy perspective, that many may feel that this approach is not consistent with the United Nations *Convention on the Rights of Persons with Disabilities*, and certainly not consistent with the move towards supported decision-making being advocated for by the Australian Law Reform Commission in relation to guardianship law.[9]

The Victorian Law Reform Commission (VLRC) specifically considered the issues of the interaction between the legislative frameworks for guardianship and mental health treatment when Victoria was reviewing its guardianship laws.[10] The VLRC sought and received a large number of submissions regarding whether it would be appropriate for a substitute-decision maker to make psychiatric treatment decisions through a multi-staged process providing a number of options for a legislative model to be implemented. There were strong and polarised views on this issue. Ultimately the VLRC recommended that although people should be permitted to make an (Victorian equivalent of) enduring power of attorney regarding their mental health treatment,[11] it should not be possible for a Tribunal to appoint a guardian with this power, except when it is clear that the person had intended, but failed, to appoint an enduring power of attorney.[12] This was due to many reasons including the fact that the 'highly personal nature of psychiatric treatment decisions produces a need for deep trust and understanding between the principal and the person who makes these decisions for them.'[13]

Resource impacts

The implementation of the 'less restrictive way' being created by the Bill relies heavily upon the guardianship system, which, if utilised, is likely to have a corresponding resource impact that it seems has not been considered. There will likely be an increase in applications to the Queensland Civil and Administrative Tribunal (QCAT) for people to be appointed as guardians or for existing appointments to be extended to other areas, for example health care or legal matters. This would then result in a commensurate increase in the reviews of appointments that QCAT must undertake. There may also be an increase in other guardianship matters coming before QCAT, such as recognition of enduring powers of attorney or applications for directions.

It is also likely that there will be a general increase in the number of people who have enquiries about or are seeking assistance to navigate the guardianship system. This will affect not only QCAT and the Public Guardian, both of which already receive a significant number of enquiries, but also other government departments and community organisations/legal centres that presently provide assistance to those people. There may also be an increase in the reporting of systemic issues, which would need to be investigated and addressed by the Public Advocate or other relevant government entities.

This impact upon the guardianship system will be on top of other new developments facing this sector such as the National Disability Insurance Scheme and the age care reforms by the Federal government.

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[9] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Report 124).

[10] Victorian Law Reform Commission, *Guardianship,* Final Report No. 24 (2012).

[11] Ibid 540 24.65.

[12] Ibid 547 24.96.

[13] Ibid 547 24.96

The lawfulness of certain treatment decisions consented to by guardians and attorneys

Of particular concern to the Public Advocate is that unlike in other jurisdictions where mental health legislation engages with guardianship, there is no legislative framework either:

- Clarifying the types of treatment decisions that guardians and attorneys can make; or
- Providing for commensurate safeguards for 'voluntary' treatment for mental illness when it is consented to on a person's behalf by a guardian or attorney.

In fact, few legislative changes have been made at all to the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998.*

The Public Advocate believes that the the operation of the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998* must be clarified in respect of whether a guardian or attorney can:

- Consent to ongoing treatment for mental illness, especially where the person is objecting;
- Enforce their treatment decisions or authorise others (such as police and health practitioners) to enforce their treatment decisions; and
- Consent to a person being detained in an authorised mental health service (which under the common law means remaining in a mental health service because they are prevented from leaving (i.e. detention)).[14]

Objections to treatment

If a guardian is appointed by QCAT with authority to consent to health care on behalf of a person, then unless otherwise restricted by QCAT, the guardian can consent to health care as defined in the *Guardianship and Administration Act 2000.* A statutory health attorney can similarly consent to health care under appropriate circumstances, or an attorney appointed by a person under an enduring document.[15] The issue becomes more problematic if a person is consistently objecting to that treatment.

If a person with mental illness for example objects to treatment that has been consented to by their guardian or attorney, the *Guardianship and Administration Act 2000* provides that:

> "generally, the exercise of power for a health matter or special health matter is ineffective to give consent to health care of an adult if the health provider knows, or ought reasonably to know, the adult objects to the health care".[16]

There are some exceptions, for example if the health care is urgent;[17] or if the adult has little to no understanding of what the healthcare involves or why it is required, and the health care is likely to cause no distress or temporary distress that would be outweighed by the benefit of the proposed healthcare.[18]

The objection to treatment (without any applicable exceptions) would therefore result in the person's guardian or attorney being unable to use their power to consent to treatment.[19] It would potentially constitute an offence for healthcare to be carried out in those circumstances.[20]

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[14] *Antunovic v Dawson* [2010] VSC 377 at para [5].

[15] *Guardianship and Administration Act 2000* (Qld) s 8(1); by enduring power of attorney or advance health directive, an adult may authorise other persons to make particular decisions and do particular other things for the adult in relation to financial matters and personal matters at a time when the adult does not have capacity to do those things.

[16] *Guardianship and Administration Act 2000* (Qld) s 67(1).

[17] Ibid s 63(1).

[18] Ibid s 67(2).

[19] Ibid s 67(1).

[20] Ibid s 79(1).

Enforceability of decision-making

Where a guardian or attorney consents to treatment on behalf of a person with mental illness, they currently have little power to enforce that decision. Section 75 of the *Guardianship and Administration Act 2000* states that "a health provider and a person acting under the health provider's direction or supervision may use the minimum force necessary and reasonable to carry out health care authorised under this Act".

In circumstances where a person's treatment for mental illness is initially authorised under the *Guardianship and Administration Act 2000*, this provision arguably cannot, and should not, be used to forcibly treat a person with mental illness on an ongoing basis. The objective of guardianship legislation is not to enable the involuntary treatment of people with mental illness or other conditions, but rather to "establish a comprehensive regime for the appointment of guardians and administrators to manage the personal and financial affairs of adults with impaired capacity in Queensland."[21]

It can be further argued that, in drafting that provision, it was not contemplated as being used for the level of force that may be required in order to provide some people with ongoing treatment for mental illness including detention in an authorised mental health service. For example, a person may require physical restraint in order to administer each dose of medication, and it is unlikely that this provision was intended to authorise such significant and ongoing levels of force. Further, the provision should not be interpreted as enabling such levels of force because there are insufficient safeguards within the *Guardianship and Administration Act 2000* to protect those people against whom force could be used.

This interpretation is given greater weight by the fact that some other states provide explicit provision for guardians to enforce, or authorise others to enforce, their decisions. For example the *Guardianship Act 1987* (NSW) provides for the tribunal to make a guardianship order that explicitly provides for either the guardian, a specified person, or a person authorised by the guardian to take such measures or action to ensure the person under guardianship complies with any decision of the guardian.[22] The *Guardianship Administration Act 1993* (SA) provides for the tribunal by order to authorise a guardian to use such force as may be reasonably necessary for the purpose of ensuring the proper medical dental or day-to-day care and well-being of the person,[23] and also authorise the detention of a person.[24]

Queensland guardianship legislation, by contrast, has not such comparative powers.

Detention in an authorised mental health service

Should a guardian or attorney be able to consent to a person receiving treatment for a mental illness on an ongoing basis as an inpatient in an authorised mental health service (without explicit statutory authority), it is possible that in some circumstances, it will constitute a deprivation of the person's liberties for which the treating doctor for example may be civilly or criminally liable. This may particularly be the case where the person expresses an intention to leave but is told that they cannot leave, or is under the impression that if they attempted to leave they would be prevented.[25]

The extent to which guardians and attorneys can consent to such detention under the *Guardianship and Administration Act 2000* is not entirely clear. The general rule is that any statutory authorisation of practices that deprive a person of their rights and liberties must be express and explicit. In *Coco v R*, the High Court discussed the common law principle that general words in a statute are insufficient to authorise interference with basic rights and immunities stating: [26]

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[21] Explanatory Memorandum, *Guardianship and Administration Bill 1999* (Qld) p 1.

[22] *Guardianship Act 1987* (NSW) s21A.

[23] *Guardianship and Administration Act 1993* (SA) s 32(1)(c).

[24] Ibid s 32(1)(b).

[25] *Antunovic v Dawson* [2010] VSC 377.

[26] *Coco v R* (1994) 179 CLR 427 [10] (Mason CJ; Brennan, Gaudron, McHugh JJ).

> *The courts should not impute to the legislature an intention to interfere with fundamental rights. Such an intention must be clearly manifested by unmistakable and unambiguous language. General words will rarely be sufficient for that purpose if they do not specifically deal with the question because, in the context in which they appear, they will often be ambiguous on the aspect of interference with fundamental rights ((8) See Chu Kheng Lim v. Minister for Immigration (1992) 176 CLR 1 at 12 per Mason CJ).*

This means that the authorisation of detention in an authorised mental health service generally requires explicit words in statute and cannot be read into legislative provisions, such as general guardianship legislation, that authorise substitute decision-makers to make decisions about accommodation, health care and service provision. As mentioned above, admission to a mental health facility by a guardian has been specifically provided for in other states such as New South Wales.[27] The New South Wales *Guardianship Act 2007* also contains specific provision for 'coercive powers' for guardians, which empowers guardians to take such measures or authorise others to take such measures to ensure the person under guardianship complies with any decision.[28]

While the Public Advocate is not advocating for guardians in Queensland to take on such a coercive function, arguably if the intention of the Bill is to rely on guardians and attorneys to consent to detention in authorised mental health services, then explicit statutory authorisation should be provided as other states have. Anything else imports a discriminatory approach into the law for people with mental illness where, unlike people without mental illness, their liberties and rights can be subject to infringements without proper authorisation or safeguards.

Safeguards

Reliance on guardians and attorneys to consent to treatment for mental illness does not bring with it the same safeguards as treatment authorised under a treatment authority.

Safeguards under a treatment authority

Consistent with most other mental health legislation in other Australian jurisdictions and internationally, there are some important safeguards that will exist for those patients who are subject to a treatment authority. For example, prior to a treatment authority being made for a person (which authorises involuntary treatment), there must be:[29]

- either a voluntary examination by an authorised doctor or an examination undertaken following an examination authority made under the Bill; and
- an assessment by an authorised doctor to determine if the person meets the treatment criteria under the Act (which includes that the person lacks capacity).

If, following these processes, the doctor determines that the person meets the treatment criteria,[30] then a treatment authority can be made, which can authorise the person's care and treatment including their detention in an authorised mental health service if required.

Once a treatment authority is made then:

- An authorised doctor must assess a patient of an authorised mental health service subject to a treatment order within 3 months of the last assessment to determine whether the treatment criteria still apply to the patient or whether there may be a less restrictive way to administer treatment.[31]
- The Mental Health Review Tribunal must also review treatment authorities:[32]

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[27] *Mental Health Act 2007* (NSW) s 7.

[28] *Guardianship Act 2007* (NSW) s 21A.

[29] *Mental Health Bill 2015* (Qld) Chapter 2.

[30] Ibid cls 48 & 49.

[31] Ibid cl 205.

- within 28 days after the authority is made;
- within 6 months after the above assessment, and within 6 months after this;
- then at intervals of not more than 12 months.

- The treatment authority can also be reviewed at any time upon application by the patient or another person.[33]

A person who is subject to a treatment authority may appeal a decision of the Mental Health Review Tribunal to the Mental Health Court.[34] Decisions made by the Mental Health Court can be further appealed to the Court of Appeal.[35]

Limited safeguards under the 'less restrictive way'

Patients who lack capacity to make decisions for themselves about their treatment because of the extent of their mental illness, and for whom treatment is authorised using the proposed 'less restrictive way' provisions, will not have these same protections.

Under the proposed regime, guardians (which may include the Public Guardian but will more likely be family members appointed by QCAT) or statutory health attorneys (who are not appointed by QCAT and are usually the person's next of kin) will decide a person's treatment for mental illness. It would appear possible, and in fact likely, that this could include the ongoing administration of a range of psychotropic medication and/or placement in an authorised mental health service.

However, contrary to the protections provided under the mental health system, aside from seeking a review of an appointment itself, the guardianship system does not provide a system by which decision-making by guardians and attorneys can be challenged or reviewed.

Arguably, the guardianship system was not designed for the imposition of treatment that is potentially highly restrictive of a person's liberties. Furthermore, and of particular concern given the limited oversight and review mechanisms, there is a significant risk that people with mental illness will be highly vulnerable to abuses of power.

Comparison of safeguards

The table below outlines the different safeguards available to patients who may potentially be receiving similar treatment under the two regimes.

Table: Different safeguards under the *Mental Health Bill 2015* for patients under a treatment authority and patients treated on the authority of a guardian under the *Guardianship and Administration Act 2000*

Safeguards	Patient subject to a treatment authority	Person subject to guardianship
How is treatment and care for a mental illness authorised?	A treatment authority **authorises treatment and care for a mental illness** both in the community and as an involuntary inpatient in an authorised mental health service.	A guardian appointed by QCAT for personal matters (including health care) can **consent to health care** for the person.
What are the criteria/steps that must be met prior to authorisation for the treatment and care of mental	First, either a **voluntary examination** (undertaken by an authorised doctor), OR an examination undertaken on the basis of an **examination authority** made by the **Mental Health Review Tribunal** (or another examination authority under law), must occur	QCAT can **appoint a guardian for personal matters (including health care)** if satisfied of certain criteria. **Criteria for appointment of guardian** ▪ the person lacks capacity for health care;

[32] Ibid cl 411(1).

[33] Ibid cl 411(2).

[34] Ibid cl 537.

[35] Ibid cl 547.

illness being provided?	to determine if a **recommendation for assessment** should be made. Second, an **assessment must be undertaken by an authorised doctor** to determine if the person meets the **treatment criteria.** **Treatment criteria** ▪ the person has a mental illness; and ▪ the person lacks capacity; and ▪ without involuntary treatment imminent serious harm may likely be suffered by the person or others; OR the person may likely suffer serious mental or physical deterioration.	and ▪ a decision about health care needs to be made; and ▪ without an appointment the adult's needs will not be adequately met OR the adult's interests will not be adequately protected.
Can the order/ authorisation for treatment and care of mental illness be reviewed?	A person subject to a treatment authority (or another person) may seek a review at any time from the **Mental Health Review Tribunal**. An **authorised doctor** must assess a patient of an authorised mental health service within **three months** to determine if the treatment criteria still apply. The **Mental Health Review Tribunal** must automatically review the treatment authority: ▪ within **28 days** of the authority being made; ▪ within **6 months** of the above assessment, then within **6 months** again; ▪ then further reviews at not more than **12 months**.	**A decision of a guardian** to consent to health care that includes treatment for mental illness **cannot be reviewed.** A person subject to a guardianship order can seek **a review of the appointment of a guardian** at any time from **QCAT**. **QCAT** must **review the appointment of a guardian** at least every **5 years**.
Is there an appeal about the decision to authorise treatment and care for a mental illness?	A person subject to a treatment authority may appeal a decision of the Mental Health Review Tribunal to the **Supreme Court (Mental Health Court)**, and then to the **Court of Appeal**.	A person may appeal a decision of the tribunal to appoint a guardian to the **QCAT Appeal Tribunal**, and then to the **Court of Appeal**.

The Public Advocate is particularly concerned about safeguards where a person is in receipt of inpatient treatment in an authorised mental health service. In other states, where either mental health or guardianship legislation specifically provides for a guardian to authorise 'voluntary' admission as such to a mental health facility, there is both explicit provision for this and numerous safeguards.

For example, in New South Wales, the *Mental Health Act 2007* (NSW) allows for a guardian to consent to a person being admitted as a voluntary patient.[36] Further to explicit provision for guardians to consent to such admission, safeguards exist to the extent that all voluntary patients must also have regular reviews (every 12 months) by the Mental Health Review Tribunal.[37] Upon such a review, the person can be discharged from the mental health facility despite the views of the guardian.[38]

The Public Advocate considers that similar reviews of voluntary inpatients should also occur in Queensland, tapered in the same manner as for the proposed schedule for involuntary patients subject to a treatment authority. A recent NSW Supreme Court case *Sarah White v The Local Health Authority*[39] is testament to the

[36] Mental Health Act 2007 (NSW) s 7.

[37] Ibid s 9.

[38] Sarah White v The Local Health Authority [2015] NSWSC 417.

[39] Ibid.

importance of such safeguards. In this case, a woman was an inpatient in a mental health facility under the authorisation of her guardian. The NSW Supreme Court ordered her release from the facility when, following a 12 month review by the Mental Health Review Tribunal that ordered her to be discharged, the guardian continued to request her detention in the facility.

Recovery-oriented model

The Public Advocate agrees that the ethical framework for the Bill should incorporate both a rights-based and recovery-oriented approach to mental health treatment, but believes there are some opportunities to strengthen this approach in the Bill.

A recovery-oriented framework for mental health treatment and legislation emphasises the value of the lived experience of people with mental illness alongside the expertise, knowledge and skills of clinicians. Such a framework challenges the conventional demarcations between consumers and clinicians, emphasising the importance of the active involvement of people with mental illness in their treatment and their empowerment (rather than disempowerment) in the treatment process.[40]

The relatively new Victorian *Mental Health Act 2014* provides a range of mechanisms by which people are supported to make and participate in decisions about their assessment, treatment and recovery, with accompanying safeguards to ensure their wishes and preferences about their treatment cannot be overridden by treating doctors without certain processes being followed.

A number of resources have been developed to encourage the development of mental health advance statements including videos and written guides.[41]

The Public Advocate believes that this provides a model more attuned to recovery orientated services for mental health than the model outlined in the current Queensland Bill. The current Queensland Bill simply relies on existing advance health directives.

Advance health directives

The Public Advocate questions whether the use of the existing advance health directives as provided for under the *Powers of Attorney Act 1998* are the best way in which to implement the recovery-based model.

First, there is not currently a practice of utilising advance health directives for this purpose. Advance health directives are generally focused on end of life decisions. Expanding the advance health directive form could prove confusing for those in the community who do not use such instruments to plan for mental health treatment, and for those with mental illness who are expected to utilise them to express their wishes and preferences about their mental health treatment.

The concept of the specific 'advance statement' in the Victorian *Mental Health Act 2014* by contrast allows for specific resources and support to be developed around making these statements which are focused on care and treatment for mental illness.

Second, despite a person preparing an advance health directive that sets out their wishes and preferences with respect to treatment of their mental illness, an authorised doctor can simply choose to ignore the advance health directive and make a treatment authority. This makes no change to the current position.

By contrast the Victorian *Mental Health Act 2014* requires that:

- an obligation on the treating psychiatrist to make a treatment decision in accordance with the advance statement unless satisfied that the treatment specified is not clinically appropriate;[42]

[40] Dr Ian Freckleton QC, Public Lecture: *Mental Health Law Reform and Human Rights,* (Queensland University of Technology, 5 May 2014).

[41] See Victoria State Government, Mental Health, Advance Statements, https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/recovery-and-supported-decision-making/advance-statements

[42] *Mental Health Act 2014* (Vic) s 73(1)

- legislative criteria that must be satisfied by the treating psychiatrist before a treatment decision is overridden;[43]
- if this occurs, the right of a person to have the decision explained to them and to request written reasons for the decision.[44]

The criteria specified in the legislation that an authorised doctor must consider before overriding a person's advance statement is that:

- the preferred treatment in the advance statement is not clinically appropriate; and
- is not a treatment ordinarily provided by the designated mental health service.[45]

In contrast the Queensland Bill only provides examples of where advance health directives may be overridden. They are not drafted in a way that outlines exclusive, predictable, and specific criteria to which people can consider as to how a doctor may assess an advance health directive. Such provisions should be expressly stated.

The Public Advocate would suggest that the criteria that must be applied by an authorised doctor in deciding that a person cannot be treated under an advance health directive could include that:

- the preferred treatment in the advance health directive is not clinically appropriate; or
- the preferred treatment in the advance health directive would mean that the person or others would be at imminent risk of serious harm; or
- the person is consistently objecting to the treatment outlined in the person's advance health directive; or
- the preferred treatment in a person's advance health directive would involve the administration of physical restraint or detention of the person.

Treatment plans

The Bill does not include the concept of a 'treatment plan'. Rather an authorised doctor has to decide on the nature and extent of treatment to be provided and record it in the patient's health records.[46]

In applying a recovery-oriented approach, the treatment plan is a valuable concept. It enables a solid infrastructure around which conversations can be held, negotiations made and outcomes recorded and agreed to (sometimes signed by both doctor and patient). It can be a collaborative document, reflecting not only the discussions of the doctor and patient but also the patient's family, carers, guardians, attorneys and other support persons.

Treatment plans can empower the patient as they are presented with a specific 'plan' in relation to their treatment, which sets out what they can expect, facilitates discussions regarding their treatment with the doctor, and encourages reflection upon their own health. If a person has an advance statement setting out what treatment they would prefer, they can see this incorporated into their treatment plan. A treatment plan can take a holistic approach to a person's treatment, incorporating consideration for not only traditional treatment but also social, cultural, environmental and other issues integral to a person's treatment and recovery.

The justifications given for the removal of treatment plans from legislation are that the plans presented practical issues in their implementation,[47] including that they created confusion in relation to the relationship between the plan and regular records that are required to be kept by doctors, as well as in many

[43] Ibid s 73(2)

[44] Ibid s 73(1)

[45] *Mental Health Act 2014* (Vic) s 73(1).

[46] *Mental Health Bill 2015* (Qld) cl 202.

[47] Background Papers, *Mental Health Bill 2015* (Qld) p 10.

cases of mental illness, a person's condition can change rapidly and therefore treatment plans can become obsolete in a short period of time.

While treatment planning can and should be a continuous process, there are alternative ways to resolve these practical issues that should be explored before resorting to the elimination of the concept of treatment plans. For example if there is confusion between a treatment plan and a person's health records, it could be legislated that any treatment plan be part of, or be copied into, the person's records, which is already contemplated by the transitional provision in the Bill regarding existing treatment plans.[48]

The complete removal of the treatment plan from legislation should be avoided. The Bill should incorporate the concept of a treatment plan that:

- is consistent with a person's advance health directive/ advance statement (unless otherwise provided);
- is developed in partnership with the person, and their family, carers, guardians, attorneys and support people;
- is developed in accordance with the principles in clause 5;[49] and
- where possible, is signed by the doctor and the person.

To support this, the Bill should include provisions to overcome difficulties in the practical implementation of treatment plans by requiring that such plans be copied or reflected in the patient's records.

Such changes would provide Queensland with a more contemporary Act that is consistent with a recovery-oriented approach while also maintaining safeguards for patients, health professionals and the community.

Register of advance health directives and EPAs

The Bill introduces a records system that keeps an electronic record of advance health directives, enduring powers of attorney (EPA) for a personal matter, and appointments of nominated support persons.[50] By request of the person making an enduring document or directive relating to the person's future treatment and care for a mental illness, the administrator must keep a record for the matter on the system.[51]

The establishment of a mechanism enabling the registration of enduring instruments is potentially a good strategy to facilitate increased engagement with advance planning. The Victorian Law Reform Commission reported that *"a register would be a highly effective means of encouraging people to appoint others to assist them with decision-making"*.[52]

However, the current draft of the Bill raises some questions regarding potential issues in its implementation including:

- the extent to which the register can be utilised by all Queenslanders who have an advance health directive or enduring power of attorney;
- the appropriateness of creating a legislative framework for a register of such instruments under the Mental Health Act and not the guardianship legislation; and
- whether there will be a fee for registration and/or searching.

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[48] *Mental Health Bill 2015* (Qld) cl 815.

[49] Ibid cl 5.

[50] Ibid cl 225(1).

[51] Ibid cl 226(2)&(3).

[52] Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012) 362 [16.89].

Accessibility

It is not clear from the Bill as to by whom and how this register will be accessed. Presumably, it would be treated like any other medical record and accessed by health staff.

However, there are a number of reasons why search and access need to be granted to other stakeholders, which would in turn require a consideration as to whom and for what reason access could be granted. For example, if a guardianship application is being made before QCAT in order to meet the current implementation of the 'less restrictive way' and the person has already made an enduring power of attorney or advance health directive, any such documents registered in the records system should be searchable by QCAT before such a guardianship order is made. Other implementations of such registers allows for the searching of documents, such as in Tasmania where a fee is payable to register/revoke an enduring power of attorney and to conduct a search of the register.[53]

The Northern Territory Government recommends that Advance Personal Plans are registered with the Public Trustee and noted on Medicare eHealth records.[54] The Public Trustee does not charge a fee to register or search for an Advance Personal Plan, however a person wishing to search for a Plan must state the reason for their search request on a search application form.[55]

Without a way for external stakeholders to access the register, injustice and conflicts could arise when decisions are being made outside of the mental health system. This could occur during a QCAT application, or when the Supreme Court is exercising its inherent *parens patriae* jurisdiction, and a decision is made regarding whether a substitute-decision maker should be appointed for a person while the court or tribunal was unaware of the person having made an advance health directive or enduring power of attorney. This issue should be clarified, preferably within legislation, to avoid any questions as to issues of privacy and access requirements.

Responses for people with intellectual disability

The fragmented nature of the system

The Bill also provides a legislative framework for the response to people with intellectual disability who come into contact with the criminal justice system and are found of unsound mind or unfit for trial.

The current scheme for involuntary treatment of people with intellectual disability is fragmented across the:

- *Mental Health Act 2000* (forensic orders for people found unfit to plead or unsound of mind);
- *Disability Services Act 2006* and the *Guardianship and Administration Act 2000* (in approving the use of restrictive practices);
- *Forensic Disability Act 2011* (detention in the Forensic Disability Service, including provisions for behaviour control medication); and
- Health care provisions of the *Guardianship and Administration Act 2000*.

This fragmentation creates confusion, leaves gaps, and often results in less than optimal responses for people with intellectual disability who come into contact with the criminal justice system as outlined below.

The establishment of the Forensic Disability Service and the commencement of the *Forensic Disability Act 2011* went some way towards addressing the concerns raised in the past when the mental health and forensic disability system was reviewed and was the subject of reports by Brendan Butler AM SC and the late

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[53] Land, Property and Titles, Department of Primary Industries, Parks, Water and Environment, *LTO Gazette Fees 2014-15* (27 October 2014) Tasmanian Government <http://dpipwe.tas.gov.au/Documents/Gazette%20Fees%202014-15.pdf>.

[54] Department of Attorney-General and Justice, *Advance Personal Planning* (24 November 2014) Northern Territory Government <http://www.nt.gov.au/justice/pubtrust/app/index.shtml>.

[55] Department of Attorney-General and Justice, *Application to search or obtain information from the Advance Personal Planning Register* (22 July 2014) Northern Territory Government <http://www.nt.gov.au/justice/pubtrust/app/documents/APP-Search-Request.doc>.

Honourable William Carter QC. In the report *Forensic Mental Health System: Final Report Review of the Queensland Mental Health Act 2000* (the Butler Report), it recommended that a review of the Act in 2006 properly address the need for secure care for people with an intellectual disability.[56] In the report *Challenging Behaviour and Disability: A Targeted Response* (the Carter Report), it was identified that placing people with intellectual disability in Authorised Mental Health Services was inappropriate, as well as the fragmented response to people with intellectual disability who exhibit challenging behaviours generally, regardless of whether they are subject to a forensic order.[57]

The *Forensic Disability Act 2011* provided a more appropriate model of care for people with intellectual disability or cognitive impairment who are found to be unsound of mind or unfit for trial by the Mental Health Court. However, the response is not sufficient. The *Forensic Disability Act 2011* only provides the legislative framework for the ten-bed Forensic Disability Service (that quickly reached its full capacity); it does not provide a holistic systems response to enable coherent, consistent and integrated care and support options for this cohort, nor is it inclusive of 'step-down' or 'transitional' services to assist people to make the transition back to community living in less restrictive environments.

Furthermore, despite the Carter and Butler Reports being released over seven years ago, there continues to be people with intellectual disability and no 'mental illness requiring involuntary treatment' residing in mental health facilities. Some of these people are subject to a forensic order, and some are not. Further, some people with intellectual disability are subject to approval for containment and seclusion by QCAT where they are held in detention-like conditions in the 'community' or at the Wacol precinct. Some of these people are also subject to forensic orders, and are receiving limited community treatment whilst subject to containment.

There are also people for whom the nature of their criminal offences does not bring them before the Mental Health Court yet their pattern of escalating behaviours clearly indicates a need for support. People who commit summary offences, particularly multiple summary offences, may never come before the Mental Health Court but may still be in need of support to mitigate against recurrent contact with the criminal justice system or escalating harmful behaviours.

Consideration should be given to the commencement of a full review of the legislative framework for this group, inclusive of the clinical, accommodation and support services available throughout Queensland. The review of the *Forensic Disability Act 2011* (now due) could provide the opportunity for this.

In view of the National Disability Insurance Scheme (NDIS) commencing in Queensland, with the likelihood that many state governments will withdraw from the provision of disability services and the expressed intention by the Commonwealth Government that the NDIS will not bear responsibility for forensic services for people with disability, there should also be a review of the support system for people with intellectual disability in relation to situations such as those mentioned above.

One particularly inequitable approach to people with intellectual disability is outlined in more detail below.

Magistrates Court proceedings

This Bill introduces procedures for Magistrates Courts to follow when the court is reasonably satisfied that a person charged with an offence was, or appears to be, of unsound mind or unfit for trial. These provisions will go some way to addressing the issues raised by the Court of Appeal in *R v AAM; ex parte A-G (Qld)*.[58]

From the Public Advocate's point of view, however, these provisions go only part way to addressing issues such as those experienced by the young woman at the centre of this case, who continued to reappear in the Magistrates Court charged with similar offences. There are a number of shortcomings in the provisions

[56] Brendan Butler AM SC, *Promoting Balance in the Forensic Mental Health System: Final Report Review of the Queensland Mental Health Act 2000* (2006) 102.

[57] William Carter QC, *Challenging Behaviour and Disability: A Targeted Response*, (Report to Warren Pitt MP, Minister for Communities, 2006, 87.

[58] *R v AAM; ex parte A-G (Qld)* QCA 305.

regarding Magistrates Court proceedings for people with an intellectual disability being charged with offences as outlined below.

The first is the question of how such persons with intellectual disability will be identified so that proper submissions can be made to the Magistrate. It has been proposed that this will be accommodated by an expansion in the Court Liaison Service that is provided by Queensland Health to assist the courts. [59] However, the Public Advocate's understanding of this service is that Court Liaison Officers are trained in mental health and only have administrative connections with Queensland Health. It is unclear whether they will have any connection to disability services to enables them to enquire into what support particular persons might already be receiving and what might be available beyond that which may fall within Queensland Health's jurisdiction.

There must be a dedicated intellectual disability focused Court Liaison Service to be able to properly assess and make submissions to the court with close administrative connections to the Department of Communities, Child Safety and Disability Services (DCCSDS) in the coming years, and then subsequently with the National Disability Insurance Scheme (NDIS) once this commences in Queensland. This will require additional and appropriate resourcing to be able to accurately assess people with intellectual disability.

There does not seem to be any clear indication as to who should be funding reports, if required, for a person with intellectual disability where there is not sufficient evidence to support a finding of unfitness or unsoundness in the Magistrates Court for a person with intellectual disability. An examination order could be ordered by a Magistrate[60] but only under certain conditions, including if the Magistrate is satisfied that the person has a mental illness/dual disability or is unable to decide whether the person has a mental illness or another mental condition.[61] Without a report or other evidence that can be presented to the court, the Magistrate may not reach a point to believe they require an examination order and may simply not accept that the person has an intellectual disability.

Further, how any of the pertinent information that could be presented by a Court Liaison Officer will come before the Magistrate is unclear. Court Liaison Officers have no right of appearance before criminal proceedings, nor do they exist in any formal capacity in law. Should a person not accept the contents of a report, and leave to appear is not granted by the court, a Court Liaison Officer may have no means of presenting evidence to the court. If the proposal is to have Court Liaison Officers play a vital role in Magistrates Court proceedings, they should be recognised and given recognition to appear in proceedings.

Another issues exists whereby, should a Magistrate discharge a person (unlike for a person with mental illness) the Bill presents no enforceable mechanism to ensure that the person is properly supported so that they do not cycle before the courts by repeatedly committing offences as a result of their intellectual disability.

Currently upon discharge, a Magistrates Court may refer a person to a 'relevant agency' for appropriate care, to the health department, or to another entity the court considers appropriate for treatment and care.[62] However, this is not intended to be enforceable[63] and there are no consequences for the person not attending at any service or even for the service to simply refuse treatment or care. There is no recourse available in these situations, or even in the case that the Magistrate has referred a person to the wrong service.

The Bill in its current form creates an incomplete system in relation to people with intellectual disability. Further consideration should be had in relation to the approach for people with intellectual disability and how they are treated by the Magistrates Court, given that such ambiguities could result in injustice and people with intellectual disability repeatedly returning to the criminal justice system.

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[59] Background Papers, *Mental Health Bill 2015* (Qld) p 29.

[60] *Mental Health Bill 2015* (Qld) cl 177.

[61] Ibid cl 177(1)(b).

[62] Ibid cl 174(2).

[63] Explanatory Notes, *Mental Health Bill 2015* (Qld) p 39.

Non-revokable forensic orders

The Bill proposes that the Mental Health Court may impose a forensic order with a non-revocation period of not more than 10 years if the person is charged with a 'prescribed offence'. In deciding the non-revocation period, the Court must have regard to the nature of the offence and the object of the Act in relation to protecting the community.[64]

This suggests that a forensic order is being used in the same way as a criminal penalty, and therefore represents punishment for a person's actions, which psychiatric treatment fundamentally is not. These provisions in the Bill are punitive in nature, affecting only those who are *alleged* to have committed more serious, 'prescribed' offences, and having no effect on lesser offences.

Currently under the Act, when a person is placed on a forensic order, the purpose of such an order is not intended for anything other than the management and treatment of people with a mental illness.[65] The legislation does not impute any intention for punitive or preventive detention. Further, it has been made clear by the High Court that any such curtailment of the right of personal liberty requires clear, unambiguous language.[66]

Similarly, the Bill in its current form does not propose any punitive or preventive detention in its objects,[67] and such non-revokable orders are therefore clearly against both the objects and the principles[68] of the Bill. In particular, a non-revokable order does not ensure that a person's rights and liberties are affected only to the extent required to protect their own health and safety or to protect others.

Approaching psychiatric treatment and potential confinement in such a way ignores the general safeguards and principles that protect those charged with a criminal offence. In a criminal proceeding, for a person to be sentenced, penalised and potentially placed in custody, the prosecution first has to discharge its burden of proof, that of beyond reasonable doubt, over the accused's presumption of innocence. Conversely, in the case of a matter before the Mental Health Court, no party bears the onus of proof, and matters are decided on the balance of probabilities.[69]

The imposition of a non-revocation period is neither person-centred nor consistent with a recovery-oriented approach. It does not require consideration of the person or their individual circumstances, and the period is not intended to reflect or be responsive to the person's anticipated future needs. The imposition of a non-revocation order, particularly insofar as it is informed by the nature of the offence, is punitive. It does not reflect the fact that persons subject to forensic orders have not been found guilty of an offence.

Rather, the imposition of a non-revocation period potentially enables an order to continue for a longer period than is necessary for protection and restricts a person's ability to live without involuntary treatment and care. It would appear that a non-revocation period does little to directly assist in improving and maintaining a person's health and wellbeing and, arguably, if people are not permitted to live independently, may have an adverse effect on their health and well-being.

The concept of a non-revokable forensic order should be removed from the Bill. A forensic order should not be viewed in the same way as a penalty under criminal law but instead be a means of effecting treatment for a person who has been found not criminally responsible for their actions.

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[64] *Mental Health Bill 2015* (Qld) cl 137.

[65] *Mental Health Act 2000* (Qld) Chapter 1, Parts 2 and 3; *Re AKB* [2005] QMHC 005.

[66] *Coco v The Queen* (1994) 179 CLR 427 at 437-438; *Plaintiff S157/2002 v Commonwealth of Australia* (2003) 211 CLR 476 at para [30] per Gleeson CJ.

[67] *Mental Health Bill 2015* (Qld) cl 3.

[68] Ibid cl 3 & 5.

[69] Ibid cl 683.

Conclusion

This review of Queensland's legislative framework for mental health treatment and care presents a unique opportunity (one that will arguably not arise for another decade) to ensure Queensland's mental health legislation represents a contemporary approach and one that is premised upon a foundation of human rights and underpinned by a recovery-oriented approach to the treatment of mental illness.

I commend the Bill to the extent that it takes Queensland some way towards fulfilling this aspiration, including the capacity-based approach to the involuntary treatment of mental illness. However, a number of changes could be made to ensure that we do not miss this important opportunity.

This submission outlines a number of ways to improve upon the Bill as currently drafted. A concerning aspect of the Bill is its lack of detail in relation to how it will interact with other systems that support those people who the Bill will impact the most, notably the guardianship system, the criminal justice system, and the fragmented system for the support and involuntary treatment of people with intellectual disability.

It is hoped that the Bill can be reconsidered particularly in relation to the reliance placed on the guardianship system and the further safeguards needed for people with mental illness whose treatment and detention decisions may now be made by guardians and attorneys.

Further, given the incomplete response to people with intellectual disability (who are once again caught by the forensic provisions in the Bill) there should be a full review inclusive of the support systems and legislative frameworks in Queensland for people with intellectual disability who come into contact with the criminal justice system or who are at risk of doing so.

In closing, thank you for the opportunity to provide a submission in relation to the proposed Bill. I would be pleased to make myself available to further discuss the issues that I have raised in this submission should additional information be required.

Yours sincerely

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