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Law Society

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Office of the President

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Our ref H&D – 2

The Research Director
Health and Ambulance Services Committee
Parliament House
George Street
BRISBANE QLD 4000

By email to: hasc@parliament.qld.gov.au

Dear Director

Submissions - Mental Health Bill 2015

Thank you for the opportunity to provide submissions to the Committee on the *Mental Health (Recovery Model) Bill 2014* and the *Mental Health Bill 2015* ("the Bill").

A copy of the Society's submission dated 2 July 2015, to the Director, Mental Health Act Review Team, regarding its review of the Bill is **attached** for your reference.

The Society reiterates its previously expressed concern about the lengthy 10 year maximum non-revocation period for particular forensic orders as expressed in section 137 of the Bill. The concern is that persons may perceive the imposition of such a period for a forensic order as a form of punishment rather than as a period of proper and continuing engagement with the treating team.

The Society makes the following further submissions about the Bill:

1. <u>Capacity</u>

   It is acknowledged that the definition of capacity (section 14 of the Bill) has been modified so that a person only needs to understand they have an illness, or symptoms of an illness, that affects the person's mental health and well-being.

   The Society recommends that similar modifications be made to the definitions of capacity in the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*. The adoption of a common definition will avoid any confusion by medical practitioners when assessing patients for the purposes of executing an Enduring Power of Attorney or an Advanced Health Directive.

2. <u>Patients' rights</u>

   Chapter 9, Division 4 of the Bill concerns the standardisation of patients' rights where matters are to be told, explained or discussed with a nominated support person, family, carer or other support person. A "nominated support person" is defined in section 223 of the Bill and "carer" is defined in Schedule 3.

The Society recommends that the obligation to communicate with a patient's nominated support person, family member, carer or support person be expanded to also include a person who is also a patient's decision-maker either as a personal guardian or as an attorney appointed pursuant to an Enduring Power of Attorney.

3 Appointment of representative – section 738

(a) Section 738 of the Bill enables the Tribunal to appoint a lawyer (or another person) for unrepresented persons at a hearing. Subsection (6) provides that any such appointment made under the circumstances listed in subsection (3) will be at no cost to the person. However, no such allowance is made if the appointment is made under subsection (2) i.e. where the Tribunal considers it is in the person's best interests to be represented at the hearing.

The Society recommends subsection (6) be amended to also include reference to subsection (2) so that those appointments will be at no cost to the person.

(b) Subsection (4) gives an adult person, with capacity, the right to waive representation. However, no such allowance is made for a competent child (although a competent child may refuse medical treatment – section 14(4)).

The Society recommends subsection (4) be amended by deleting the words *"If the person is an adult with capacity…"* and substituting the words *"If the person has capacity…"*

Should you have any queries in this matter, please do not hesitate to contact the Society's Policy Solicitor, Ian Foote on 3842 5896 or by email to i.foote@qls.com.au.

Yours faithfully

Michael Fitzgerald
President

Queensland
Law Society

Submission

Review of the Mental Bill 2015

Department of Health

A Submission of the

Queensland Law Society

2 July 2015

The overall impression of the Queensland Law Society (**QLS**) to the *Mental Health Bill 2015* is generally positive, with one stand out concern being the 10 years maximum non-revocation period, which confuses the need for treatment for a person with a mental illness, to that of punishment. This impression may increase stigma and discrimination toward people with a mental illness and reduce their ability to recover and works against the stated main objects of section 3 of the Bill.

The following discussion is in relation to the identified specific sections of the *Mental Health Bill 2015*.

<u>Chapter 1, Part 2 – Principles for Administration of Act</u>

Within this section are two main departures from the present *Mental Health Act 2000* that the QLS wishes to observe.

First, there is increased reliance on the threshold concept of capacity of an individual to consent to their mental health care, which is a focus welcomed by QLS.

However, the definition of capacity has changed from a definition similar to the definition in schedule 4 of the current *Guardianship and Administration Act 2000*:

> *capacity, for a person for a matter, means the person is capable of—*
>
> *(a) understanding the nature and effect of decisions about the matter; and*
>
> *(b) freely and voluntarily making decisions about the matter; and*
>
> *(c) communicating the decisions in some way.*

to a definition that has some parallels with section 3(1) of the *UK Mental Capacity Act 2004*, outlined below

> *For the purposes of section 2, a person is unable to make a decision for himself if he is unable—*
>
> *(a) to understand the information relevant to the decision,*
>
> *(b) to retain that information,*
>
> *(c) to use or weigh that information as part of the process of making the decision, or*
>
> *(d) to communicate his decision (whether by talking, using sign language or any other means).*

The proposed definition of capacity (section 14 of the *Mental Health Bill 2015*), is more prescriptive, in that it requires acceptance of a diagnosis of a mental illness:

> *A person has capacity to consent to be treated if the person—*
>
> *(a) <u>recognises the person has a mental illness</u>; and*
>
> *(b) is capable of understanding, in general terms—*
>
> > *(i) the nature and purpose of the treatment for the mental illness; and*
> >
> > *(ii) the benefits and risks of the treatment, and alternatives to the treatment; and*

(iii) the consequences of not receiving the treatment; and

(c) is capable of making a decision about the treatment and communicating the decision in some way (emphasis added)

The QLS is concerned about the departure from the current definitions of capacity, to the more restrictive position that requires the person to do more than "*understand the information relevant to the decision*" or "*understanding the nature and effect of decisions about the matter*" to them being cognisant of a mental illness. One concern relates to realities of clinical practice in that a person's actual diagnosis can change over time, the other concern being that a person may accept and understand relevant information in regards to treatment, but not accept a diagnosis of a particular illness or condition at that point in time (which may subsequently change).

Perhaps, if the person "recognises the person has a mental illness – in general terms", it will be a less restrictive approach, and more in accordance with other provisions in the Act. It may also be more acceptable to people from diverse cultural backgrounds and for young people with emerging mental health problems (previously undiagnosed conditions).

The above main definition of capacity to consent is also different to the definition used in regulated treatments, as outlined in section 221:

*A person gives **informed consent** to the person's treatment by regulated treatment only if—*

(a) the person has capacity to give consent to the treatment; and

(b) the consent is in writing signed by the person; and

(c) the consent is given freely and voluntarily.

(2) For subsection (1)(a), the person has capacity to give consent to the regulated treatment <u>if the person has the ability to understand the nature and effect of a decision relating to the regulated treatment, and the ability to make and communicate the decision.</u> (emphasis added)

This definition, (apart from the need for the consent to be in writing) is more aligned to the *Guardianship and Administration Act 2000.* Given the reliance on the *Guardianship and Administration Act 2000,* for the *less restrictive way,* outlined in s 13 MHB, it would be more helpful for the definitions of capacity to be more aligned, and may assist in reducing confusion amongst many clinicians, tribunals, courts, people with a mental illness and their families.

The other main difference is the reliance on a *less restrictive way.* Generally, the QLS welcomes the *less restrictive way* and notes the alignment with the substitute decision-making framework in the *Guardianship and Administration Act 2000.* This will have enormous impact on families, but should result in them being more included in the care of their family member. One practical concern, however, is how the privacy provision in section 284, may operate to thwart consent under the *less restrictive way* outlined in section 13. It places great difficulty on the family and support network of a person if they do not receive sufficient information to ensure the safety of the person with a mental illness. It is obviously of less concern if the family are not providing direct care to the person.

Perhaps the privacy provision could be modified to allow families and support people to be given information in general terms only, when the person with a mental illness is reliant on their care and support in the community.

If these provisions are to give effect to the *less restrictive way* approach, then the information must be provided in a full and free manner so that persons who are authorised to make decisions on their behalf, can do so effectively.

Chapter 4 - Psychiatrist reports for serious offences

It is the Society's view that the provisions of this chapter do not protect the rights of persons subject to involuntary treatment. This is because psychiatric reports prepared by treating psychiatrists will no longer be mandatory for people subject to involuntary orders who are charged with offences.

Under the *Mental Health Act 2000* Health Department psychiatric reports for people subject to involuntary orders charged with criminal offences are mandatory. The *Mental Health Act 2000* is consistent with the *International Covenant on Civil and Political Rights* and the *United Nations Convention on the Rights of Persons with Disabilities,* because the mandatory process under Chapter Seven, Part Two of the *Mental Health Act 2000* ensures that the State consistently and fairly applies the law to a citizen subject to involuntary treatment. That process ensures that the State enquires into the question of unsoundness of mind and fitness for trial of persons subject to involuntary treatment charged with criminal offences, thus protecting the person from indiscriminate application of the presumptions of sanity and fitness.

The proposed amendments will effect indiscriminate and inconsistent application of the criminal law at the State's convenience – as the State will at once diminish the liberty of a person on involuntary treatment on account of the person's health, but not protect that person's liberty on account of their health.

The Discussion Paper on the proposed amendments to the *Mental Health Act 2000* expressly acknowledges that the proposed legislation will inform "increased potential for persons who may have a mental health defence to receive a criminal penalty". Yet the authors of the Paper regard that as less important than resources being "redirected" to "higher priority frontline services."[1] This exemplifies the State choosing to apply laws when it is convenient to do so, notwithstanding that the citizen in question will be subject to criminalisation without proper legal processes being ensured.

Given a person has a fundamental right to be who they are, a sick person ought not to be regarded as criminal without proper investigations into their capacity first being applied. But if the *Mental Health Bill 2015* is enacted, there is a very real risk that a very significant number of mentally ill persons will unjustly transition from the status of sick persons needing treatment to the status of criminals needing punishment.

The submitted effect of the proposed changes will not be addressed by others assuming responsibility for provision of the expert reports currently supplied under Chapter Seven Part Two *Mental Health Act 2000*. First, it is unlikely that those others will have sufficient money to do so. Second, they will not have sufficient access to the information required to properly report. Most importantly, they will not have any lawful obligation to do so. The person with a mental illness subject to criminal proceedings may not appreciate the need to properly determine those matters currently the subject of Chapter Seven Part Two of the *Mental Health Act 2000* reports, due to the effect of their illness.

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[1] Background Paper, *Impact of Proposals*, p 4.

Concluding, the proposed law will significantly reduce the number of psychiatric reports on involuntary patients facing criminal charges, and will have hugely negative consequences for mentally impaired persons, and the whole community.

Chapter 5 - Mental Health Court References

The implication on Mental Health Court references of the changes proposed by Chapter 4

Under the present legislation the Mental Health Court is the fundamental mechanism resolving the criminal responsibility and fitness for trial of mentally impaired defendants. The Court thus provides stable, consistent and fair resolutions to the mentally impaired cohort and the community. In our view, the Court's role and resources ought to be fiercely protected, not eroded. It is respectfully submitted that the jurisdiction of the Mental Health Court will be sharply diminished if the proposed laws are enacted.

As noted above, under the proposed amendments psychiatric reports on involuntary patients charged with offences will no longer be mandatory. In a large number of cases the Department will not even be required to contemplate provision of such reports.[2] In other cases, although reports on "serious offences" may be made by the Department on request by patients or their lawyers, given the very illness resulting in the involuntary order many patients may well lack insight into the need for a report, and so not make such requests themselves or instruct their lawyers to do so.[3] In other cases whether a report is prepared will be left to the chief psychiatrist's discretion.[4] However, even if a report is prepared pursuant to such discretion, and even if the report discloses that the person may have been of unsound mind or be unfit for trial, the chief psychiatrist is not required to refer the matter to the Mental Health Court. The chief psychiatrist can only refer the matter if "having regard to the report and the protection of the community, there is a compelling reason in the public interest for the reference to be made".[5] This proposed amendment is flawed on two grounds. First, because it supplies far too much discretion to the chief psychiatrist to make or refuse to make a reference. Secondly, because it completely disregards the importance of considering the patient's own interest in being protected the consequences of his or her illness.

Forensic orders

Under the *Mental Health Act 2000* forensic orders may be made to effect the patient's own needs.[6] The Mental Health Bill 2015 removes that humane consideration, and makes only the community interest determinative.[7] Whilst the shift in language is relatively subtle, the impact may be profound, in that the law does not require a fulsome understanding of the impact of the illness upon the person with the illness.

Further, it is proposed that a non-revocation period for particular forensic orders be applied.[8] Such a proposal fundamentally misconceives the nature of a forensic order.

A forensic order is not a punishment. It is an order mandating that the person subject to the order except reasonable treatment for their condition. A healthy therapeutic alliance between

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[2] *Mental Health Bill 2015*, s 84 of the proposed Act, and the definition of "serious offence" in proposed Schedule 3.
[3] *Mental Health Bill 2015*, s 88.
[4] *Mental Health Bill 2015*, s 91.
[5] *Mental Health Bill 2015*, s 99.
[6] *Mental Health Act 2000*, s 288(4).
[7] *Mental Health Bill 2015*, s 138.
[8] *Mental Health Act 2000*, Chapter 5, Part 4, Division 4.

the person and their treating team is fundamental to such treatment. If the person does not believe that there is some prospect of liberation from the order by proper and continuing engagement with the treating team, then the person may well begin to conceive of the order as a punishment, and disengage from treatment. Once disengagement occurs any risk from the illness increases.

Therefore, fixed-term forensic orders have a distinct prospect of increasing risk.

<u>Chapter 6, Powers of courts hearing criminal proceedings and related processes, with particular consideration of Part two, regarding Magistrates' Courts</u>

It is important for magistrates to have a provision allowing consideration of unsoundness of mind or fitness for trial. The common law currently provides same, but statutory provisions augmenting the common law may provide additional support.

However, the proposed amendments fall short, because the vast majority of persons on involuntary orders appearing as defendants before magistrates will not be subject to expert psychiatric reports on their criminal responsibility or fitness for trial. Rather, the Department hopes that reports from Mental Health Liaison Officers of the Court Liaison Service will be sufficient to allow magistrates to determine these fundamental issues. However:

a. Court Liaison Officers are not expert to make such determinations, so legal challenge to their findings will be made; and
b. The Court Liaison Service may not be adequately funded to properly report on the multitude of persons appearing before each of the Magistrates' Courts.
    a. Allied to this issue is the fact that there are a many conditions, outside the remit of the expertise of mental health services that impact on criminal responsibility and fitness for trial. These would include intellectual disability, developmental disability, acquired brain injury and dementia.

As a result of these deficiencies, a great many persons may pass through the Magistrates' Court without proper determination of their mental condition.

Some of the proposed amendments are not as the Department claims principally informed by a desire to enhance the human rights of mentally ill persons. For some people, there is a real risk that their mental illness or condition may go undetected, resulting, unfairly in them being diverted down a criminal justice path when care and treatment are required. Regrettably, this diminishes us as a civilised society, in particular the cohort of mentally ill persons, will bear the moral, emotional and financial cost of the proposed amendments, in many instances.

Thank you again for the opportunity to provide these comments and we look forward to continuing to engage in the policy and legislative process.

Should you wish to discuss these matters further, please do not hesitate to contact me. If you require clarification of any of the issues raised in our letter, please contact our Senior Policy Solicitor, Ms Binari De Saram on [redacted].