Submission No: 073

public guardian

Queensland Parliament
Health and Ambulance Services Committee

Submission on the Mental Health Bill 2015

Public Guardian
October 2015

About the Office of the Public Guardian

On 1 July 2014, the OPG was established as a new independent statutory body to protect the rights and well-being of vulnerable adults with impaired decision-making capacity, and children and young people in out-of-home care (foster care, kinship care, residential care) and youth detention. This new statutory body was created as a result of the acceptance by Government of recommendations contained in the report from the Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection*.[1]

The OPG combines roles that were previously separately undertaken by the Office of the Adult Guardian, and the community visitor function of the former Commission for Children and Young People and Child Guardian.

The OPG supports children and young people through two specific programs:

- the community visitor program, which aims to ensure children and young people in out-of-home care are safe and are being properly cared for, and
- the child advocate program, which gives children engaged with the child protection system an independent voice, ensuring their views are taken into consideration when decisions are made that affect them.

The *Child Protection Act 1999*, section 74 and Schedule 1, sets out the Charter of rights for a child in care. This Charter establishes core rights that apply to every child and young person who is in the child protection system in Queensland, including the right to be provided with a safe and stable living environment, and to be placed in care that best meets their needs, and is culturally appropriate.

The OPG also works to protect the rights and interests of adults who have impaired capacity to make their own decisions, recognizing that everyone should be treated equally, regardless of their state of mind or health.

OPG's charter with respect to adults with impaired capacity is to:

- make personal and health decisions if OPG is their guardian
- make health decisions as the statutory health attorney of last resort
- investigate allegations of abuse, neglect or exploitation
- advocate and mediate for people with impaired capacity, and
- educate the public on the guardianship and attorney systems.

The OPG also provides an important protective role in Queensland by administering a community visitor program to protect the rights and interests of the adult if they reside at a visitable site.

Visitable sites for children and adult community visitors include mental health services authorised under the *Mental Health Act 2000.*

The *Public Guardian Act 2014* and *Guardianship and Administration Act 2000* set out OPG's legislative functions and powers, and the *Powers of Attorney Act 1998* regulates the authority for adults to appoint representative decision-makers, and who can act as statutory health attorneys.

[1] Recommendation 12.7, Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection*, June 2013 available at http://www.childprotectioninquiry.qld.gov.au/publications.

Engagement of the Office of the Public Guardian in the review of the *Mental Health Act 2000*

The Office of the Public Guardian (OPG) has engaged closely with Queensland Health and other agencies during the review of the *Mental Health Act 2000* (MHA). The Bill is a critical piece of legislation for the operation of the OPG. If passed by Parliament into law, the Bill will impact upon many clients and specific functions of the OPG. During the consultation process, the OPG has sought to ensure the protection of the rights and interests of adults with impaired capacity and children and young people who fall within the jurisdiction of the Mental Health Bill 2015 (the Bill).

The OPG is generally supportive of the Bill. There are many positive reforms proposed under the Bill that will provide greater recognition to the rights of persons with mental illness, strengthen the role of supporters, and encourage a focus upon the recovery of persons with mental illness.

A key aspect of the OPG's engagement in the consultation process has been to ensure that the Bill proposes principles and practices that are consistent with, and complement the *Public Guardian Act 2014* (PGA), the *Guardianship and Administration Act 2000* (GAA), and the *Powers of Attorney Act 1998* (PoAA), which regulate the functions and responsibilities of the OPG.

There are five primary areas of interaction between the role of OPG and the principles and practices provided for in the Bill (which are explored in detail later in this submission).

First, under the community visitor program one of the sites[2] that community visitors must visit is a mental health service authorised under the MHA. The main function of the community visitor program is to protect the rights and interests of children and young people, and adults with impaired capacity, residing at these mental health facilities.

Second, many guardianship clients of the public guardian will fall within the purview of the proposed Bill if they have a mental illness. They may be deemed to be unable to provide informed consent to their own mental health treatment and care, and a guardian may be requested to consent to treatment in accordance with the new 'less restrictive way' proposed by the Bill.

Third, guardianship clients may come into contact with the criminal justice system and face prosecution in the courts. In such circumstances, depending upon the seriousness of the offence, they may either be diverted from the criminal justice system in the Magistrate's Court, or be subject to the jurisdiction of the Mental Health Court, where they may be found to have been of unsound mind at the time of an alleged offence, or unfit for trial, and be made the subject of a forensic order.

Fourth, the OPG is the decision-maker of last resort under the statutory health attorney hierarchy of decision-makers.[3] The OPG may therefore be requested to act as statutory health attorney and consent to mental health treatment and care, where under current legislation, involuntary treatment would be ordered by a medical practitioner.

[2] See the *Public Guardian Act 2014,* section 51 (child visitable sites), section 39 (adult visitable sites).
[3] *Powers of Attorney Act 1998*, section 63(2).

Fifth, the OPG has a discretionary power to investigate any complaint or allegation that an adult with impaired decision-making capacity is being, or has been, neglected, exploited or abused, or has inappropriate or inadequate decision-making arrangements.[4]

Mental illness is a condition that can be episodic, and often requires long term, ongoing treatment and care. Given that in 2013-14 there were 6,601 involuntary treatment orders made,[5] it is highly probable that under the 'less restrictive way', far greater use will be made of guardians and attorneys to provide consent to psychiatric treatment and care.

Under the 'less restrictive way', there are likely to be more guardians and attorneys exercising a decision-making power in relation to mental health treatment and care. As such, there is a heightened risk that these powers may be exercised inappropriately, and therefore may require investigation by the OPG. The impact of these last two proposals may impact significantly upon the resources of the OPG.

Background

Legislative recognition of fundamental human rights

Capacity based legislation, such as mental health legislation and guardianship legislation should be underpinned by a strong human rights framework. The contemporary international standard for human rights for persons with disability (mental, physical, intellectual or cognitive) is articulated in the United Nations *Convention on the Rights of Persons with Disabilities* [6] (the Convention). Reforms relating to persons with impaired capacity, whether due to mental illness, intellectual or cognitive disability, should ensure these rights are legislatively protected, recognised and enshrined as enforceable rights, in line with Australia's international obligations under the Convention.[7]

Article 12 of the Convention re-affirms the fundamental human right that a person with disability has the right to make their own decisions, and should be provided with decision-making support where required rather than have another person make substituted decisions on their behalf. The Australian Law Reform Commission in its report *Equality, Capacity and Disability in Commonwealth Laws*[8] proposed a rights based approach to decision-making support, arguing for a shift in focus in capacity based laws away from substitute decision-making towards laws that support a person to make their own decisions. This supported decision-making model maximizes the rights of the individual with a mental, intellectual or cognitive disability, and requires society to provide effective mechanisms to support the individual to make decisions for themselves.

[4] *Public Guardian Act 2014,* section 19.
[5] Queensland Health, *Annual Report of the Director of Mental Health 2013-2014*, page 28.
[6] Australia formally ratified the *Convention on the Rights of Persons with Disabilities* on 17 July 2008, see https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en#EndDec .
[7] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (ALRC Report 124), November 2014, available at https://www.alrc.gov.au/publications/equality-capacity-disability-report-124; see also see P. Gooding, 'Supported Decision-Making: A Rights-Based Disability Concept and its Implications for Mental Health Law', *Journal of Psychiatry, Psychology and Law*, 20:3 (2013), 431-451; and also the majority of articles in B. McSherry and P. Weller eds., *Rethinking Rights-Based Mental Health Laws,* Oxford, Hart, 2010 and the emphasis upon human rights in mental health laws.
[8] Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (ALRC Report 124), November 2014, available at https://www.alrc.gov.au/publications/equality-capacity-disability-report-124 .

These rights should be enshrined in law, and should be consistent with existing legislation that protects the human rights and interests of persons with impaired capacity, such as are currently articulated under the GAA and PoAA. In particular:

- the right of an adult to make decisions is fundamental to the adult's inherent dignity, including the right to make decisions with which others may not agree (s.5(b) GAA)
- the right of an adult with impaired capacity to make decisions should be restricted, and interfered with, to the least extent possible (s.5(d) GAA)
- an adult with impaired capacity has the right to adequate and appropriate support for decision-making (s.5(e) GAA).

Further, decisions regarding treatment and care should seek to strike an appropriate balance between the right of the adult with impaired capacity to have the greatest possible degree of autonomy in decision making, and their right to adequate and appropriate support to do so (s.6 GAA).

Recognition of human rights should be on an equal basis with others

It is imperative that persons with a disability have their rights recognized on an equal basis with others in the community, and that a person with one disability (eg., mental illness) should not be treated differently from another disability (eg., intellectual or cognitive disability). The Bill includes forensic provisions which impact persons with mental illness, as well as persons with a sole diagnosis of intellectual disability. The OPG is committed to the principle that where rights or opportunities are afforded to persons with mental illness, equivalent rights should be afforded to persons with intellectual or cognitive disability who are offenders or alleged offenders of unsound mind, or unfit for trial.

The rights and interests of the most vulnerable children and young people should be strongly protected

Finally, in keeping with the mandate of the Queensland Child Protection Commission of Inquiry,[9] the OPG is committed to focusing upon the protection of the rights and interests of those children and young people who are deemed most vulnerable. For the OPG, minors who are resident in an authorised mental health service (AMHS), are already considered vulnerable. When a minor is transferred to an adult or high secure facility, they are then deemed to be highly vulnerable. It is crucial that the rights and interests of these minors are protected as strongly as possible.

Mental Health Bill

Notification of admissions of minor to a high secure unit or adult facility

On 1 July 2014 the Office of the Public Guardian (OPG) took over the community visitor program for children and young people from the Commission for Children and Young People and Child Guardian, with the role expanded to include a child advocacy function. This role includes visiting children and young people in the child protection system, and visiting children and young people at visitable sites, such as mental health services authorised under the MHA. In relation to the latter, the role of the Public Guardian is to inspect the AMHS and report on its appropriateness for the accommodation of the child or the delivery of services to the child or young person, having regard to relevant State and Commonwealth laws, policies and standards, and ensure the child's needs are being met by staff members at the AMHS.[10]

[9] See Recommendation 12.8, Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection*, June 2013 available at http://www.childprotectioninquiry.qld.gov.au/publications.
[10] *Public Guardian Act 2014*, section 56(g).

The Queensland Child Protection Commission of Inquiry report *Taking Responsibility: A Roadmap for Queensland Child Protection* highlighted the importance of the community visiting program, recommending that resources be focused upon those children and young people who were deemed most vulnerable. [11]

Under the Bill, a minor might be admitted to a high secure unit or adult facility. While Queensland Health noted in the public hearing before the Health and Ambulance Services Committee on 14 October 2015 that this is not a routine occurrence, this *may* occur in circumstances of last resort. Notably, it may occur in circumstances where the minor's behavior is too difficult to manage in a pediatric ward, or they are deemed to be a high risk to the safety of others.

Children or young people admitted to high secure units, where they are located with adults who pose either a high risk to themselves or the community, places children and young people at considerable risk and makes these minors highly vulnerable. Given the statutory responsibilities of the Public Guardian, it is critical that there is a legislative requirement that the OPG is notified as soon as a child or young person is admitted to a high secure unit, so that the child or young person can be prioritized for visitation and monitoring by community visitors while they are in a unit intended for adults.

Recommendation: **The Bill should include a requirement for notification to the Public Guardian as soon as a minor is admitted to a high secure unit, or adult facility.**

Notification on the use of restrictive practices on minors

Queensland is known for its commitment to the strict regulation of the use of restrictive practices within disability services in order to protect, as far as possible, the rights of a person with disability who is subject to the use of such practices. For example, in section 80ZE of the GAA, a guardian is permitted to approve the use of restrictive practices *only* if strict conditions are complied with. This is an essential element of protection of human rights in the restrictive practices regime. These strict legislative provisions were made in recognition that a guardian's consent to the use of restrictive practices will result in a person being subjected to chemical, physical or mechanical restraint against their will, and as such amounts to a significant infringement upon their fundamental human rights. It is noted that the Bill does not provide the same commitment to strict legislative oversight of restrictive practices in mental health services, as is articulated in the GAA and the *Disability Services Act 2006* (DSA) for disability services.

One of the issues for OPG community visitors and child advocates visiting an AMHS relates to the treatment and care of minors who are subjected to restrictive practices. The OPG will advocate for the minimum use of restrictive practices on minors and where possible, the elimination of the use of restrictive practices on minors.

Under the Bill, minors may be subjected to the use of restrictive practices. When these practices are authorised or used it is essential that the Public Guardian is advised. This enables the Public Guardian to fulfil its statutory role of providing independent monitoring and protection of the rights of these vulnerable minors and to ensure that the child's needs are being met.

Another critical reason for notification to the Public Guardian is in situations where the OPG is appointed by the Queensland Civil and Administrative Tribunal (QCAT) as guardian for a young person aged 17 ½. This may occur

[11] Queensland Child Protection Commission of Inquiry (Child Protection Inquiry) *Taking Responsibility: A Roadmap for Queensland Child Protection*, June 2013 available at http://www.childprotectioninquiry.qld.gov.au/publications. See Recommendation 12.8 "That the role of Child Guardian – operating from Statewide 'advocacy hubs' that are readily accessible to children and young people, assume the responsibilities of the child protection community visitors and re-focus on young people who are considered most vulnerable".

in anticipation of being guardian when the young person turns 18 years of age. If that person has an intellectual disability and is admitted to an AMHS, there are potentially two different and conflicting restrictive practices regimes that may apply. This may be either as part of a treatment regime under the Bill, and the person may also be subject to a personalized behaviour support program under the provisions of the GAA and DSA.

It is for these two reasons the OPG considers that there should be legislative requirements that the Public Guardian is notified whenever restrictive practices are authorised or used on a minor in an AMHS. This will support the Public Guardian's statutory role as community visitor or child advocate for minors at visitable sites, and/or where the Public Guardian is guardian for a young person.

Recommendation: **The Bill should include a requirement for automatic notification to the Public Guardian where restrictive practices (seclusion, physical or mechanical restraint) are authorised or used with respect to a minor.**

Interaction with the Guardianship system

Recommendation:	**A review of the implementation of the provisions relating to the proposed 'less restrictive way' of authorising mental health treatment and care should be undertaken 18 months after the Bill comes into force.**

The Bill provides for a new concept of a 'less restrictive way' for a person to receive treatment and care for their mental illness.[12]

Under the Bill, the 'less restrictive way' of treating a person who cannot consent is for the treatment to be authorised under the health care provisions of the *Guardianship and Administration Act 2000* (GAA). That is, treatment may be authorised:

a) through a person's advance health directive, in which the person expresses their views and wishes about what mental health treatment they wish or do not wish to receive, and had expressed these wishes at a point in time when they had capacity

b) by a guardian appointed by QCAT to make health care decisions on behalf of the person

c) by an attorney nominated by the person in an enduring document (such as an enduring power of attorney) to make health care decisions for them or

d) by a third party (such as a family member or friend) who consents to treatment on behalf of the person, and who does so on an informal basis and without an appointment (that is, as statutory health attorney[13]).

The universally recognised use of the term 'least restrictive' refers to the practices applied to the person, and the level of restriction which these practices impose on the person's rights, liberty or autonomy[14], rather than the legal mechanism whereby treatment is authorised. Whether treatment is authorised under a treatment authority or via an advance health directive, guardian or attorney, has no bearing on what treatment or practices are applied; it refers only to the legal mechanism of the treatment's authorisation.

Under the Bill, consideration must be had to whether treatment can be authorised via one of the above mechanisms, before a treatment authority can be made. That is, a treatment authority can be made only if the

[12] Clause 13, Mental Health Bill 2015.
[13] *Powers of Attorney Act 1998*, section 63.
[14] For example, under Clause 3(3), Mental Health Bill 2015.

treatment cannot be authorised through an advance health directive, by an appointed guardian or attorney, or by a statutory health attorney[15].

This represents a significant shift in the system of involuntary mental health treatment in Queensland, particularly in relation to people who are detained for the purpose of receiving treatment involuntarily, and who are detained on an ongoing basis for some time. The MHA and the GAA, both introduced in the same year, were intended to be complementary pieces of legislation (the GAA to provide for decision-making for persons with impaired capacity for a matter, and the MHA to provide for the involuntary assessment, treatment, care and protection of persons with mental illness).

Under the statutory health attorney provisions of the legislation, the Public Guardian is the "statutory health attorney of last resort" for all Queensland adults[16]. In effect, these provisions ensure there is for every Queensland adult, an attorney available to consent to healthcare, if required. Under the Bill, with the preference for the use of the less restrictive way, this creates the potentiality for increased reliance on the guardianship system, and consequential resource impacts.

Noting the potential for the operation of the new mechanisms to authorise mental health treatment and care to lead to an increase in reliance on the consent of attorneys and guardians, it is recommended that a review of the operation of the provisions be undertaken after the provisions have been in effect for eighteen months. The review should consider, among other things, data in relation to the number of consents provided by guardians and attorneys, particularly private statutory health attorneys. It should also consider the average length of time a person is subject to treatment authorised via the 'less restrictive way' approach.

Such a review would be particularly important should other recommendations in this paper, relating to the different levels of protections afforded to 'involuntary patients' under the Bill, compared to patients who may be treated with the authority of an advance health directive, or consent by a guardian or attorney, not be effected.

A review would also ensure consideration is given to any resource implications associated with implementation of the Bill.

Regulation of the use of 'less restrictive way' should be legislated and not in policy

The Bill requires the Chief Psychiatrist to make a policy relating to the treatment and care of patients whose treatment is authorised by an advance health directive, guardian or attorney[17]. In deciding whether a person should be treated under a Treatment Authority or as authorised by an advance health directive, guardian or attorney, the doctor must comply with this policy[18].

The Bill contains no requirements or prescriptions in relation to this policy; the policy is left to the sole discretion of the Chief Psychiatrist. The use of a policy mechanism to determine the basis for a person's treatment, including what safeguards they are afforded – rather than incorporating this in legislation – may lead to a two-tiered system for involuntary mental health treatment in Queensland. A policy safeguard is a weaker form of protection than a legislative safeguard. There is potential under the Bill for patients to be afforded different levels of rights protections, based on how their treatment has been authorised. Appendix A sets out a potential scenario regarding the differences between involuntary treatment and care under the current MHA and the Bill, and the 'less restrictive way' (statutory health attorney) as proposed under the Bill.

[15] Clause 18(2), Mental Health Bill 2015.
[16] *Guardianship and Administration Act 2000*, section 66 and *Powers of Attorney Act 1998*, section 63.
[17] Clause 303, Mental Health Bill 2015.
[18] Clause 13(2), Mental Health Bill 2015.

The Public Guardian is of the view that the following issues, in particular, should be addressed in the legislation, to provide enforceable rights for patients and clear parameters and protections for health practitioners, and not left to policy.

1. Equivalent legislative requirements for all patients

In the Bill, a person receiving treatment which has been authorised under an advance health directive or by a guardian or attorney is excluded from the definition of 'involuntary patient'.[19] The implication of this is that a range of legislative obligations on doctors and mental health services, and a range of safeguards afforded to other categories of involuntary patients under the Bill do not apply to people whose treatment has been authorised as healthcare under guardianship legislation.

The most significant safeguard which is not available to this group of patients is the independent scrutiny and review of the Mental Health Review Tribunal.[20] The Tribunal is independent of the treating mental health service, the authorised doctor, and the Chief Psychiatrist. It is a critical, external mechanism of review designed to protect the fundamental human rights of people who are being detained against their will for treatment.

For example, it is not clear under the Bill if a person whose treatment has been authorised under an advance health directive, or by a guardian or attorney (including under the consent of a family member acting informally as the person's statutory health attorney) may be detained in a mental health facility to receive treatment. This detention may extend for some time, and without external review by the Tribunal as to and the person's ongoing need for treatment, including whether the person should continue to be detained against their will for treatment.

The Bill contains mandatory requirements which govern the application of Examination Authorities and Treatment Authorities, however the same protections do not apply where consent is provided by an advance health directive, or a guardian or attorney. For example, the following safeguards apply to a person who is subject to an Examination Authority:

- Only force that is "necessary and reasonable in the circumstances" may be used to enable a person to be examined[21]
- The doctor must provide a copy of the Examination Authority to the person's nominated support person or guardian/attorney, and take a number of other steps, before the doctor exercises examination powers under the Bill[22]
- A person may be detained for a maximum of only 1 hour in order for a doctor to make a recommendation that an assessment be undertaken[23]
- The doctor must make the recommendation for assessment within 7 days after the examination[24], and

[19] Clause 11, Mental Health Bill 2015.
[20] Clause 28, Mental Health Bill 2015.
[21] Clause 33, Mental Health Bill 2015.
[22] Clause 35, Mental Health Bill 2015.
[23] Clause 36(2), Mental Health Bill 2015.
[24] Clause 39(2), Mental Health Bill 2015.

- If the doctor recommends the person for assessment, the person may be detained for assessment for not more than 24 hours[25].

Treatment Authorities are subject to a series of safeguards set out in the Bill, including:

- Only an authorised doctor may make a treatment authority[26]
- When making a treatment authority, the doctor must consider whether the patient can be treated in the community, rather than as an inpatient, and an inpatient treatment authority can only be made in certain limited circumstances[27]
- When making an inpatient treatment authority, the doctor must consider whether limited community treatment should be authorised[28]
- If a treatment authority is made by a doctor who is not a psychiatrist, it must be reviewed by a psychiatrist within 3 days of the authority having been made[29], and
- A person subject to a treatment authority must be regularly assessed to decide if the treatment authority should continue.[30]

All patients being treated under an advance health directive, or with the consent of a guardian or attorney, or in accordance with a treatment authority under the Bill must be subject to the same set of safeguards regardless of how their treatment is authorised.

It should also be clear in the legislation that guardians and attorneys should not be able to consent to the restriction of liberty, such as the use of any restrictive practices, enforced detention, or searches of the patient.

Recommendations: **The Bill should provide that treatment and care should not be able to be provided to a person involuntarily (such as through their detention in a health facility), where this treatment has been authorised on the basis of a guardian or attorney's consent. The Bill should expressly provide that guardians and attorneys should not be able to consent to detention, or restrictions on a person's liberty, or property.**

If the above recommendation is not accepted, then it is recommended that the Bill should provide that where people whose treatment has been authorised under an advance health directive or by a guardian or attorney, they should be subject to the same set of safeguards as other people who are under a treatment authority, including the review processes of the Mental Health Review Tribunal.

2. Advance Health Directives

The Public Guardian supports the proposed role of advance health directives in relation to the provision of mental health treatment. An advance health directive is an important tool for a person to articulate their views and wishes about the treatment they wish or do not wish to receive, and should uphold a person's fundamental right to exercise autonomy over the health care they receive. The Public Guardian is committed to fostering greater take-up of advance health directives in the Queensland community.

[25] Clause 45(1), Mental Health Bill 2015.
[26] Clause 49, Mental Health Bill 2015.
[27] Clause 51, Mental Health Bill 2015.
[28] Clause 52, Mental Health Bill 2015.
[29] Clause 56, Mental Health Bill 2015.
[30] Clause 23(2), Mental Health Bill 2015.

Under the Bill, an advance health directive may be overridden by the authorised doctor[31], however the Bill provides very little in the way of accountability or oversight of the doctor's decision in situations where a person's expressed wishes are overridden. The Bill states no requirements as to when or why an advance health directive may be overridden. The protections are particularly weak relative to Victorian legislation, as previously documented by the Queensland Mental Health Commissioner.[32]

If mental health care and treatment is to be authorised under an advance health directive, it must be subject to the same legislative requirements that govern all advance health directives, and this must be enshrined in the mental health legislation.

Specifically, the legislation must make reference to the requirements of the PoAA, under which an advance health directive may be overridden only when a direction in the advance health directive is '*uncertain or inconsistent with good medical practice or [when] circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate*'[33].

As discussed earlier, a range of safeguards which apply to 'involuntary patients' will not apply to a patient whose treatment is authorised by an advance health directive, including the scrutiny of the Mental Health Review Tribunal.

To provide for the protections which apply to an 'involuntary patient' under the Bill, it is recommended that a person treated involuntarily, and whose treatment has been authorised on the basis of a direction specified in their advance health directive, should be included within the definition of 'involuntary patient'.

Recommendations:

The Bill should provide that treatment and care provided to a person involuntarily (such as through their detention in a health facility) should not be able to be authorised on the basis of an advance health directive, unless the advance health directive includes an express direction authorising that their treatment and care can be given involuntarily.

The Bill should mirror the requirements in the PoAA which provide that an advance health directive may only be overridden when a direction in the advance health directive is uncertain or inconsistent with good medical practice or when circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate.

Where involuntary treatment and care has been authorised on the basis of a person's advance health directive, such treatment should be included within the definition of 'involuntary patient' in the Bill and be subject to the same provisions and protections afforded to other categories of involuntary treatment, including review by the Mental Health Review Tribunal.

Less restrictive forensic orders for person with intellectual disability

Queensland Health stated in the public hearing before the Health and Ambulance Services Committee on 14 October 2015 that during the review of the MHA they identified a lack of step down orders as an alternative to the Mental Health Court making a restrictive forensic order. The Bill therefore creates a new and less restrictive

[31] Clause 54, Mental Health Bill 2015.
[32] p.17, *Mental Health Bill 2015: Submission to the Department of Health on the Consultation Draft Bill* (June 2015), Qld Mental Health Commissioner
[33] Powers of Attorney Act 1998 , s.103.

order, namely, a treatment support order[34] which can be ordered by the Mental Health Court in lieu of making a forensic order. The OPG strongly supports this measure.

However the OPG is deeply concerned that this step down order applies *only* to persons with mental illness. A person who is found to be of unsound mind or unfit for trial *due to an intellectual disability*, and does not need treatment and care for a mental illness (clause 143(3)) cannot receive any order other than a forensic order. No alternative step down order is provided for within the Bill for persons with a sole diagnosis of intellectual disability.

It is inequitable that there is no equivalent step down provision for persons with a sole diagnosis of intellectual disability. The Bill should be amended to provide that a person with a sole diagnosis of intellectual disability has the same opportunity for receiving a less restrictive forensic order, as a person with mental illness.

Recommendation: **The Bill should provide a step down order for persons with a sole diagnosis of intellectual disability that is equivalent to the treatment support order for persons with mental illness.**

The OPG would be pleased to lend any additional support as development of the Bill is progressed. Should clarification be required regarding any issues raised, the OPG would be happy to make representatives available for further discussions.

[34] Clause 143, Mental Health Bill 2015.

Summary of Recommendations

Recommendation 1: **The Bill should include a requirement for notification to the Public Guardian as soon as a minor is admitted to a high secure unit, or adult facility.**

Recommendation 2: **The Bill should include a requirement for automatic notification to the Public Guardian where restrictive practices (seclusion, physical or mechanical restraint) are authorised or used with respect to a minor.**

Recommendation 3: **A review of the implementation of the provisions relating to the proposed 'less restrictive way' of authorising mental health treatment and care should be undertaken 18 months after the Bill comes into force.**

Recommendation 4: **The Bill should provide that treatment and care should not be able to be provided to a person involuntarily (such as through their detention in a health facility), where this treatment has been authorised on the basis of a guardian or attorney's consent. The Bill should expressly provide that guardians and attorneys should not be able to consent to detention, or restrictions on a person's liberty, or property.**

Recommendation 5: **If the above recommendation is not accepted, then it is recommended that the Bill should provide that where people whose treatment has been authorised under an advance health directive or by a guardian or attorney, they should be subject to the same set of safeguards as other people who are under a treatment authority, including the review processes of the Mental Health Review Tribunal.**

Recommendation 6: **The Bill should provide that treatment and care provided to a person involuntarily (such as through their detention in a health facility) should not be able to be authorised on the basis of an advance health directive, unless the advance health directive includes an express direction authorising that their treatment and care can be given involuntarily.**

Recommendation 7: **The Bill should mirror the requirements in the PoAA which provide that an advance health directive may only be overridden when a direction in the advance health directive is uncertain or inconsistent with good medical practice or when circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate.**

Recommendation 8: **Where involuntary treatment and care has been authorised on the basis of a person's advance health directive, such treatment should be included within the definition of 'involuntary patient' in the Bill and be subject to the same provisions and protections afforded to other categories of involuntary treatment, including review by the Mental Health Review Tribunal.**

Recommendation 9: **The Bill should provide a step down order for persons with a sole diagnosis of intellectual disability that is equivalent to the treatment support order for persons with mental illness.**

Appendix A - Mental Health Bill 2015 Case Study

Case study:
Mr M is a 25 year old male with a history of schizophrenia. Mr M lives at home with parents and siblings in a supportive environment. He is studying at university and works part time in customer service. He also has a large group of friends. He is usually compliant with medications, however has required two involuntary emergency admissions due to his mental illness in the last five years. After each admission, a successful medication regime has been established and Mr M has resumed normal activities.

Mr M is brought into the emergency department of the local hospital in Brisbane after having been verbally abusive in public.

The examples below examine how Mr M would be treated where he does not have capacity to consent to treatment and care under the current Act, and under the Bill through the 'less restrictive way' (statutory health attorney), or a treatment authority.

Mental Health Act 2000 ***Involuntary treatment order***	***Mental Health Bill 2015*** ***'less restrictive way'*** **(statutory health attorney)**	***Mental Health Bill 2015*** ***Treatment authority***
Mr M is brought to the emergency department by ambulance officers under an emergency examination order. On arrival at the emergency department, Mr M is assessed by an authorised doctor and immediately placed under an involuntary treatment order. Mr M is admitted as an inpatient in the mental health unit for monitoring and medication review. Mr M objects to being kept in the mental health unit and objects to being forced to take his medication. He absconds from the ward, without leave, on several occasions.	Mr M is brought to the emergency department by ambulance officers under an examination authority. Under the **less restrictive way** Mr M's parents are contacted by an emergency department doctor as his statutory health attorneys to consent to his mental health treatment and care. The doctor is not an authorised doctor under the Bill, and there is no legislative requirement that an authorised doctor or psychiatrist review Mr M prior to consent being received from his parents. The parents are not clear what information they need to give the doctor, and are not	Mr M is brought to the emergency department by ambulance officers under an examination authority. Mr M arrives at the emergency department and his parents (as his statutory health attorneys) do not consent to him receiving the administration of medications that doctors consider are clinically necessary for his treatment and care. Mr M is examined by an authorised doctor and placed under a treatment authority. As the authorised doctor who made the authority is not a psychiatrist, the treatment

Appendix A - Mental Health Bill 2015 Case Study

On these occasions, he was returned by police to the mental health unit under the involuntary treatment order. Mr M requires long term involuntary treatment and care. Mr M has had some, limited community treatment, during which time he took his medications. However, he has remained as an inpatient in the hospital for a total of 8 months. Mr M has his involuntary treatment order reviewed after 6 weeks of the making of the involuntary treatment order, and it is required to be reviewed every 6 months thereafter by the Mental Health Review Tribunal. During his time as an inpatient, he had the initial review and a subsequent review. The order was revoked shortly after his second review.	sure what information they are entitled to receive from the doctor in order to consent to mental health treatment. However, they consent to treatment as they want their son to get better. Mr M is admitted as a patient to the mental health unit. Mr M objects to being kept in the mental health unit, and objects to being forced to take his medication. He attempts to leave the ward on several occasions. He would like to have treatment in the community, rather than be kept as an inpatient. The patient remains an inpatient of the mental health unit for 8 months under the original consent of the statutory health attorney. There is no legislated review or assessment by the Mental Health Review Tribunal (or any other body) for the entirety of his stay, as to whether the consent to inpatient care as provided under the statutory health attorney remains appropriate.[1] Mr M is finally discharged into the community after 8 months as an inpatient. His statutory health attorneys are not aware	authority is reviewed by a psychiatrist within 3 days. The doctor must ensure that the treatment authority complies with the following: • Must be in an approved form • State the treatment criteria • The mental health service responsible • The category (inpatient, community, limited community treatment) • If inpatient category, consideration must be given to community treatment • Nature and extent of the treatment and care • Any conditions considered necessary As Mr M is an inpatient, consideration must be given to reasons his treatment and care cannot be met in the community. Under the Bill, the nature and extent of the treatment and care must be discussed with Mr M and regard must be had to his views, wishes and preferences. Within seven days after Mr M is placed under the treatment authority, the Mental

[1] Note: if the consent had been provided by a guardian, they may have been appointed for a term of 1 to 5 years, and at the end of the appointment period there would be a review by QCAT to determine whether the appointment should be ended, revoked or changed.

	of this as there is no requirement that they be notified.	Health Review Tribunal is notified that a treatment authority has been made for Mr M. The Mental Health Review Tribunal schedules a review of Mr M's treatment authority within 28 days. As Mr M remains on a treatment authority for in excess of 6 months, the Mental Health Tribunal schedules a further review of his treatment authority, 6 months after his first review.