

Mental Health Act 2000 (Qld)

Submission to the Queensland Government
for the review of the Mental Health Act
2000 (Qld) – Second Round of Consultation

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Mental Health Law Practice

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Introduction

Queensland Public Interest Law Clearing House's (QPILCH) Mental Health Law Practice (MHLP) welcomes the opportunity to make submissions during this second round of consultation for the review of the *Mental Health Act 2000* (Qld) ("the Act").

With the prevalence of mental illness in the community and the increasing rates of people on ITOs, mental illness is an increasing burden on both the health and legal systems. The existing system works a majority of the time, however there are significant issues that remain to be addressed. It is absolutely vital that the proposed amendments to the Act address these issues. Should the amendments fail to achieve this, the mental health system will continue to be an unnecessary burden on people who experience mental ill-health, the community and the health and legal systems.

Throughout this submission we have responded directly to the questions posed in the Discussion Paper, commented on the details of the recommendations in the Discussion Paper, or offered new ideas or alternative recommendations in relation to the proposed amendments to the Act. Given the MHLP primarily assists people who are subject to involuntary treatment orders ("ITO"), and , our recommendations focus on to the proposed amendments to provisions relating to involuntary treatment under ITOs, rather than forensic orders.

A list of our additional recommendations is provided below, followed by a detailed discussion of each recommendation.

List of QPILCH Recommendations

Involuntary Examination & Assessment

QPILCH Recommendation 1 – The Act should require that, where practicable, upon a person’s application for an involuntary examination authority, an “involuntary examination statement” be served on the person who is the subject of the application, explaining:

- (a) that the person is the subject of an application for an involuntary examination authority;
- (b) the involuntary examination application process;
- (c) the consequences for the person if an involuntary examination authority is ordered;
- (d) that the person should seek voluntary examination of their mental health by a doctor or authorised mental health practitioner within the next 7 days and the consequences of the person failing to do so;
- (e) that there are concerns about the person’s mental health and that a doctor or authorised mental health practitioner may provide the person with options to maintain or improve their mental wellbeing;
- (f) that the doctor or authorised mental health practitioner may recommend to the person that they accept treatment and care for their mental health, and the consequences of the person failing to comply with this recommendation; and
- (g) the consequences of the person absconding to another state or overseas during this period.

QPILCH Recommendation 2 – If the person presents before a doctor or authorised mental health practitioner voluntarily, the doctor or authorised mental health practitioner who examines the person should be required to:

- (a) immediately notify the relevant magistrate or authorised justice of the peace that the person has presented for examination of their mental health;
- (b) document this examination and as soon as practicable, and no later than 7 days after the person presents for examination, provide this document to the magistrate or authorised justice of the peace together with a written recommendation in relation to whether an involuntary examination authority should or should not be ordered for the person.

QPILCH Recommendation 3 – As an alternative to Recommendation 2(b), the person who has presented to the authorised mental health practitioner or doctor be required to:

- (a) document the advice given by the authorised mental health practitioner or doctor;
- (b) obtain certification from the authorised mental health practitioner or doctor that the documented advice is accurate; and
- (c) provide this document to the magistrate or justice of the peace no later than 7 days after the person presented for examination.

QPILCH Recommendation 4 – If the person does not present to a doctor or authorised mental health practitioner within 7 days, the magistrate or justice of the peace must then obtain oral or written advice from a doctor, as per recommendation 1.5 of the Discussion Paper.

Treatment Criteria

QPILCH Recommendation 5 – The treatment criteria should contain, in addition to the criteria outlined in recommendation 1.17 of the Discussion Paper, a requirement that there is no less restrictive means reasonably available to ensure that:

- (a) the person receives appropriate treatment and care for his or her mental illness; and
- (b) the risk of the person causing imminent serious harm to himself, herself or someone else, or suffering serious mental or physical deterioration, does not materialise.

QPILCH Recommendation 6 – Recommendation 1.19 of the Discussion Paper should be amended to read, “An authorised psychiatrist may maintain a person on an involuntary treatment order, notwithstanding that a person appears to have capacity to consent, if the psychiatrist reasonably believes that:

- (a) revoking the order is likely to result in the person:
 - i. causing *serious* harm to himself, herself or someone else; or
 - ii. suffering serious mental or physical deterioration; and
- (b) there is no less restrictive means reasonably available to ensure that these risks do not materialise.”

QPILCH Recommendation 7 – In addition to the above recommendations, the psychiatrist should be required to obtain a second opinion from another psychiatrist which confirms that there is a likely risk of serious harm.

QPILCH Recommendation 8 – The Act should more clearly define what constitutes ‘treatment’ under the Act.

QPILCH Recommendation 9 – The Director of Mental Health should be required to publish detailed guidelines on the assessment of ‘risk’ and ‘imminent risk’.

Mental Health Review Tribunal

QPILCH Recommendation 10 – ITO review hearings should be conducted by the Tribunal at six weeks, three months, six months, 12 months in the initial year of an ITO.

Statements of Reasons

QPILCH Recommendation 11 – Audio recordings should be made of Tribunal hearings where practicable and used by members of the Tribunal when preparing a statement of reasons.

Independent Patient Companion

QPILCH Recommendation 12 – The Act should require each authorised mental health service to engage a person or persons as an ‘Independent Patient Companion’ from an organisation or service that is *independent* of the State government and the authorised mental health service. The Independent Patient Companion should be a person who holds a position of seniority and who will command a significant level of respect from clinicians and staff at the authorised mental health service.

QPILCH Recommendation 13 – The Independent Patient Companion should be required to report to a person who holds a higher position than the administrator of the authorised mental health service.

QPILCH Recommendation 14 – The Act should explicitly provide that the Independent Patient Companion’s paramount responsibility is to be a representative for the patient.

Seclusion

QPILCH Recommendation 15 – The Act should permit an authorised mental health practitioner to place a person who is voluntarily receiving mental health services in an authorised mental health service in seclusion for a maximum duration of 30 minutes, without first placing the person on an involuntary treatment order, where:

- a) the person does not need to be treated involuntarily for their mental health;
- b) this is necessary to protect the person or other persons from imminent physical harm; and

- c) there is no less restrictive way of ensuring the safety of the patient or others.

Regulated Treatments

QPILCH Recommendation 16 – The Act should contain separate provisions in relation to the use of electroconvulsive therapy on voluntary patients and involuntary patients. These separate provisions may be framed as follows:

- a) Involuntary patients: a doctor may only perform electroconvulsive therapy on an involuntary patient at an authorised mental health service if the Tribunal has approved the use of the treatment on that patient.
- b) Voluntary patients: a doctor may perform electroconvulsive therapy on a voluntary patient at an authorised mental health service if the person has given informed consent to the treatment or the Tribunal has approved the use of the treatment on the person.

QPILCH Recommendation 17 – An application to the Tribunal for approval of ECT for an involuntary patient should be supported by the recommendations of two psychiatrists.

Monitoring Conditions

QPILCH Recommendation 18 – The Director of Mental Health should only be authorised to impose monitoring conditions to an involuntary patient while in the community if:

- a) there is significant risk that the patient would not return to the authorised mental health service as required; or
- b) the patient has not complied with previous obligations while in the community and this non-compliance has resulted in a significant risk of harm to the patient or others; and
- c) the Director has consulted with the treating psychiatrist or administrator of the authorised mental health service about the potential clinical impact of imposing a monitoring condition on the patient's mental wellbeing.

QPILCH Recommendation 19 – Where the Mental Health Review Tribunal makes a decision to revoke monitoring conditions, the Director should not be permitted to overturn this decision and subsequently decide to impose monitoring conditions on the involuntary patient.

Treatment and Care of Involuntary Patients

QPILCH Recommendation 20 – The Act should expressly require an authorised mental health practitioner, when considering the treatment and care needs of a patient, to consider co-morbidity issues, social, financial and cultural impediments to recovery, and any other health issues. Additionally, the Act should require the authorised mental health practitioner to discuss these issues with the patient and, where appropriate, the patient’s family, carers and other support persons.

QPILCH Recommendation 21 – Where a doctor or authorised mental health practitioner is required to decide or review a patient’s treatment and care needs, and to determine whether the treatment criteria continue to apply to the patient, the doctor or authorised mental health practitioner should be required to discuss their decision and reasons for their decision with the patient.

QPILCH Recommendation 22 – The doctor or authorised mental health practitioner should be required to document their treatment decisions including reasons for their decision in appropriate clinical records.

Access to Independent Second Psychiatric Opinions

QPILCH Recommendation 23 – The Act should require the Tribunal or the hospital to facilitate an independent second psychiatric opinion before the first Tribunal hearing. If the ITO continues, the Act should require the Tribunal or the hospital to facilitate an independent second psychiatric opinion after six months, after 12 months and every two years thereafter.

QPILCH Recommendation 24 – As an alternative, the Act should require the Tribunal or the hospital to facilitate access to an independent second psychiatric opinion upon request.

QPILCH Recommendation 25 – At a minimum, the Act should require the Tribunal or the hospital to facilitate access to an independent second psychiatric opinion when an application is made to the Tribunal for a review of the patient’s treatment and care.

QPILCH Recommendation 26 – The Act should define what constitutes a second opinion.

Access to Health Information

QPILCH Recommendation 27 - The Act should require that the patient’s clinical report be given to the patient at least seven days before a Tribunal hearing.

QPILCH Recommendation 28 - The Act should stipulate that people subject to an ITO have the right to access their medical records.

Confidentiality and Privacy

QPILCH Recommendation 29 – The Act should require that a doctor or authorised mental health professional only consult with an involuntary patient’s family, carer or other support person if:

- a) the patient has given informed consent for the doctor or authorised mental health practitioner to consult with the family member, carer or other support person; or
- b) the family member, carer or other support person is the involuntary patient’s primary carer.

Advance Health Directives

QPILCH Recommendation 30 – Where an advance health directive is lawfully made, treatment must be given in accordance with the directive, except:

- (a) in an emergency;
- (b) where there is a serious risk that compliance with the directive is likely to result in the person:
 - i. causing serious harm to himself, herself or someone else; or
 - ii. suffering serious mental or physical deterioration;
- (c) where disregarding the directive is necessary to ensure the person receives treatment and care that is responsive to the person’s particular needs at the time the treatment decision is being made;
- (d) where there have been advances in medical science to the extent that the person, if they had known of the change in circumstances, would have considered the terms of the directive inappropriate.

QPILCH Recommendation 31 – If a doctor or authorised mental health practitioner makes a treatment decision that is not in accordance with the patient’s advance health directive, the doctor or authorised mental health practitioner must inform the patient of the decision and provide written reasons for the decision.

QPILCH Recommendation 32 – Wherever the Act permits a patient to give informed consent, the Act should explicitly recognise that informed consent may be given by a direction in an advance health directive.

Legal Representation

QPILCH Recommendation 33 – A legal representative should also be appointed to:

- a) people subject to ECT or psychosurgery applications; and
- b) people with multiple vulnerabilities.

QPILCH Recommendation 34 – The role of advocates should be explicitly recognised in the Act.

Involuntary Examination & Assessment

QPILCH agrees that the recommendations outlined in the Discussion Paper in relation to involuntary examination and assessment provide a simpler and more robust process. However we propose the following recommendations to:

- encourage voluntary participation wherever possible;
- ensure that involuntary processes are used only where justified; and;
- provide safeguards against the risk of vexatious applications.

QPILCH Recommendation 1 – The Act should require that, where practicable, upon a person’s application for an involuntary examination authority, an “involuntary examination statement” be served on the person who is the subject of the application, explaining:

- (a) that the person is the subject of an application for an involuntary examination authority;
- (b) the involuntary examination application process;
- (c) the consequences for the person if an involuntary examination authority is ordered;
- (d) that the person should seek voluntary examination of their mental health by a doctor or authorised mental health practitioner within the next 7 days and the consequences of the person failing to do so;
- (e) that there are concerns about the person’s mental health and that a doctor or authorised mental health practitioner may provide the person with options to maintain or improve their mental wellbeing;
- (f) that the doctor or authorised mental health practitioner may recommend to the person that they accept treatment and care for their mental health, and the consequences of the person failing to comply with this recommendation; and
- (g) the consequences of the person absconding to another state or overseas during this period.

The Discussion Paper’s recommendations aim to ensure that involuntary processes are used only where justified.¹ The use of involuntary examination and assessment procedures is a serious infringement of personal autonomy and can be very traumatic.² Existing involuntary

¹ Queensland Health, *Review of the Mental Health Act 2000 Background Paper 1: Involuntary Examinations and Assessments* (2014) 5-6.

² *Ibid* 6.

procedures, particularly Justices Examination Orders (JEO), can lead to confrontational examinations because the person is unaware of the process, their rights, and the reasons for their detainment and examination. The trauma of this experience often continues beyond involuntary examination and treatment. This can reduce willingness to cooperate with clinicians during the involuntary process, thereby impeding the person's pathway toward recovery.³

Under existing provisions a person may not be informed that there are concerns about their mental wellbeing before involuntarily examination and assessment. This makes it difficult for the person to understand the seriousness of their illness, the reason for involuntary examination and assessment, and the risk that they may be treated involuntarily under an involuntary treatment order. It is our opinion that if people who are the subject of an involuntary examination authority application are informed of these issues prior to involuntary examination and assessment, more will be encouraged to seek mental health services voluntarily. This may be because they are made aware of the seriousness of their illness, or because they are concerned about the risk of potential involuntary treatment if they do not seek support voluntarily. Indeed under existing mechanisms many people do seek mental health services voluntarily after being involuntarily examined. As outlined in the Background Paper, between 2012 and 2013 approximately 40 per cent of people who did not meet the assessment criteria following involuntary examination accepted mental health services voluntarily, either as an inpatient or outpatient, within the following 14 days.⁴

In our view, providing people with information through an "involuntary examination statement" prior to involuntary examination and assessment may help to increase willingness to seek mental health services voluntarily. This would minimise the need for involuntary examination and reduce the financial burden of involuntary examination, assessment and treatment, as well as minimise the traumatic impact that involuntary examination can have on people. Patient engagement with mental health services will also be improved and may lead to more therapeutic outcomes.

It is proposed that the "involuntary examination statement" be provided to a person for whom an involuntary examination authority application has been made once the application has been received by a magistrate or justice of the peace. The person should then be given a reasonable amount of time, such as 7 days, to receive and understand the statement, seek further advice on

³ Australian Health Ministers' Advisory Council, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers* (Commonwealth of Australia, 2013) 19

<<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde>>.

⁴ Queensland Health, above n 1, 6.

the implications of involuntary examination and treatment, and to make arrangements to speak with an authorised mental health practitioner or doctor directly. Subsequent stages of the process and how an “involuntary examination statement” would fit in this process are discussed below. A flowchart outlining the proposed process is also provided in Appendix A.

This process, though less simple, will provide greater fairness and transparency by encouraging voluntary treatment, and by increasing respect for personal autonomy through the provision of information and options. This is consistent with national and international human rights commitments⁵ and is more conducive to the recovery model of treatment.⁶

QPILCH Recommendation 2 – If the person presents before a doctor or authorised mental health practitioner voluntarily, the doctor or authorised mental health practitioner who examines the person should be required to:

- (a) immediately notify the relevant magistrate or authorised justice of the peace that the person has presented for examination of their mental health;
- (b) document this examination and as soon as practicable, and no later than 7 days after the person presents for examination, provide this document to the magistrate or authorised justice of the peace together with a written recommendation in relation to whether an involuntary examination authority should or should not be ordered for the person.

QPILCH Recommendation 3 – As an alternative to Recommendation 2(b), the person who has presented to the authorised mental health practitioner or doctor be required to:

- (a) document the advice given by the authorised mental health practitioner or doctor;
- (b) obtain certification from the authorised mental health practitioner or doctor that the documented advice is accurate; and
- (c) provide this document to the magistrate or justice of the peace no later than 7 days after the person presented for examination.

⁵*Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 75th plen mtg, UN Doc A/RES/46/119 (17 December 1991), principle 9(1) and (4); Standing Council on Health, *Mental Health Statement of Rights and Responsibilities* (Commonwealth of Australia 2012) pt IV (19)(e),(f) and (i).

⁶ Australian Health Ministers’ Advisory Council, above n 3, 19-20.

The Background Paper acknowledges that under existing involuntary examination procedures there are risks of the involuntary processes being used inappropriately.⁷ In particular, these processes are occasionally engaged for vexatious reasons.⁸ The Background Paper also recognises that to reduce this risk, a person should be encouraged to speak to a doctor directly so that a magistrate or justice of the peace can make a decision based on direct clinical observation of the person's mental wellbeing.⁹

Recommendations in the Discussion Paper propose additional safeguards by requiring increased clinical input¹⁰ and imposing limitations on the categories of people who are authorised to order involuntary examination.¹¹ We agree that these additional requirements will make the system more robust and transparent.

However we submit that the proposed changes will not adequately safeguard against the potential for vexatious applications. An applicant may inaccurately or dishonestly represent facts to the authorised mental health practitioner or doctor. An applicant may also inaccurately or dishonestly represent facts in his or her application for an involuntary examination authority. If the application contains inaccurate or dishonest information, advice obtained by the magistrate or justice of the peace from an authorised mental health practitioner or doctor,¹² and ultimately the final decision whether to order an involuntary examination authority, will be misinformed. Consequently, despite the proposed changes, an involuntary examination authority may still be ordered on the basis of an inaccurate or vexatious application.

Further, it is difficult for a person's mental health to be properly and accurately assessed according to behaviours stated in a written application. Even if accurately represented in a person's application, stated behaviours taken out of context and seen through the 'lens of mental illness' are more likely to be perceived as actual and legitimate symptoms of a mental illness requiring involuntary examination.¹³ In this way, advice obtained from an authorised mental health practitioner or doctor¹⁴, although informative, may not accurately reflect the person's mental wellbeing, and may result in greater numbers of unnecessary involuntary examinations.

⁷ Queensland Health, above n 1, 5.

⁸ Ibid 5.

⁹ Ibid 6.

¹⁰ Ibid 6.

¹¹ Ibid 7-8.

¹² In accordance with recommendation 1.5 of the Discussion Paper: Queensland Health, *Review of the Mental Health Act 2000*, Discussion Paper 233 (2014) 8.

¹³ D. L. Rosenhan, 'On Being Sane in Insane Places' (1973) 179 *Science* 250, 252-253.

¹⁴ Queensland Health, *Review of the Mental Health Act 2000*, Discussion Paper 233 (2014) 8, recommendation 1.5.

These issues may be addressed by ensuring, wherever possible, that the person whose mental health is in question be directly observed by an authorised mental health practitioner or doctor. If information were then provided directly from the practitioner who has observed the person, or is at least certified by the practitioner, this would avoid the potential for misrepresentation or dishonesty during the application process. This creates a more thorough, transparent and fair process by ensuring the person's behaviour is not considered out of context.

These benefits are contingent on the person being encouraged to seek examination voluntarily, which further highlights the importance of our first recommendation above.

QPILCH Recommendation 4 – If the person does not present to a doctor or authorised mental health practitioner within 7 days, the magistrate or justice of the peace must then obtain oral or written advice from a doctor, as per recommendation 1.5 of the Discussion Paper.

We acknowledge that the risk for vexatious applications will still exist where attempts to encourage the person to seek voluntary examination are unsuccessful. In these circumstances, the involuntary examination and assessment process proposed in the Discussion Paper would be necessary, along with the additional safeguards recommended in the Discussion Paper. That is, where the person does not present to a doctor within 7 days of the involuntary examination statement, the relevant Magistrate or Justice of the Peace should then obtain oral or written advice from a doctor, as per recommendation 1.5 of the Discussion Paper.

While perhaps a less simple process, encouraging direct observation of the person's mental health creates a more thorough, transparent and fair process.

Of course, these proposals would only apply in non-urgent cases. Instances where people require urgent examination, treatment and care for their mental health would still be dealt with under emergency examination procedures.

Where there is no urgent need for examination, we submit that the Act should contain these additional recommendations. In our view, the changes we have proposed will:

- encourage voluntary participation in examination and treatment;
- be minimally intrusive to the rights of people whose mental health is in question;

- involve authorised mental health practitioners and doctors more directly in the determination of the need for examination and assessment;
- reduce the need for involuntary examination and treatment;
- reduce the burden, including the financial burden, that involuntary examination and treatment has on mental health facilities and the community;
- increase cooperation when involuntary examination and assessment is appropriate;
- reduce the risk of involuntary examination and assessment procedures being used inappropriately; and
- minimise opportunities for vexatious applications.

Treatment Criteria

Involuntary treatment, like involuntary examination and assessment, is a serious infringement of personal autonomy and can be very traumatic for individuals. Involuntary treatment in some cases may hinder a person's path to recovery by denying the person the opportunity and dignity to take responsibility for his or her own wellbeing. However we are mindful that involuntary treatment is a necessary therapeutic experience for many people, and one for which many involuntary patients are grateful. We are also mindful of the importance of clinical objectives and the rights and safety of the community.

The treatment criteria must be framed in a way that strikes an appropriate balance between these interests. The Discussion Paper's recommendations to clarify the definition of capacity and to remove the unreasonable refusal criterion help to achieve this. We support these changes. However we propose that the following changes should also be incorporated in order to strike a balance that more appropriately respects patient autonomy and dignity, the fundamental right of involuntary patients to receive necessary treatment and care, and the rights and needs of the community. Certain terms used in the treatment criteria should also be more clearly defined to provide more consistent, transparent and fair application of the criteria.

QPILCH Recommendation 5 – The treatment criteria should contain, in addition to the criteria outlined in recommendation 1.17 of the Discussion Paper, a requirement that there is no less restrictive means reasonably available to ensure that:

- (a) the person receives appropriate treatment and care for his or her mental illness;
and
- (b) the risk of the person causing imminent serious harm to himself, herself or someone else, or suffering serious mental or physical deterioration, does not materialise.

QPILCH Recommendation 6 – Recommendation 1.19 of the Discussion Paper should be amended to read, “An authorised psychiatrist may maintain a person on an involuntary treatment order, notwithstanding that a person appears to have capacity to consent, if the psychiatrist reasonably believes that:

- (a) revoking the order is likely to result in the person:
 - i. causing *serious* harm to himself, herself or someone else; or
 - ii. suffering serious mental or physical deterioration; and
- (b) there is no less restrictive means reasonably available to ensure that these risks do not materialise.”

QPILCH Recommendation 7 – In addition to the above recommendations, the psychiatrist should be required to obtain a second opinion from another psychiatrist which confirms that there is a likely risk of serious harm.

We acknowledge concerns discussed in the Background Paper that the existing treatment criteria often result in “persons ‘cycling’ on and off involuntary treatment orders”, and that “this is not in the interests of the patient or the community and does not, over time, support a least restrictive approach to treatment.”¹⁵ While we agree that many patients do cycle on and off ITO’s under current procedures, and note that this can sometimes have negative impacts on treatment and recovery, in our experience, we have found that this cycling process has often assisted patients to accept their illness and responsibility for their own recovery.¹⁶

In many instances a longitudinal approach to diagnosis and interpretation of the treatment criteria is appropriate to protect the long-term interests of the patient and the community. We support recommendation 1.19 of the Discussion Paper,¹⁷ which would allow an authorised psychiatrist to maintain a person on an ITO in certain circumstances, even if the person appears to have capacity. In our experience, this already occurs in practice. Indeed the Tribunal already takes a longitudinal approach to diagnosis and the need for involuntary treatment. People are kept on an ITO, despite appearing to have capacity, where there is a legitimate risk of serious deterioration or harm to the patient or another person. While maintaining the order is often necessary for this reason, telling the patient that they do not have capacity can be

¹⁵ Queensland Health, above n 1, 14.

¹⁶ Mike Slade, *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals* (Cambridge University Press, 2009) 184.

¹⁷ Queensland Health, above n 14, 10.

disempowering. It can have a detrimental impact on the patient's confidence and dignity, and on the patient's trust in and willingness to cooperate with involuntary treatment.

Involuntary treatment remains a serious infringement on personal autonomy. Making or maintaining an ITO where it is not absolutely justified can delay a person's recovery by denying them the dignity of taking responsibility for their own wellbeing, instead of encouraging them to take care of their own health.

In our experience, allowing a person to "cycle" on and off ITOs can promote dignity and responsibility. Some patients are unable to accept the existence or seriousness of their mental illness, or their need for treatment, until they have cycled on and off an ITO a number of times. This cyclical process becomes an essential step in accepting their mental illness and in learning to manage and live with their mental illness. Denying patients this autonomy, dignity and responsibility may unnecessarily hinder the person's pathway towards recovery by drawing out involuntary treatment, and prevent the person from developing the capacity or willingness to accept their mental illness and need for treatment.

It is in the long-term interests of the community to empower involuntary patients to accept responsibility for their own wellbeing and to engage in treatment and care voluntarily. Promoting the patient's understanding and capacity to manage their mental illness will support long-term stability in the person's mental wellbeing, reducing the risk of relapse or mental deterioration and potential risks to members of the community.¹⁸ A reduction in the need for involuntary treatment will also reduce the financial burden that involuntary treatment has on the State's health system.

We acknowledge that it will not be appropriate to permit this cyclical process in many situations. A person's mental illness may pose serious risks to their own wellbeing or to the safety and wellbeing of others and may reduce the effectiveness of treatment. We agree that in these circumstances, maintaining an ITO is likely to promote the long-term interests of the patient and the community. However, we submit that the following minor changes should be incorporated into the Discussion Paper's recommendations to ensure ITOs are only made or maintained where absolutely justified. These proposed changes are designed to encourage patient dignity and responsibility wherever appropriate in order to promote the best interests of patients and the community.

¹⁸ Mike Slade, above n 16, 184.

Least restrictive measure

An ITO should only be made or maintained where there is no less restrictive way of ensuring the other treatment criteria are met. It is possible for example, that a person may be at the same risk of mental or physical deterioration regardless of whether or not they are on an ITO. This may be the case where a person has engaged a private psychiatrist to manage their mental wellbeing.

Furthermore, 'risk of harm' can be, and in our experience often is, broadly interpreted and may include, for example, risk of harm to social standing and reputation.¹⁹ A risk of harm to the patient's reputation may be used as a reason for maintaining a person on an ITO even if the risk poses no serious threat to the person's mental wellbeing. While people with mental illness need protection against risks, as does the community, they should also be entitled to the dignity of taking these risks if the potential consequences are not serious. This dignity may be unnecessarily denied if a 'least restrictive measure' requirement is not included in the treatment criteria.

Without a provision ensuring an ITO is only maintained where it is the least restrictive measure, a person may be kept on an ITO unnecessarily. This disempowers a patient by depriving the patient of the opportunity to take responsibility for his or her own treatment and wellbeing, and may hinder the patient's pathway towards independent and voluntary participation in treatment.

Requiring this 'no less restrictive means' element would be consistent with many other jurisdictions around Australia, including Victoria,²⁰ Northern Territory,²¹ Western Australia,²² New South Wales²³ and South Australia.²⁴

Serious harm

While the treatment criteria under recommendation 1.17 of the Discussion Paper require there to be a likely risk of imminent *serious* harm, no such qualification is included in recommendation 1.19. Recommendation 1.19 allows a psychiatrist to maintain a person on an ITO, even where the person appears to have capacity, in circumstances where the psychiatrist

¹⁹ Director of Mental Health, *Mental Health Resource Guide* (Queensland Health, 31 May 2013) 3-8 <http://www.health.qld.gov.au/mha2000/resource_guide.asp>.

²⁰ *Mental Health Act 2014* (Vic) s 5.

²¹ *Mental Health and Related Services Act 2004* (NT) s14(c).

²² *Mental Health Act 1996* (WA) s26(1)(d); *Mental Health Bill 2013* (WA) s25(1)(e)

²³ *Mental Health Act 2007* (NSW) s12(1)(b).

²⁴ *Mental Health Act 2009* (SA) ss10(1)(d), 16(1)(d), 21(1)(c).

reasonably believes that there is a risk, however significant, of the person causing harm to themselves or another person.

'Harm' is open to broad interpretation. While not defined under the Act, the *Mental Health Act 2000 Resource Guide* ("the MHA Resource Guide") states that harm may include risk to "[a person's] social standing and reputation, losing their employment, being subject to criminal charges, suffering significant financial losses"²⁵ or "adverse financial or social impacts".²⁶ In all other domains, a person who has capacity is afforded the autonomy to act in ways that may result in harm to themselves. While people with mental illness may need to be protected against risks, they should also be entitled to the dignity of risk if the consequences for them or the community are not serious. To ensure maximum respect of a patient's autonomy, we submit that the broad concept of harm should be tempered by a qualification that the harm be 'serious'.

Many other Australian jurisdictions, including Victoria,²⁷ Northern Territory,²⁸ New South Wales²⁹ and Tasmania,³⁰ have adopted this approach.

Second psychiatric opinion about risk of harm

The question of whether or not a person is likely to suffer harm is subjective, and psychiatrists may reasonably differ in their opinions as to whether a person is likely to cause harm or suffer serious deterioration. The Act should require the Tribunal or the hospital to facilitate access to a second psychiatrist's opinion to ensure that a person is maintained on an ITO only where there is a real and corroborated opinion of likely risk, and that people are not arbitrarily maintained on an involuntary treatment order because of the opinion of an individual psychiatrist. Please see our recommendations 23-26 below for more discussion on this issue. This is especially important if automatic review periods are changed from 6 to 12 months, as psychiatrists will be less accountable for their decisions to maintain a person on an ITO.

QPILCH Recommendation 8 – The Act should more clearly define what constitutes 'treatment' under the Act.

Currently, 'treatment' is defined under the Act as 'anything done, or to be done, with the intention of having a therapeutic effect on the person's illness'.³¹ This definition is very broad

²⁵ Director of Mental Health, above n 19, 3-8.

²⁶ Ibid 4-9.

²⁷ *Mental Health Act 2014* (Vic) s 5;

²⁸ *Mental Health and Related Services Act 2004* (NT) s14(b)(ii).

²⁹ *Mental Health Act 2007* (NSW) s14(1).

³⁰ *Mental Health Act 2013* (Tas) s40(b).

and provides no clear indication of what constitutes ‘treatment’ under the Act. In our experience, this broad definition has been used by certain clinicians to justify keeping a person on an ITO without any need for treatment (and without actually receiving any treatment) solely for the purpose of allowing doctors to monitor the person’s mental wellbeing and potential risk following discharge from hospital.

Doctors should not be permitted to maintain a person on an ITO solely for the purposes of monitoring the person’s behaviour. People not required to receive treatment should be permitted the dignity to take responsibility for their wellbeing without the continuous oversight of doctors. As discussed above, promoting dignity and responsibility is in the long-term interests of both the patient and the community. Therefore, the definition of treatment should be amended to exclude monitoring of a person’s behaviour in the absence of any other treatment.

QPILCH Recommendation 9 – The Director of Mental Health should be required to publish detailed guidelines on the assessment of ‘risk’ and ‘imminent risk’.

The treatment criteria currently, and under the Discussion Paper’s recommendations, require an assessment of risk of harm to the person or someone else, or the risk of physical or mental deterioration. Furthermore, under recommendation 1.17 of the Discussion Paper, the treatment criteria require an authorised mental health practitioner or doctor to be satisfied that the absence of involuntary treatment is likely to result in *imminent* serious harm to the person or someone else.³² The Act currently provides no clear guidance to clinicians for assessing risk. Interpretations of ‘risk’ and ‘imminent risk’ may therefore vary widely between clinicians, and may also be inconsistent with interpretations of the Tribunal. Clinical interpretations, as well as the Tribunal’s interpretations of ‘risk’ and ‘imminent risk’ may vary between immediate or short-term risks (a cross-sectional interpretation) and more long-term or remote risks (a longitudinal interpretation). While recommendations made in the Discussion Paper and discussed in the Background Paper appear to prefer a more longitudinal approach to diagnosis, treatment and assessment of risk, no clear guidance is given to clinicians in their interpretation of risk.

In our experience, the assessment of risk in clinical reports can be vague, general and often based on hearsay from third parties. The clinical report may simply state “risk to social standing” or “risk to reputation” without giving adequate consideration to the specific risk for

³¹ *Mental Health Act 2000* (Qld) schedule.

³² Queensland Health, above n 14, 10.

the particular person, the likelihood of the risk eventuating or the consequences for the person or the community if the risk did materialise. In our view, clinicians should give much more attention to the assessment and explanation of risks and the significance of these risks.

Though the assessment of risk is a clinical determination, we recommend that the Act should specifically require the Director of Mental Health to publish detailed guidelines on the proper assessment of risk. The *Mental Health Bill 2013* (WA) includes a similar provision:

[t]he Chief Psychiatrist must publish guidelines for ... making decisions about whether or not a person is in need of an inpatient treatment order or a community treatment order.³³

³³ *Mental Health Bill 2013* (WA) s 513(1)(a).

Mental Health Review Tribunal

QPILCH strongly opposes the Discussion Paper's proposal to change the automatic Tribunal reviews of ITOs from six months to 12 months in the initial year of an ITO.³⁴ Where such significant human rights consequences as detention and involuntary treatment are at issue, procedural fairness requires maintenance of regular Tribunal reviews, particularly in the initial year of an ITO. The proposal for yearly reviews would put Queensland out of step with other states and territories in this regard.

We agree that the initial review at six weeks is important, as is the patient's right to apply for an early hearing. However, rather than *less frequent* review hearings after the initial ITO, in our view, there should be *more frequent* review hearings in the first year of an ITO. This will ensure treating teams are accountable for maintaining a person on an ITO. A person's circumstances and response to treatment can change substantially over the course of 12 months, particularly after initial diagnosis. Without regular reviews there may be a temptation to maintain a person on an ITO "just in case". In our experience, many patients already feel a serious power imbalance in relation to the treating team and are not aware of their right to seek an early review. Less frequent reviews will merely exacerbate these issues.

Regular reviews also provide a critical safeguard in protecting the rights and interests of involuntary patients and help to foster a more cooperative patient-clinician relationship. In our view, the benefits of having regular review hearings during the first year of a person's ITO outweigh any potential cost implications.

QPILCH Recommendation 10 – ITO review hearings should be conducted by the Tribunal at six weeks, three months, six months, 12 months in the initial year of an ITO.

The Background Paper raises the concern that automatic review periods are currently too frequent and create unnecessary stress for patients and do not make the best use of the Tribunal and treating teams' resources.³⁵ This is not our experience. In our experience, review by the Tribunal provides a critical opportunity for patients to express their concerns and to be heard.

Implications for involuntary patients

³⁴ Queensland Health, *Review of the Mental Health Act 2000*, Discussion Paper 223 (2014) 28, recommendation 9.6.

³⁵ Queensland Health, *Review of the Mental Health Act 2000 Background Paper 9: Mental Health Review Tribunal*(2014), 5.

While the Tribunal process can be stressful for some involuntary patients, particularly very unwell patients who are on an ITO for long periods (for example, elderly patients with dementia and delusions), regular reviews are not stressful for all patients. It is patronising to deny patients the right to more regular automatic reviews just in case the process may be stressful for them.

In our experience the stress of Tribunal reviews can result from a number of factors, including a lack of understanding of the Tribunal process, lack of awareness of the potential benefits of the review process and concerns about being labeled as a “trouble-maker”. For long-term patients the stress may arise from the nature of their illness but this may be addressed by having less frequent reviews after 12 months.

For most patients, however, the stressful nature of ITO review hearings can be addressed by providing involuntary patients with appropriate support services and information to facilitate better understanding of and participation in the hearing process. This is a role that may be fulfilled by the proposed Independent Patient Companion. Reducing the frequency of automatic review hearings will not address this concern.

We acknowledge that in many cases where a patient is very unwell over a long period of time (years rather than months), regular six monthly reviews are unlikely to have any impact on the patient’s involuntary status or the direction of that patient’s treatment and care. However regular reviews of ITOs are beneficial for both the patient and the treating team even where there is little or no expectation that the patient’s involuntary status will change as a result of the hearing. Regular reviews provide patients with the opportunity to meaningfully engage in decisions about their treatment and care. Involuntary patients who are able to meaningfully participate in treatment decisions are more likely to understand their mental health issues and need for treatment, and to take responsibility for their recovery.³⁶ Furthermore, involuntary patients are often more willing to engage with mental health services after a hearing if they feel they have been heard, taken seriously and treated respectfully.³⁷

Most importantly, the prospect of an upcoming review hearing serves to remind clinicians of their obligation to consider whether the treatment criteria still apply to a patient. In our experience, a number of ITOs are revoked by clinicians just prior to a hearing. Adopting more regular reviews in the initial year of an ITO (or at least maintaining the current six monthly

³⁶ *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 75th plen mtg, UN Doc A/RES/46/119 (17 December 1991), Principle 11 (9).

³⁷ K Diesfeld et al, ‘The unintended impact of the therapeutic intentions of the New Zealand Mental Health Review Tribunal?’ (2007) 14 *Journal of Law of Medicine* 566

review period) is necessary to ensure treating teams remain fully accountable for decisions to maintain a person on an ITO. While existing provisions and recommendations in the Discussion Paper attempt to encourage treating teams to regularly consider a patient's need for involuntary treatment and care,³⁸ there is no mechanism to ensure treating teams are accountable for refusing or failing to regularly review a patient's circumstances.

Reducing the frequency of automatic reviews could also place additional strain on the patient-clinician relationship. Anecdotal evidence from clinicians confirms that the current automatic six monthly review hearings can support the therapeutic relationship between the doctor and patient by providing independent confirmation of the ITO. The decision to keep a person on an ITO is not just the doctor's decision but that of an external legal entity. Without regular ITO review hearings, particularly in the initial period, the patient is more likely to question the clinician's decision, as all the responsibility for maintaining the patient on an ITO will lie with the clinician and only rarely with the Tribunal. This additional strain on patient-clinician relationships may have ongoing impacts on the patient's recovery. It may reduce cooperation between the patient and the treating team and limit the patient's willingness to understand and accept their mental illness and need for treatment. In this way, reducing the frequency of automatic ITO review hearings may hinder involuntary patients' recovery, extending the need for involuntary treatment.

Cost implications

The proposal to conduct less frequent reviews, in our view, is likely to result in a greater financial burden on the State's health system. As discussed above, frequent automatic review hearings help to remind clinicians to assess whether the treatment criteria apply to an involuntary patient. ITOs are commonly revoked just prior to the patient's review hearing and this should be seen as a positive effect of the scheduled review. More frequent automatic reviews may therefore reduce the costs of involuntary treatment by reducing the duration of ITOs. In contrast, less frequent reviews may lead to people being unnecessarily kept on ITOs for longer periods. Because more frequent review hearings may reduce the duration of many ITOs, the cost implications of increasing the frequency of automatic review hearings may be considerably less than they appear.

³⁸ Queensland Health, *Review of the Mental Health Act 2000*, Discussion Paper 223 (2014) 19, recommendations 5.2-5.7.

Right to apply for early review

We support the preservation of patients' rights to apply for an early review hearing. In our experience however, many involuntary patients are unaware of the right to apply for an early review hearing under the existing provisions. We anticipate that the Independent Patient Companion may help to address this issue. However this issue will persist unless the Independent Patient Companion performs its role adequately and independently. Please see our recommendations 13-15 below for more discussion on this issue. The risk of involuntary patients remaining unaware of their right to apply for an early review hearing further supports the importance of requiring regular automatic review hearings.

Statements of Reasons

It is sometimes difficult for the Tribunal to produce sufficiently detailed and timely statements of reasons (“SOR”) because, currently, proceedings are not recorded and because of the sheer volume of hearings. We acknowledge that this issue could be alleviated by requiring the Tribunal to record reasons for decisions at the time they are made.³⁹ However we believe that the following recommendation would provide a more practicable and efficient means of ensuring the Tribunal is adequately resourced to provide accurate and detailed SOR upon request, even when prepared months after the decision was made.

QPILCH Recommendation 11 – Audio recordings should be made of Tribunal hearings where practicable and used by members of the Tribunal when preparing a statement of reasons.

In our experience, statements of reasons provided by the Tribunal are often uninformative, lacking in detail and sometimes contain inaccurate statements about the patient’s circumstances. We appreciate that it is difficult for Tribunal members to provide accurate and detailed statements of reasons where there is significant delay between a decision and a request for a statement of reasons. Even where there is no significant delay, details of individual matters can easily become blurred due to the large number of hearings and the similar nature of successive cases. These difficulties could be overcome by ensuring Tribunal members have more detailed information when preparing a statement of reasons.

The need for more information

Tribunal members are often limited by the quality of sources of information available to them when preparing a SOR. Typically, the Tribunal will be limited to:

- personal memory of the matter;
- handwritten notes made during the hearing and recorded in a Record of Proceedings and a supplementary document, as well as a Forensic Dossier in reviews of forensic patients, which will usually contain only a summary of the patient’s history;

³⁹ Queensland Health, above n 25, 4.

- the clinical report, which may be quite brief and lacking in detail, may provide inaccurate representations of the patient’s history and will not encompass the patient’s opinions of the contents of the report; and
- written submissions made by the patient, support person or advocate.

In the absence of clear and detailed recordings of a hearing, Tribunal members are unable to provide accurate and detailed explanations for their decisions. On some occasions, this has resulted in statements of reasons containing vague conclusions such as ‘lack of insight’ without any clear explanation of why this conclusion has been made.

If audio recordings of hearings were available to Tribunal members, statements of reasons would provide a far more informative and accurate representation of reasons for the Tribunal’s decisions.

Patient consent

We appreciate that some patients may not be comfortable with their Tribunal hearing being recorded. Because of this, it is anticipated that before each hearing, Tribunal members would obtain the patient’s consent for the recording to be made. Tribunal members would explain to the patient that the sole purpose of the recording is to assist with the preparation of a SOR, and indicate that unrecorded hearings may lead to them receiving a SOR with less detail if one is requested at a later stage. It would then be the patient’s choice if they consent to the hearing being recorded.

Recording reasons at the time they are made

We acknowledge similar concerns about accuracy of information raised in the Background Paper.⁴⁰ It has been suggested that “if the Tribunal recorded reasons for decisions at the time they were made, it would not be a difficult matter to produce a hard copy statement of reasons on request”.⁴¹ However, we believe that it would be difficult for Tribunal members to make a sufficiently detailed recording of reasons for decisions immediately after each hearing.

Currently, when the Tribunal makes its decision it does not generally provide the patient with reasons for its decision at the time it is made. Requiring the Tribunal to record reasons for their decisions at the time they are made would involve an additional time commitment after each hearing. This would reduce the number of hearings that could be heard by the Tribunal each

⁴⁰ Ibid 4.

⁴¹ Ibid.

day. This would not be the most efficient and cost effective means of ensuring SOR are accurately provided when requested.

Furthermore, there would still be a risk that SOR would not be as detailed or thorough as they should be. Tribunals would only be permitted a limited amount of time between hearings in which to record reasons for their decisions. Time constraints could discourage or prevent Tribunal members from providing detailed and thorough notes on reasons for their decisions.

Audio recordings of Tribunal hearings

Audio recordings should be made of hearings in their entirety to supplement the limited resources available to Tribunal members when preparing a SOR. This will allow Tribunal members to prepare a written SOR that truly reflects the Tribunal's reasoning, without being limited by time constraints or inaccurate or incomplete information. It would reduce time and costs commitments that would be necessary to enable Tribunals to record reasons for their decisions after each hearing, increasing efficiency and cost-effectiveness.

Detailed SORs would better facilitate patients' levels of understanding of the Tribunal's decision-making process and why the Tribunal considers the patient still needs to be maintained on an ITO. Inaccurate, uninformed or incomplete SORs may leave patients with only a vague idea of what decision-makers consider relevant to their recovery and wellbeing, and may make them question the validity and the reliability of the review process. By providing patients with an accurate reflection of the reasons why they are being maintained on an ITO, patients may gain a clearer understanding (as well as an ongoing reminder) of the sorts of factors that are impeding their recovery and pathway towards taking responsibility for their own treatment.

Independent Patient Companion

We applaud the recommendation to require each authorised mental health service to engage or employ a person or persons as an Independent Patient Companion (IPC).⁴² However given the particular vulnerabilities of involuntary patients and the important roles that the IPC will fulfil, we stress the importance of ensuring that the IPC is, and is seen to be, independent of the State government and the authorised mental health service that engages them. A failure to preserve independence may result in conflict, or the appearance of conflict, between responsibilities to the involuntary patient and responsibilities, or perceived responsibilities, to the authorised mental health service at which the patient is receiving treatment. Should such conflicts arise, the IPC may fail to properly perform its roles in the best interests of the patient. We have proposed the following recommendations to help address these concerns.

QPILCH Recommendation 12 – The Act should require each authorised mental health service to engage a person or persons as an ‘Independent Patient Companion’ from an organisation or service that is *independent* of the State government and the authorised mental health service. The Independent Patient Companion should be a person who holds a position of seniority and who will command a significant level of respect from clinicians and staff at the authorised mental health service.

QPILCH Recommendation 13 – The Independent Patient Companion should be required to report to a person who holds a higher position than the administrator of the authorised mental health service.

Importance of independence and the appearance of independence

It is imperative that the IPC be, and appear to be, an independent support person for involuntary patients. If the IPC is not independent of the authorised mental health service that engages them, circumstances may arise where the IPC is conflicted between responsibilities, or perceived responsibilities, to the authorised mental health service and responsibilities to the patient. An IPC that is not independent of the authorised mental health service, or who is required to report directly to the administrator of the authorised mental health service, may develop perceived responsibilities or sentiments toward the administrator, service or staff.

⁴² Queensland Health, above n 14, 25, recommendation 7.6.

Where such circumstances arise, it is possible that the IPC may not be able to perform their obligations solely in the interests of patients.

The appearance of independence is also vital. A patient who believes the IPC is affiliated with the members of their treating team, or the authorised mental health service in which they are receiving treatment, may be reluctant to fully engage with the IPC in fear that they may not represent their best interests.

It is also important that the person or persons who fill the role of the IPC command a significant degree of respect from clinicians and staff at the authorised mental health service. The IPC should therefore be a person who has significant clinical experience and seniority in the field of mental health. This is because the IPC's decisions and actions must carry clout if they are to be respected and complied with by clinicians and staff at the authorised mental health service. Furthermore, a person who has less experience or holds less seniority in the field may be more reluctant to make decisions or take actions because of concerns that their actions may not be respected by clinicians and staff or may be detrimental to their relationship with clinicians or staff. Requiring authorised mental health services to engage senior and well-respected individuals will maximise the effectiveness of the IPC's role.

Further, an IPC should only be engaged from a non-government organisation that is independent of the authorised mental health service, and the IPC should report to a person who holds a more senior position than the administrator of the authorised mental health service.

Importance of the Independent Patient Companion's role

The IPC will fulfil a vital role in promoting patient rights and involvement in involuntary treatment and care. Should this system fail to operate as it is intended, many of the proposals made in the Discussion Paper that are intended to improve transparency and efficiency may result in ongoing and long-term neglect of fundamental rights of involuntary patients.

An example of this is the proposal to extend periodic reviews of involuntary treatment orders from 6 months to 12 months.⁴³ Under the proposed recommendations, the only way to ensure patients receive regular reviews is through the patient's right to apply for an early review hearing. In our experience, most involuntary patients are unaware of their right under existing provisions to apply for an early review hearing. This is likely to be exacerbated if the review period is extended unless the IPC properly reminds involuntary patients of their rights under the Act. The IPC will often be the only source of information about this right. Under the existing

⁴³ Ibid 28, recommendation 9.6.

system many patients are also discouraged from applying for an early review hearing because of a fear that they will be identified as a ‘trouble-maker’ if they apply. Again, in many cases this fear will only be overcome if the IPC properly discusses this issue with the patient.

Similarly, in the absence of regular reviews and of any clear formal right to independent second psychiatric opinions (see recommendations 24-27 below), an involuntary patient’s treatment and care needs are unlikely to be regularly scrutinised unless the patient is aware of their right to seek a review of their treatment and care. We recognise that recommendations in the Discussion Paper would require an authorised doctor to regularly review the patient’s treatment and care needs.⁴⁴ However there is no mechanism to enforce this requirement. In our opinion, many doctors are unlikely to give adequate consideration to the patient’s treatment and care needs on a regular basis. We have witnessed similar neglect under existing provisions. Authorised doctors often fail to explain to patients their rights, discuss details about treatment and care, prepare clinical reports on time, and provide clear explanations for decisions to maintain a patient on an ITO. In light of this, whether the patient’s treatment and care needs will be regularly reviewed is, again, likely to depend on the IPC thoroughly explaining to involuntary patients their rights under the Act.

These issues are compounded by the general reluctance amongst patients on ITOs to attend Tribunal hearings. From 2012 to 2013, only 28 percent of patients on ITOs attended their Tribunal hearing.⁴⁵ In our experience, this reluctance can result from a lack of understanding of the Tribunal process, a belief that the Tribunal lacks independence from the patient’s treating team, fear of being labelled as a ‘trouble-maker’, or an expectation that the Tribunal will merely confirm their ITO. To ensure patients attend Tribunal hearings and make full benefit of attending their hearing, the IPC will need to be properly equipped and willing to explain the Tribunal process and benefits of attendance.

QPILCH Recommendation 14 – The Act should explicitly provide that the Independent Patient Companion’s paramount responsibility is to be a representative for the patient.

We acknowledge that the Discussion Paper proposes that part of the IPC’s role will be to assist involuntary patients as well as family, carers and other support persons.⁴⁶ While we recognise the important role that family, carers and other support persons play in the treatment, care and

⁴⁴ Ibid, recommendation 5.3.

⁴⁵ Queensland Health, above n 25, 2 [9.2.2].

⁴⁶ Queensland Health, above n 14, 25, recommendation 7.7.

recovery of involuntary patients, this needs to be balanced with the involuntary patient's general rights to privacy and confidentiality.

In our experience, some patients do not want family, carers and other support persons to know they are being treated involuntarily, and want to exclude or minimise their involvement in treatment and care decisions. Family members, carers and other support persons are not necessarily the best advocate for a patient as the opinion of a family member, carer or other support person may not accurately represent, or may conflict with, the patient's own wishes. Some patients may also be at risk of being unduly influenced by family members, carers or other support persons, or may have a disruptive relationship with them. These concerns often arise in relation to family disputes, disputes about family estates, and in culturally sensitive contexts.

The Act should attempt to minimise these risks by expressly providing that the IPC's paramount duty is to assist the patient. Wherever the involvement of family members, carers and support persons would conflict with the patient's wishes or interests, the interests of the patient should take priority.

Seclusion

Current trends support the reduction and, where possible, elimination of restraint and seclusion.⁴⁷ In general, we do not support the use of seclusion on people with mental illness. However we recognise that in very tightly defined circumstances seclusion or restraint may be appropriate to safely manage dangerous behaviours. Our consultations have revealed that ITOs are used in some circumstances as a convenient means of authorising the use of seclusion to manage a patient's behaviour. The ITO may be made for this purpose even where there is no legal justification for the order. We submit that the following recommendation is necessary to minimise this practice, while still permitting the use of seclusion where it is necessary to safely manage dangerous behaviours.

QPILCH Recommendation 15 – The Act should permit an authorised mental health practitioner to place a person who is voluntarily receiving mental health services in an authorised mental health service in seclusion for a maximum duration of 30 minutes, without first placing the person on an involuntary treatment order, where:

- a) the person does not need to be treated involuntarily for their mental health;
- b) this is necessary to protect the person or other persons from imminent physical harm; and
- c) there is no less restrictive way of ensuring the safety of the patient or others.

In our experience, a person may be placed on an ITO and subsequently placed in seclusion solely for the purpose of managing the person's behaviour. The person may be placed on an ITO regardless of whether the person's behaviour requires involuntary treatment under the Act. The ITO will then typically be revoked immediately after the person is removed from seclusion (generally less than 30 minutes following seclusion), leaving no practical means of assessing whether the ITO was justified in the circumstances. Evidently, under the current system, authorised mental health practitioners are able to illegitimately place a person on an ITO for the purpose of a short period of seclusion without any fear of accountability.

⁴⁷ Director of Mental Health, above n 19, 7; Australian Health Ministers' Advisory Council, Mental Health Working Group, *National Safety Priorities in Mental Health: A National Plan for Reducing Harm* (2005) <<http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-safety-toc~mental-pubs-n-safety-3~mental-pubs-n-safety-3-use>>; Department of Social Services, Australian Government, *Draft Proposed National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector* (2013) <<http://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/draft-proposed-national-framework-for-reducing-the-use-of-restrictive-practices-in-the-disability-service-sector>>.

Reasons for this practice

Under the Act, seclusion of an involuntary patient may be authorised at any time by a doctor or, in urgent circumstances, by the senior registered nurse on duty.⁴⁸ The doctor or senior registered nurse may authorise seclusion if they are reasonably satisfied that seclusion is necessary to protect the patient or other persons from imminent physical harm and there is no less restrictive way of ensuring the safety of the patient or others.⁴⁹ This is only permitted for patients being involuntarily assessed or treated under the Act.

Outside of the Act, the only other legislative framework that allows the use of seclusion is the *Disability Services Act 2006* (Qld) ('DSA'). The DSA permits a relevant service provider to seclude an adult with an intellectual or cognitive disability under short term approval if a short term approval has been given by the adult guardian (now the Office of the Public Guardian) or is otherwise approved under the *Guardianship and Administration Act 2000* (Qld), and the service provider keeps and implements a policy about the use of seclusion.⁵⁰

The process of placing a person in seclusion is more onerous under the DSA than under the Act. Authorised mental health services will face fewer barriers to authorising seclusion by placing the person on an ITO and subsequently authorising seclusion under the Act. A person may be placed on an ITO even where the treatment criteria are not satisfied, as the Act provides no practical means of ensuring authorised mental health practitioners are accountable for placing a person on an ITO where the order is revoked a short time after it is made.

Furthermore, as discussed in the Background Paper,⁵¹ the authorisation of short periods of seclusion is most often used to manage behaviours of young people. As the DSA only permits the use of seclusion for adults, a service provider's only avenue to placing a young person in seclusion is either under common law principles or by first placing them on an ITO. Given common law principles are uncertain, and most clinicians are unsure of what circumstances justify the use of seclusion under common law principles, most clinicians are reluctant to authorise seclusion other than under the Act.

Impacts of this practice

An ITO, even if unjustified, will be recorded on a person's medical record. This may have ongoing impacts, including the stigma associated with ITOs and the potential for a medical

⁴⁸ *Mental Health Act 2000* (Qld) s 162L.

⁴⁹ *Ibid* s 162M.

⁵⁰ *Disability Services Act 2006* (Qld) s 123O.

⁵¹ Queensland Health, *Review of the Mental Health Act 2000 Background Paper 18: Children and Adolescents* (2014) 2.

history of involuntary treatment raising questions about the person's mental wellbeing when receiving treatment voluntarily for other health issues.

Our proposal

We propose that an authorised mental health service should be permitted under the Act to place a person in seclusion (or 'time-out') for a short period of time (at most 30 minutes) without first placing the person on an ITO. This should only be permitted where:

- the person is voluntarily receiving mental health services in an authorised mental health service;
- the treatment criteria under the Act are not satisfied and there is no need for the person to be on an involuntary treatment order;
- there are significant risks posed by the person's behaviour; and
- seclusion is the least restrictive way of safely managing the person's behaviour.

Scope of the Act

It is suggested in the Background Paper that a power to authorise seclusion to manage the behaviour of a person who is not on an ITO or forensic order would be outside the scope of the Act.⁵² We note that the purpose of the Act is "to provide for the involuntary assessment and treatment, and *the protection, of persons (whether adults or minors) who have mental illnesses...*"⁵³ We submit that permitting an authorised mental health practitioner to place a person who is receiving mental health services in seclusion for a short period of time, where seclusion is necessary for the protection of the person, without placing the person on an ITO, would come within the scope of "providing for ... the protection of persons (whether adults or minors) who have mental illnesses."⁵⁴

We further note that some parts of the Act do authorise the provision of mental health services to voluntary patients. For example, section 139 of the Act authorises the use of electroconvulsive therapy on both involuntary and voluntary patients. Section 161 of the Act also permits the use of psychosurgery on both involuntary and voluntary patients.

The assertion that this issue falls outside the scope of the Act should not be a barrier to giving effect to this recommendation.

⁵² Ibid.

⁵³ *Mental Health Act 2000* (Qld) s 4 (emphasis added).

⁵⁴ Ibid.

Regulated Treatments

QPILCH acknowledges that the recommendations outlined in the Discussion Paper in relation to psychosurgery and electroconvulsive therapy (“ECT”) will help to clarify uncertainty surrounding these controversial treatments. We also recognise that the recommendations in relation to ECT will provide a more flexible and efficient process for ECT hearings. However, we note that the recommendations fail to acknowledge or address some significant concerns surrounding the use of ECT on involuntary patients. We propose that the following additions be incorporated into the recommendations to ensure that regulated treatments such as ECT are only administered where necessary.

QPILCH Recommendation 16 – The Act should contain separate provisions in relation to the use of electroconvulsive therapy on voluntary patients and involuntary patients. These separate provisions may be framed as follows:

- a) Involuntary patients: a doctor may only perform electroconvulsive therapy on an involuntary patient at an authorised mental health service if the Tribunal has approved the use of the treatment on that patient.
- b) Voluntary patients: a doctor may perform electroconvulsive therapy on a voluntary patient at an authorised mental health service if the person has given informed consent to the treatment or the Tribunal has approved the use of the treatment on the person.

Currently, ECT may be used to treat an involuntary patient if that person gives informed consent to the treatment.⁵⁵ Generally, if a person is placed on an ITO he or she is deemed to not have capacity to consent to treatment for his or her mental illness.⁵⁶ Nonetheless, in practice, the consent to ECT of a person on an ITO is accepted by the treating team as sufficient to allow ECT to be given. We believe it is inconsistent to suggest that a person on an ITO has capacity to give informed consent to the use of ECT but not to other treatments.

Furthermore, in our experience, it is not uncommon for ‘consent’ to be given by an involuntary patient under the false belief that they are not permitted to refuse any treatment, including ECT, while they are on an ITO. To avoid this in the future, an involuntary patient should only be given ECT if approval has been given by the Tribunal.

⁵⁵ *Mental Health Act 2000* (Qld), s 139(1)(a).

⁵⁶ *Ibid* s 14(1)(f)(i).

We acknowledge that we have earlier submitted that Recommendation 1.19 may allow a psychiatrist to keep a person on an ITO despite appearing to have capacity.⁵⁷ On its face, it would seem that QPILCH Recommendation 16 would similarly deny these patients the right to give informed consent to ECT, despite appearing to have capacity. However, we submit that, as it is often difficult for practitioners to determine whether a person has capacity, a person's capacity to give consent to ECT, and the patient's desire to be treated with ECT, would more appropriately be considered by the Tribunal. It is anticipated that the Tribunal would take into consideration the patient's apparent capacity to give informed consent and their desire to have ECT when determining whether to authorise the use of ECT. In doing so, if the Tribunal is satisfied that the patient has capacity, and does consent to ECT, this would weigh strongly in favour of authorising the use of ECT. Therefore, we submit that this recommendation would pose only minimal, if any, limitations on a patient's freedom to consent to ECT where they have capacity to do so.

This recommendation is consistent with the *Mental Health Act 2007* (NSW) and the *Mental Health Bill 2013* (WA), each of which provides a separate provision for the administration of ECT to involuntary patients that permits the use of ECT only after a determination has been made by the Tribunal.⁵⁸

Voluntary patients should still be permitted to give informed consent to ECT. A separate provision should be included in the Act for the use of ECT on voluntary patients. This provision should take the form of the existing provision under the Act,⁵⁹ permitting voluntary patients to receive ECT if they give informed consent to its use.

Despite the fact that ECT applications represented only 3.3% of all Tribunal matters between 2012 and 2013,⁶⁰ we recognise that there could be cost implications if this recommendation is adopted. However, we submit that the potential benefits for involuntary patients far outweigh any additional cost burden.

QPILCH Recommendation 17 – An application to the Tribunal for approval of ECT for an involuntary patient should be supported by the recommendations of two psychiatrists.

⁵⁷ Queensland Health, above n 14, 10, recommendation 1.19.

⁵⁸ *Mental Health Act 2007* (NSW) ss 87-97; *Mental Health Bill 2013* (WA) s 198.

⁵⁹ *Mental Health Act 2000* (Qld) s 139(1).

⁶⁰ Queensland Health, *Mental Health Review Tribunal 2012-13 Annual Report* (2013) 7.

We also believe that the Tribunal should only authorise the use of ECT on an involuntary patient if the application for use of ECT is supported by the recommendations of two psychiatrists. Given the intrusive nature and potentially serious side effects of ECT, and the lack of clinical consensus on the suitability of ECT for treatment of mental illnesses, the Tribunal should be satisfied that there is strong clinical support for the use of ECT before authorising its use on an involuntary patient. This is especially important where consent to ECT is not forthcoming.

This recommendation is consistent with the *Mental Health and Related Services Act* (NT)⁶¹ and the *Mental Health Act 2007* (NSW),⁶² which contain similar provisions. In our experience, it is already common practice for the Tribunal to authorise ECT only in circumstances where the application is supported by the opinions of two psychiatrists. However, we believe it is important to formalise this practice to ensure it is consistently followed.

⁶¹ *Mental Health and Related Services Act 2004* (NT), s 66.

⁶² *Mental Health Act 2007* (NSW) s 93.

Monitoring Conditions

The Act currently allows the Director of Mental Health to apply a monitoring condition to a classified, forensic or court order patient who is at high risk of absconding when accessing leave in the community.⁶³ QPILCH supports the proposal to introduce a requirement that the Director be satisfied of certain criteria before applying monitoring conditions. We believe this will promote transparency and accountability. However we submit that more stringent safeguards should be added to ensure monitoring conditions are used only where necessary and clinically appropriate.

QPILCH Recommendation 18 – The Director of Mental Health should only be authorised to impose monitoring conditions to an involuntary patient while in the community if:

- a) there is significant risk that the patient would not return to the authorised mental health service as required; or
- b) the patient has not complied with previous obligations while in the community and this non-compliance has resulted in a significant risk of harm to the patient or others; and
- c) the Director has consulted with the treating psychiatrist or administrator of the authorised mental health service about the potential clinical impact of imposing a monitoring condition on the patient’s mental wellbeing.

Under section 131A of the Act, the Director of Mental Health may require a monitoring condition be imposed on a classified patient, forensic patient, or court order patient while they undertake limited community treatment. The purpose of these conditions is to manage risks of the patient absconding.⁶⁴ While we believe the imposition of monitoring conditions, especially electronic monitoring devices, can have harmful impacts on a patient’s mental health and recovery, we appreciate that in very limited circumstances this may be more appropriate and beneficial for the patient than returning to an authorised mental health service to receive treatment as an in-patient.

We welcome the inclusion of certain criteria that the Director should consider before applying monitoring conditions to an involuntary patient.⁶⁵ However we recommend that these criteria

⁶³ *Mental Health Act 2000* (Qld), s 131A.

⁶⁴ Director of Mental Health, above n 19, 9-35.

⁶⁵ Queensland Health, above n 14, 22, recommendation 6.13.

should be tightened to ensure monitoring conditions are imposed on involuntary patients in the community only where they are justified and clinically appropriate.

Under recommendation 6.13 of the Discussion Paper, it is proposed that the Director be authorised to apply monitoring conditions to an involuntary patient (including a patient on an ITO) while in the community if:

- there is a significant risk that the patient would not return to the authorised mental health service as required; or
- the patient has not complied with previous obligations while in the community and this non-compliance has resulted in a significant risk of harm to the patient or others.⁶⁶

As noted above, in very limited circumstances imposing monitoring conditions may be more appropriate and beneficial for the patient than returning to an authorised mental health service for treatment and care as an in-patient. However this will not be the case in all circumstances. Imposing monitoring conditions, and particularly electronic monitoring devices, may have harmful impacts on the mental wellbeing of some patients, especially those who experience delusions or those with symptoms of paranoia.

Given these concerns, the Director should be required to consult with the patient's treating psychiatrist or the administrator of the authorised mental health service to consider whether monitoring conditions would be clinically appropriate for the particular patient. It is anticipated that if monitoring conditions may have a negative impact on the patient's mental wellbeing, then the patient may instead be required to return to the authorised mental health service to receive treatment and care as an in-patient. This would promote a least restrictive approach to the patient's treatment.

The MHA Resource Guide already requires the Director to be satisfied of these criteria before applying monitoring conditions.⁶⁷ However recommendation 6.13 of the Discussion Paper only proposes to formalise criteria regarding risk. We believe it is important to also formalise the requirement that the Director consult with the patient's treating team or the administrator of the relevant authorised mental health service.

⁶⁶ Queensland Health, above n 14, 22.

⁶⁷ Director of Mental Health, above n 19, 9-18.

QPILCH Recommendation 19 – Where the Mental Health Review Tribunal makes a decision to revoke monitoring conditions, the Director should not be permitted to overturn this decision and subsequently decide to impose monitoring conditions on the involuntary patient.

Under the proposed changes, the Tribunal would be permitted to revoke monitoring conditions authorised by the Director of Mental Health.⁶⁸ However it is unclear whether the Director would be authorised to overturn the Tribunal's decision and subsequently re-apply monitoring conditions on an involuntary patient.

This should be clarified under the Act. The Tribunal's decision on review of monitoring conditions on a patient should only be subject to an appeal to the Mental Health Court. The Director should not be permitted to overturn the Tribunal's decision and subsequently re-apply monitoring conditions for a patient.

⁶⁸ Queensland Health, above n 14, 22, recommendation 6.14.

Treatment and Care of Involuntary Patients

Provisions under the Act, and recommendations proposed in the Discussion Paper, promote the inclusion of involuntary patients in decisions about treatment and care. However in our experience, despite various requirements under the Act to maximise patient involvement wherever possible, many patients continue to feel excluded from and uninformed of decisions about their treatment and care.

In particular, some patients feel that issues external to their diagnosis are ignored or inadequately addressed. These issues may include co-morbidity issues, and social and financial issues. Furthermore, many patients are not permitted to access information about the content and consequences of decisions made by their treating team, or reasons for these decisions. As a result, patients are unable to clarify whether decisions made by their treating team have addressed their full range of issues and, in the absence of any information to the contrary, typically believe that these issues have not been addressed. We believe that the recommendations proposed in the Discussion Paper will not adequately address these issues in practice. While we believe this is to a large extent due to training and resource constraints, we submit that the following recommendations should be implemented to help address these issues and promote a fairer, more transparent and more efficient process.

QPILCH Recommendation 20 – The Act should expressly require an authorised mental health practitioner, when considering the treatment and care needs of a patient, to consider co-morbidity issues, social, financial and cultural impediments to recovery, and any other health issues. Additionally, the Act should require the authorised mental health practitioner to discuss these issues with the patient and, where appropriate, the patient’s family, carers and other support persons.

Mental health issues rarely develop in isolation. There are often many contributory factors that may predispose or trigger the onset of a particular illness.⁶⁹ Many of these factors such as stress, alcohol and drug dependence, stability of housing and social isolation continue to affect the recovery of a person who has a mental illness and are therefore factors that warrant consideration when assessing the treatment and care of a person under an ITO. Within the MHLP we frequently assist people who feel that the services they receive under an ITO address only the immediate treatment issues associated with their mental health, and that other

⁶⁹ World Health Organisation, *Mental Health Action Plan 2013–2020* (2013) 7 [9] – [11].

important factors that impact upon their recovery are not appropriately addressed or even considered.

Authorised doctors who are responsible for the treatment of a person under an ITO should therefore be required to consider, and where necessary take steps to assist the person to address, any issues that are relevant to that person's recovery process. These steps may include treating co-morbidity issues, assessing whether the person might benefit from being linked with support services and agencies, and asking about financial arrangements and any cultural issues that may impact upon recovery. This approach provides for a more comprehensive, longitudinal understanding of a person's health and the factors that may contribute to "'cycling' on and off ITOs".⁷⁰ This is more consistent with the recovery model of service delivery. Discussion of issues that do not directly relate to the mental illness itself may also foster better patient-clinician relationships. This will translate to better outcomes for the individual and a reduced burden on mental health services.

It is anticipated that the IPC would also take part in the planning process. The IPC may for example refer and assist involuntary patients to access other services that can address other social, financial or cultural issues.

QPILCH Recommendation 21 – Where a doctor or authorised mental health practitioner is required to decide or review a patient's treatment and care needs, and to determine whether the treatment criteria continue to apply to the patient, the doctor or authorised mental health practitioner should be required to discuss their decision and reasons for their decision with the patient.

QPILCH Recommendation 22 – The doctor or authorised mental health practitioner should be required to document their treatment decisions including reasons for their decision in appropriate clinical records.

We applaud the Discussion Paper's recommendation that an authorised mental health practitioner must decide and review the treatment and care of an involuntary patient in consultation with the patient and where practicable, their family and wider support network.⁷¹ However we submit that this recommendation should be strengthened to include a requirement that once an authorised doctor has made a decision regarding treatment and care, the patient

⁷⁰ Queensland Health, above n 1, 14.

⁷¹ Queensland Health, above n 14, 8, Recommendation 5.4.

should be informed of the content and consequences of the decision and the reasons behind the decision. This engenders transparency in the decision making process and may also help the person under the ITO to accept a decision that, without reasons for the decision, he or she might otherwise not agree with.

Importantly, where a person feels that some aspect of their treatment or care was not considered or given enough weight, reasons will either allow them to see that the aspect was addressed or allow them to raise the issue of concern. The person under the ITO may then seek to address the issue by raising it with his or her doctor, the administrator or, by way of final resort, the Tribunal (under recommendations that propose to allow the Tribunal to review treatment and care decisions). This right of review is an essential check and balance to ensure involuntary patients' treatment and care needs are appropriately addressed. However, a patient who has applied for a review of their treatment and care before the Tribunal will be unable to clearly express concerns about the treating practitioner's decisions unless they have access to those decisions and reasons. In this way, ensuring involuntary patients have access to decisions made by their treating team will facilitate a fairer and more transparent review process.

This may also minimise the frequency with which involuntary patients apply to the Tribunal for a review of their treatment and care. By allowing involuntary patients to understand the treating team's decisions and reasons for decisions, and providing them with the opportunity to address any concerns directly with their treating team, these recommendations may facilitate resolution of the patient's concerns directly between the patient and treating team and avoid any need for the patient to apply to the Tribunal. These recommendations may thereby promote greater efficiency as well as increased transparency in treatment and care decisions.

Access to Independent Second Psychiatric Opinions

Involuntary patients should be entitled to an independent second psychiatric opinion regarding their treatment and the application of the treatment criteria. A right to access independent second psychiatric opinions would serve to improve psychiatrists' accountability for making or maintaining an ITO, promote a more supportive and inclusive patient-clinician relationship, and facilitate the patient's willingness to accept their diagnosis and need for treatment. The Act currently provides no clear framework to facilitate access to independent second psychiatric opinions and no recommendation has been made in the Discussion Paper to provide for such a framework. In our view, the lack of adequate access to independent second psychiatric opinions is a significant flaw in the operation of the Act. We propose the following recommendations to address this issue.

QPILCH Recommendation 23 – The Act should require the Tribunal or the hospital to facilitate an independent second psychiatric opinion before the first Tribunal hearing. If the ITO continues, the Act should require the Tribunal or the hospital to facilitate an independent second psychiatric opinion after six months, after 12 months and every two years thereafter.

In our experience, one of the main concerns of people who are under an ITO is that they are unable to get a second opinion from an independent psychiatrist regarding their treatment or the application of the treatment criteria. Involuntary patients do not have adequate access to an independent second psychiatric opinion at any stage of their involuntary treatment.

Current procedures

It is possible for involuntary patients to obtain a second opinion on their own initiative, through their treating team or by order of the Tribunal.⁷² The *Queensland Health Public Patients' Charter* also states that all public patients have a right to a second opinion either through their treating team or by arranging for a second opinion privately.⁷³ A treating team may organise a second opinion where requested by the patient; however this is at the discretion of the treating team and, in our experience, not always permitted. The Tribunal also has the power to make an order

⁷² *Mental Health Act 2000* (Qld) s 457.

⁷³ Queensland Health, *Queensland Health Public Patients' Charter* (Queensland Government, 2002) <<http://www.health.qld.gov.au/qhppc/docs/booklet.pdf>>.

requiring a second opinion,⁷⁴ and is also required to consider whether an examination and report should be obtained from another psychiatrist.⁷⁵ However, in our experience, these powers are rarely exercised. Lastly, a person under an ITO may seek an independent second opinion from a private psychiatrist.⁷⁶ However, private second opinions are rarely obtained due to excessive costs, long delays in getting an appointment and the unwillingness of many private psychiatrists to visit hospitals where the person is receiving involuntary treatment.

Evidently, while access to independent second opinions is currently *permitted* under the Act, the Act fails to provide any clear processes to *facilitate* a patient's request for a second opinion and, in our experience, second opinions are rarely obtained.

We acknowledge that the Discussion Paper has placed greater emphasis on review processes to ensure treatment criteria continue to apply and that the treatment and care provided is appropriate.⁷⁷ We agree with the recommendations made, in particular the recommendations providing clearer processes to gain access to a review of treatment and care.⁷⁸ However, we submit that these recommendations will not adequately secure the rights of patients, the accountability of treating psychiatrists or transparency of decisions relating to treatment criteria or treatment and care.

Our proposal

In our view, the Act should require the Tribunal or the hospital to facilitate access to a second psychiatric opinion for all patients subject to involuntary treatment. Involuntary treatment is a serious infringement on a person's autonomy and can have ongoing traumatic impacts for the person and their family. The grounds for involuntary treatment should therefore be subject to effective scrutiny and oversight. Medical errors are always a possibility. The consequences of medical error for the patient are particularly grave in the context of involuntary treatment where the patient's rights and liberty are at stake. To ensure effective scrutiny, an independent second psychiatrist should be required to comment on whether the treatment criteria are satisfied and on the proposed treatment and care.

The need for review of involuntary treatment at regular intervals supports the facilitation of ongoing second psychiatrist opinions. Requiring the Tribunal or the hospital to facilitate access

⁷⁴ *Mental Health Act 2000* (Qld) s 457.

⁷⁵ *Ibid* s 190.

⁷⁶ *Ibid* s 347.

⁷⁷ Queensland Health, above n 14, 8, Recommendations 5.3 and 5.6.

⁷⁸ Queensland Health, *Review of the Mental Health Act 2000 Background Paper 5: Treatment and Care of Involuntary Patients* (2014) 3 – 4.

to an independent second psychiatric opinion before the first Tribunal hearing and after six months, 12 months and every two years thereafter will ensure that the medical basis and justification for ongoing involuntary treatment is adequately scrutinised. This recommendation is particularly important in light of the Discussion Paper's recommendation to change the six-monthly automatic reviews of ITOs to yearly reviews. Providing an effective framework to facilitate access to an independent second psychiatric opinion is necessary to keep treating teams accountable.

This will also have additional benefits for patients, including:

- promoting self-determination for patients by providing them with information about their treatment and possible alternative treatments;
- allowing patients to better understand their illness; and
- empowering patients to contribute to decision-making about their treatment and fully participate in their treatment and recovery.

QPILCH Recommendation 24 – As an alternative, the Act should require the Tribunal or the hospital to facilitate access to an independent second psychiatric opinion upon request.

If recommendation 24 is not accepted, it is critical that people on an ITO have access to at least one independent second psychiatric opinion over the duration of the ITO. This is because second psychiatric opinions are a critical safeguard in the context of involuntary treatment, for the reasons outlined above.

QPILCH Recommendation 25 – At a minimum, the Act should require the Tribunal or the hospital to facilitate access to an independent second psychiatric opinion when an application is made to the Tribunal for a review of the patient's treatment and care.

We welcome the addition of a right to apply to the Tribunal for a review of the patient's treatment and care. To assist this process, we recommend that the Tribunal or the hospital should be required to facilitate access to an independent second psychiatric opinion whenever an application is made for a review of the patient's treatment and care.

This would assist the Tribunal in making a decision about whether to direct the authorised mental health service to review the patient's treatment and care. If such an order is made, the second opinion would also help to ensure the authorised mental health service considers any alternative methods of treatment and care identified by the second opinion. If the authorised mental health service declines to adopt recommendations made in the second opinion, their

report back to the Tribunal should include reasons for this decision. This would help to maximise efficiency in the application process, ensure accountability of the authorised mental health service when considering appropriate treatment and care, and improve clinical outcomes for the patient.

QPILCH Recommendation 26 – The Act should define what constitutes a second opinion.

To ensure independent second psychiatric opinions address the concerns discussed above, the Act should explicitly define a second opinion as:

an in-person psychiatric assessment where practicable, or an assessment via video-link in other circumstances, given by a psychiatrist from outside the mental health service at which the patient is receiving treatment or a psychiatrist within the same mental health service, provided the identity of the psychiatrist remains confidential to the treating psychiatrist, which addresses both the treatment criteria and the treatment and care needs of the patient.

The second opinion must be independent

It is vital that a second opinion is given by an independent psychiatrist. There is a risk that doctors working closely together will be reluctant to make findings that are substantially different from the findings of their colleagues. Doctors may have reasonable concerns about the damage this could do to their professional relationships with colleagues. The appearance of independence is also critical to the patient's willingness to accept the second opinion. Opinions from doctors within the same system as the authorised psychiatrist are likely to be perceived to be lacking independence and therefore illegitimate.

The above definitions indicates that where an in-person psychiatric assessment is not practicable (for example, where the patient is located in a rural, regional or remote facility), the psychiatrist may examine the patient via video-link.

Alternatively, where a psychiatrist is not available from a separate mental health facility, some degree of independence may be maintained by ensuring that the report of the second psychiatrist remains confidential to the treating psychiatrist.

Access to Health Information

QPILCH Recommendation 27 - The Act should require that the patient's clinical report be given to the patient at least seven days before a Tribunal hearing.

The *Mental Health Review Tribunal Rule 2009* (Qld) ("the Rule") requires that a copy of a patient's clinical report be given to the executive officer and the relevant patient at least seven days before a hearing.⁷⁹ Alternatively, the treating psychiatrist is allowed to make the relevant patient aware of the clinical report's contents.⁸⁰

In our experience the timeframe contained in this rule is rarely complied with. The clinical report is often handed to the patient one or two days before the hearing or sometimes even on the day of the hearing. The Tribunal's Annual Report notes that clinical reports were received on time in only 38.1 per cent of cases between 2012 and 2013.⁸¹ This issue has not been addressed in the Discussion Paper.

In order for the patient to properly prepare for the Tribunal hearing, the patient must have sufficient time to review and respond to the information contained in the clinical report. We submit that this rule be incorporated in the Act.

Currently there is no consequence for non-compliance with the rule. We appreciate that there can be many legitimate reasons for non-compliance including the workloads of clinicians and the demands on mental health services. For this reason, we have not recommended that the Act be amended to provide a penalty for non-compliance. However, we submit that incorporating the requirement in the Act, rather than the Rules, will serve an educative function.

QPILCH Recommendation 28 - The Act should stipulate that people subject to an ITO have the right to access their medical records.

Patient participation in treatment decisions is an essential aspect of the recovery framework. This is reflected in the Australian National Standards for Mental Health.⁸²

In Queensland, patients or their representatives are rarely given access to the patient's clinical file. Access to clinical information is important as it allows a patient to gain a better

⁷⁹ *Mental Health Tribunal Review Rule 2009* (Qld) r 3.

⁸⁰ *Ibid* r 3(4)(b).

⁸¹ Queensland Health, above n 60, 15.

⁸² Department of Health and Aging, *National Standards for Mental Health Services* (Australian Government, 2010) Standards 1.10, 6.7, 6.9 and 6.14.

understanding of their condition and treatment and assists patients in preparation for Tribunal hearings. Informing patients about their condition and need for treatment would also promote the patient's capacity to engage in treatment and care decisions and facilitate their pathway towards taking responsibility for their recovery. Access to health records would also provide a strong incentive for healthcare professionals to ensure the accuracy of the records they keep.⁸³

QPILCH recognises that procedures for informal administrative release of records are provided for under the *Health Information: Disclosure and Access Policy (February 2005)* ("the Policy"), as referred to in the Background Paper.⁸⁴ While the Policy is intended to provide access through informal, administrative release processes in most cases,⁸⁵ in our view the policy does not provide an adequate mechanism for access. In our experience, patients have rarely been able to access their medical records through these informal avenues. Instead patients are generally only able to access their medical records through Right to Information applications. This is a time-consuming process, and patients generally will not receive their records until well after their Tribunal hearing has passed.

We recommend that the Act should specifically provide for patients to have a right of access to their medical records. Ideally patients should have a right to access medical records at any time. However at a minimum, patients should be permitted to access records prior to Tribunal hearings.

Furthermore, under the Policy, authorised mental health services are permitted to either adopt the Policy or develop their own administrative access policy, which may result in inconsistent procedures across different services.⁸⁶ Providing for a right to access medical records in the Act will promote uniformity across services and give greater status to the importance of having access to records. The *Mental Health Act 2007* (NSW) already provides for this recommendation.⁸⁷

Safeguards

QPILCH recognises that in some situations, granting full access to a patient may not be appropriate, and safeguards are necessary to address such situations. One of these situations is where granting full access could be detrimental to the physical or mental health or well-being of

⁸³ See House of Representatives Standing Committee on Legal and Constitutional Affairs, *Advisory Report on the Privacy Amendment (Private Sector) Bill 2000*, 76-7.

⁸⁴ Queensland Health, above n 78, 3.

⁸⁵ *Ibid.*

⁸⁶ *Ibid.*

⁸⁷ *Mental Health Act 2007* (NSW) s 156.

the patient. However, any detrimental effect to the patient should be balanced against the dignity of having the opportunity to know and understand medical information concerning themselves, as well as the ability to participate in their own medical treatment.

Where a patient is denied access on the grounds that it would be detrimental to the patient's physical or mental health, the Act should grant access to the patient's representative. This would facilitate the representative's preparation for the patient's Tribunal hearing. Where access is granted to the representative but not the patient, appropriate conditions may be imposed, such as not to reveal the records to the patient. This would be consistent with similar provisions enacted in mental health legislation in other Australian jurisdictions such as NT⁸⁸ and NSW.⁸⁹

⁸⁸ *Mental Health and Related Services Act*, s 92.

⁸⁹ *Mental Health Act 2007 (NSW)*, s 156(2)-(3).

Confidentiality and Privacy

The Discussion Paper and Background Paper propose strengthening the role of family, carers and other support persons in decisions about a patient's involuntary treatment and care.⁹⁰ While we accept that the involvement of family, carers and other support persons will in most circumstances promote better outcomes for the patient, this needs to be balanced with involuntary patients' rights to privacy and confidentiality. In our experience, some patients do not want family members or other carers involved in decisions about their treatment and care. In light of this, we submit that the Act should explicitly recognise involuntary patients' rights to privacy and confidentiality.

QPILCH Recommendation 29 – The Act should require that a doctor or authorised mental health professional only consult with an involuntary patient's family, carer or other support person if:

- a) the patient has given informed consent for the doctor or authorised mental health practitioner to consult with the family member, carer or other support person; or
- b) the family member, carer or other support person is the involuntary patient's primary carer.

We agree that in the majority of circumstances, increased participation of family, carers and other support persons will help to promote involuntary patients' best interests and result in better and more sustained health outcomes. Indeed family, carers and support persons often have information and insight that can be useful to the treating team when considering treatment and care options.⁹¹ Family, carers and support persons also undoubtedly have a role to play in the protection of involuntary patients' rights.

While we recognise the importance of the role that family, carers and other support persons play, we stress that a balance must be achieved with the patient's rights to privacy and confidentiality. Family members and others are not always the best narrators of a person's history, nor do they always act in the patient's best interests. In our experience, some involuntary patients do not want family members or other support persons involved in decisions about their treatment and care. A patient may disagree with the opinions of their family members, especially where the involuntary examination and assessment process was

⁹⁰ See, e.g. Queensland Health, above n 14, recommendations 5.4, 5.8, 5.10, 7.1, 7.5, and 7.7.

⁹¹ Queensland Health, *Review of the Mental Health Act 2000 Background Paper 7: Support for Involuntary Patients* (2014) 4.

initiated by a family member. Some patients are concerned about the amount of influence that the family member or other support person may have on their doctor's clinical decisions. Other patients, especially young patients, have also expressed concerns that they are unduly influenced by family members or other support persons and are, through fear of retaliation, pressured into misrepresenting their history or treatment needs to clinicians. In other circumstances, patients may simply not want family members or friends to know that they are on an ITO.

Although the proposals in the Discussion Paper are not intended to override an involuntary patient's right to privacy,⁹² this should be more clearly articulated in the Act. The Background Paper suggests that an involuntary patient has the right to control who contacts them and what information is provided to other people.⁹³ However in our experience, most patients are either not aware that their family or other support persons have been or are being consulted, or are unable to enforce any right to privacy to prevent their treating team from consulting with family members or other support persons. Furthermore, many clinicians are uncertain of their rights to consult with family members or other support persons and how this is to be balanced with their obligations to respect the involuntary patient's right to privacy. The fact that patients are involuntary and deemed unable to make decisions about their treatment and care often contributes to this uncertainty. Therefore, despite the general right to privacy, further protections are needed to clarify and enforce patients' rights to privacy when receiving treatment under an ITO.

The *National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*⁹⁴ ("the Guide"), which provides guidance to doctors and authorised mental health practitioners in upholding the rights of involuntary patients, also recognises this tension. The guide provides that mental health practitioners and providers should, as a core principle of good recovery-oriented practice, recognise that "choices about the involvement in personal recovery of family and significant others rests with the person living with mental health issues."⁹⁵ The *Queensland Health Public Patients' Charter* also recognises that all patients within public hospitals have a right to privacy and confidentiality.⁹⁶ International rights instruments

⁹² Ibid 4-5.

⁹³ Ibid.

⁹⁴ Australian Health Ministers' Advisory Council, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers* (Commonwealth of Australia 2013)

<<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde>>.

⁹⁵ Australian Health Ministers' Advisory Council, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers* (Commonwealth of Australia 2013) 57

<<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde>> .

⁹⁶ Queensland Health, *Queensland Health Public Patients' Charter* (Queensland Government, 2002) 8
<<http://www.health.qld.gov.au/qhppc/docs/booklet.pdf>>.

also recognise a right to privacy and confidentiality for people who have a mental illness or a disability.⁹⁷

To ensure greater protection and enforcement of involuntary patients' rights to privacy and confidentiality, the Act should explicitly permit, wherever practicable, a doctor or authorised mental health practitioner to consult with or release information to the patient's family, carer or other support person only if they have received consent from the involuntary patient or where the family member, carer or other support person is the involuntary patient's primary carer. A similar provision exists in the *Mental Health Act 2007* (NSW),⁹⁸ which permits an involuntary patient to nominate a person as their primary carer while they are receiving involuntary treatment. Therefore, to give effect to this recommendation, the Act would also require an additional provision allowing an involuntary patient to nominate a person as their primary carer.

This recommendation would allow a patient to exclude or minimise the involvement of family members or other support persons where their involvement may be detrimental to the patient's wellbeing. It would also promote clinical understanding of obligations to respect patient privacy. Family members, carers or support persons would still be permitted to participate in the patient's treatment and care, either through consent or encouraging the patient to nominate them as their primary carer. Doctors and authorised mental health services would also still be permitted to obtain important information from family members, carers or support persons when making decisions about treatment and care, but only where this would be appropriate and in the patient's best interests.

⁹⁷ *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 75th plen mtg, UN Doc A/RES/46/119 (17 December 1991), principle 6, 13(1)(b); United National Convention on Rights of Persons with Disabilities, UN doc A Res 61/106 (3 May 2008) art 22 <<http://www.un.org/disabilities/convention/conventionfull.shtml>>.

⁹⁸ *Mental Health Act 2007* (NSW) s 189.

Advance Health Directives

Meaningful participation in treatment decisions is a fundamental aspect of the recovery framework. Every individual's recovery pathway is unique, underlying the importance of measures which assist the person to be involved and take responsibility for decisions about their treatment and care. Indeed the Act itself states that "to the greatest extent practicable, a person is to be encouraged to take part in making decisions affecting the person's life, especially decisions about treatment."⁹⁹ Denying patients the dignity of being involved in decisions about their treatment and care and the opportunity to take responsibility for their own wellbeing may place unnecessary strain on patient-clinician relationships, reduce patients' willingness to cooperate with involuntary treatment, prevent patients from developing a capacity or willingness to accept their mental illness and need for treatment, and unnecessarily delay the patient's recovery.

Advance health directives are an important mechanism to give effect to this principle, and allow people with mental illness to meaningfully participate in treatment decisions. We propose that the following recommendations should be included to strengthen the role of advance health directives in a person's treatment and care, so as to maximise patient involvement, and increase their dignity and responsibility in the treatment process.

QPILCH Recommendation 30 – Where an advance health directive is lawfully made, treatment must be given in accordance with the directive, except:

- (a) in an emergency;
- (b) where there is a serious risk that compliance with the directive is likely to result in the person:
 - i. causing serious harm to himself, herself or someone else; or
 - ii. suffering serious mental or physical deterioration;
- (c) where disregarding the directive is necessary to ensure the person receives treatment and care that is responsive to the person's particular needs at the time the treatment decision is being made;
- (d) where there have been advances in medical science to the extent that the person, if they had known of the change in circumstances, would have considered the terms of the directive inappropriate.

⁹⁹ *Mental Health Act 2000* (Qld) s 8(1)(b).

While some recommendations in the Discussion Paper promote a greater degree of patient involvement in treatment decisions, the Discussion Paper does not provide any recommendations for changes to the status of advance health directives under the Act.

Improving the status of advance health directives under the Act would help minimise the significant infringement that involuntary treatment imposes on a person's liberty by promoting patient involvement and responsibility for their own treatment. Therefore, we propose the Act should do more to recognise and enforce the important role of advance health directives.

Current status of mental health advance directives

The status of advance health directives in the context of mental illness is unclear. Under the *Power of Attorney Act 1998* (Qld) ("the POA Act"), a health care provider is required to follow a valid directive unless:

- they have reasonable grounds to believe the directive is uncertain;
- they have reasonable grounds to believe the directive is inconsistent with good medical practice; or
- circumstances, including advances in medical science, have changed to the extent that the adult, if he or she had known of the change in circumstances, would have considered that the terms of the direction are inappropriate.¹⁰⁰

However the Act prevails where there is any inconsistency with the POA Act. Therefore, when a person who has made an advance health directive is subsequently placed on an ITO, the legal status of their directive becomes subject to the Act. Under the Act, a treating team is not required to follow the patient's directive. The treating team therefore has considerable discretion in its treatment decisions and how any directive is taken into account.

This is inconsistent with fundamental principles espoused under the Act, which provides that people with mental illness are entitled to the same human rights protections as other people.¹⁰¹ To genuinely give effect to that principle, advance health directives made by people with a mental illness should be afforded the same weight as those made by any other person.

¹⁰⁰ Ibid s 103. 'Good medical practice' is defined in sch 2, s 5B by reference to medical and ethical practices and standards of the medical profession in Australia.

¹⁰¹ Ibid s 8(1)(a).

Importance of mental health advance directives

Often an advanced health directive will be the only mechanism by which a person receiving involuntary treatment can express their treatment preferences. Improving the strength of advance health directives under the Act would enable people with mental illness to express their preferences about a wide range of important issues and to make important decisions regarding their treatment at a time when they have capacity to make those decisions.

Further, directives can assist people to assess all aspects of their treatment and identify in advance the role that family or carers will play if they lose capacity to make treatment decisions in the future.¹⁰² Advance health directives should therefore play a more prominent role in maximising patient involvement in decisions about treatment and care.

These recommendations would also help to ensure that the Act's substantive provisions are consistent with its guiding principles. The Act states that "to the greatest extent practicable, a person is to be encouraged to take part in making decisions affecting the person's life, especially decisions about treatment."¹⁰³ As noted above, advance health directives allow people with mental illnesses to meaningfully participate in treatment decisions, and are therefore an important mechanism to give effect to this principle.

When an advance health directive may not be followed

We acknowledge that while it is imperative that the Act promote the integrity of advance planning and the importance of choice and control, these must be balanced with interests in the safety and wellbeing of people experiencing mental illness. It is possible that a person may include directions in an advance health directive that refuse all treatment, or which consent only to alternative treatments such as herbal medication or spiritual enlightenment. Where following such directions would pose risks to the health or safety of the patient or the safety of others, it is anticipated that an authorised mental health practitioner would be permitted to administer treatment inconsistent with the advance health directive.

Under existing provisions, an authorised mental health practitioner is permitted to disregard a patient's advance health directive for any reason, not only where the direction would pose risks to health or safety. As a result, the existing provisions effectively exclude patient integrity, choice and control. A more appropriate balance needs to be struck between patient wellness

¹⁰² Australian Health Ministers Advisory Council, *Carers Identified? Identifying the Carer Report 2010* (Mental Health Standing Committee, 2010) <<http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/pub-sqps-carers-toc~pub-sqps-carers-toc-3~pub-sqps-carers-toc-3-5>>.

¹⁰³ *Mental Health Act 2000* (Qld) s 8(1)(b).

and safety and patient integrity, choice and control. We submit that these recommendations will strike a more appropriate balance between these imperatives.

The default position should be that treating teams are required to follow an involuntary patient's advance health directive. The treating team should be permitted to provide treatment inconsistent with the patient's advance health directive only in defined circumstances. Just as the Act requires authorised mental health practitioners to consider risk of harm and risk of mental or physical deterioration when contemplating the appropriateness of involuntary treatment for a patient, we submit that the Act should require practitioners to consider these factors when deciding whether to provide treatment inconsistent with a direction in a patient's advance health directive. If complying with the direction would not pose any significant risk, but would still ensure the patient receives treatment and care that is appropriate to their particular treatment and care needs, the patient's integrity, choice and control should be respected and prioritised.

In considering these factors, it is contemplated that an authorised mental health practitioner would be reasonable in deciding whether to follow or disregard a patient's advance health directive, and would, where appropriate and practicable, seek the views of the patient's support persons regarding the circumstances in which the particular direction was made and the reasons for the person's direction.

QPILCH Recommendation 31 – If a doctor or authorised mental health practitioner makes a treatment decision that is not in accordance with the patient's advance health directive, the doctor or authorised mental health practitioner must inform the patient of the decision and provide written reasons for the decision.

It is expected that the above recommendations, if implemented, may not be followed on all occasions. This may be the case where a doctor or authorised mental health practitioner considers it is clinically appropriate to provide treatment that is not in accordance with the patient's advance statement. We appreciate that training and resource issues, and issues with locating and accessing patients' advance health directives may also prevent clinicians from acting in accordance with a patient's advance statement. To further improve the status of advance health directives and patients' rights to autonomy and self-determination, we propose that practitioners be required to record reasons for any treatment decision that is not in

accordance with the patient's advance health directive. Other jurisdictions have already implemented this recommendation, including the *Mental Health Act 2014* (Vic).¹⁰⁴

We believe this would help to increase practitioner accountability and the transparency of decisions made by practitioners. This would also enable people to understand the reasons why their directions were not complied with, and may assist patients to understand their mental illness and need for treatment.

QPILCH Recommendation 32 – Wherever the Act permits a patient to give informed consent, the Act should explicitly recognise that informed consent may be given by a direction in an advance health directive.

The Act permits a patient to give informed consent to ECT or psychosurgery. A person may be treated with ECT only if the person has given informed consent or the Tribunal has approved the use of ECT.¹⁰⁵ Psychosurgery must not be performed unless the person has given informed consent to the treatment.¹⁰⁶

Given the Act explicitly recognises the possibility of a patient giving informed consent, the patient should be entitled, as in all other health domains, to make a decision for these purposes in advance through an advance health directive. It is unclear whether the Act in its current state permits a patient to give informed consent to these treatments through an advance health directive.

Currently, informed consent may only be given if the person has capacity,¹⁰⁷ and must be given in writing signed by the person.¹⁰⁸ These requirements would be satisfied by a decision in an advance health directive. The Act also requires consent to be given freely and voluntarily,¹⁰⁹ and that a full explanation of the proposed treatment is given and understood by the person.¹¹⁰ This information is usually given immediately prior to the proposed treatment and is tailored to the particular circumstances of the patient. However there is no reason why a person could not be given a full explanation of the general purpose and method of treatment, the potential benefits and side effects, and possible alternative methods of treatment in advance when the person has the capacity to consent to or refuse these treatments. If, when the treatment is being

¹⁰⁴ *Mental Health Act 2014* (Vic) s 73(2).

¹⁰⁵ *Mental Health Act 2000* (Qld) s 139(1).

¹⁰⁶ *Ibid* ss 161(2)(a), 230(1) and 233(4)(a).

¹⁰⁷ *Ibid* s 134.

¹⁰⁸ *Ibid* s 135.

¹⁰⁹ *Ibid* s 136.

¹¹⁰ *Ibid* s 137.

contemplated, there is legitimate concern about the validity of the advance health directive, or there are reasonable grounds to believe that a direction in an advance health directive is uncertain or inconsistent with good medical practice, or circumstances have changed to the extent that the direction is inappropriate, the advance health directive may be disregarded as in all other health domains.¹¹¹

There is no convincing reason why the Act should not explicitly recognise a patient's right to consent to ECT or psychosurgery in advance through an advance health directive, as the Act already permits a person to give informed consent to these treatments. Similar amendments have been proposed in the *Mental Health Bill 2013 (WA)*.¹¹²

Part of the Independent Patient Companion's role will be to advise patients of the benefits of having an advance health directive.¹¹³ As noted above, the status of decisions made in an advance health directive is very unclear. To assist Independent Patient Companions to advise patients of the benefits of advance health directives, the status of advance health directives under the Act should be clarified. Explicitly recognising that informed consent, wherever permitted under the Act, may be given by a direction in a valid advance health directive will help clarify the status of advance health directives under the Act, at least in relation to ECT and psychosurgery.

¹¹¹ *Power of Attorney Act 1998 (Qld)* s 103(1).

¹¹² *Mental Health Bill 2013 (WA)* ss 197 and 208.

¹¹³ Queensland Health, above n 14, 25, Recommendation 7.7.

Legal Representation

QPILCH welcomes the Discussion Paper's recognition of the important role that legal representatives and advocates play in ensuring patients' rights are protected. There is currently a low rate of attendance at hearings for patients on an ITO and just over two per cent of patients have any form of representation.¹¹⁴ Legal representation and advocacy services help improve the quality and efficiency of Tribunal hearings, increase patient participation at Tribunal hearings, improve the patient's perception and understanding of the review process, and improve communication between patients and their treating teams.

We acknowledge and endorse the proposal for legal representatives to be appointed by the Tribunal for hearings involving minors, fitness for trial reviews, and where the State is represented by the Attorney General.¹¹⁵ We also appreciate that financial and resource limitations prevent the provision of legal representation in all cases. Provided it is financially viable to do so, we believe that legal representation should also be provided in hearings for:

- people subject to electroconvulsive therapy (ECT) or psychosurgery applications; and
- people with vulnerabilities in addition to mental illness.

QPILCH Recommendation 33 – A legal representative should also be appointed to:

- a) people subject to ECT or psychosurgery applications; and
- b) people with multiple vulnerabilities.

ECT or psychosurgery applications

Because of the controversial nature of ECT and psychosurgery, and the social stigma attached to these treatments, we recommend that the Act require legal representation to be appointed to all people subject to ECT or psychosurgery applications. These treatments are often perceived by the community to be particularly intrusive and far more invasive than medication. There is currently no clinical consensus that the use of ECT or psychosurgery is appropriate for treatment of mental illnesses. These treatments represent a serious infringement on the bodily integrity of the patient. Furthermore, many patients for whom ECT or psychosurgery is being considered will be seriously unwell, reducing the patient's capacity to represent themselves. Legal representation would help to ensure that the patient's rights and interests are adequately protected, the Tribunal is suitably informed when considering an ECT or psychosurgery

¹¹⁴ Queensland Health, above n 60, 7.

¹¹⁵ Queensland Health, above n 14, 28, recommendation 9.2.

application, and ECT and psychosurgery are used only where necessary and clinically appropriate.

Multiple vulnerabilities

People who have vulnerabilities in addition to their mental illness may also be at a special disadvantage in Tribunal hearings. People with intellectual disabilities, Aboriginal and Torres Strait Islander people, and people from culturally and linguistically diverse backgrounds may face difficulties in clearly and concisely expressing themselves and their cultural backgrounds or beliefs to the Tribunal. This reduces their capacity to engage meaningfully in Tribunal hearings and decisions about their treatment and care. Appropriate legal representation would help to ensure the person can fully and clearly express themselves to the Tribunal, and would improve the Tribunal and treating team's perception and understanding of the person's unique circumstances.

People with intellectual disability

People with an intellectual disability and mental illness are particularly vulnerable and limited in their ability to protect their interests and navigate the complexities of the mental health system, especially due to limitations in their capacity to comprehend information and understand their rights, and articulate their views clearly.

Aboriginal and Torres Strait Islander people

There is an over-representation of Aboriginal and Torres Strait Islander people in mental health systems across Australia.¹¹⁶ A high percentage of Aboriginal and Torres Strait Islanders experience multiple disadvantages, which inhibit their ability to meaningfully participate in mental health treatment.

Aboriginal and Torres Strait Islander people face additional barriers to meaningful engagement in the Tribunal process including reluctance to attend hospital-based hearings due to cultural associations between hospitals and death, an inability to express cultural sensitivities to the Tribunal, and language barriers that may inhibit their ability to understand information and communicate their views.

People from culturally and linguistically diverse backgrounds

¹¹⁶ Darren Garvey, "Review of the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples - considerations, challenges and opportunities" (2008), <http://www.healthinonet.edu.edu.au/sewb_review>.

People from culturally and linguistically diverse backgrounds may also face difficulties in expressing cultural sensitivities to the Tribunal. A person's cultural background may for example impact their opinion about the types of treatments that are suitable for their condition. An understanding of the person's cultural background may help Tribunal members and the person's treating team to understand the reasons for the person's reluctance to take certain medications or to accept a particular diagnosis. Language barriers may also inhibit the person's ability to understand information and communicate their views. Appropriate legal representation would therefore help the patient, the Tribunal and the treating team to more clearly understand each other's position and facilitate a more cooperative approach to treatment and care that takes the person's special circumstances into account. This would be more consistent with the recovery model of treatment.

We acknowledge that there would be cost implications of appointing a legal representative to each person under these categories. If this is not financially viable, we recommend that an advocate should instead be appointed from an approved advocacy service.

QPILCH Recommendation 34 – The role of advocates should be explicitly recognised in the Act.

QPILCH acknowledges that the Discussion Paper has recognised the right of advocates to appear at Tribunal hearings.¹¹⁷ However, in order to further strengthen the role of advocates in the mental health framework, we recommend that the role of advocates be explicitly recognised in the Act.

We recommend that the following provisions be included in the Act:

Who is an advocate?

An advocate for an involuntary patient is the person chosen or declared under this part to be the patient's advocate.

Function of advocate

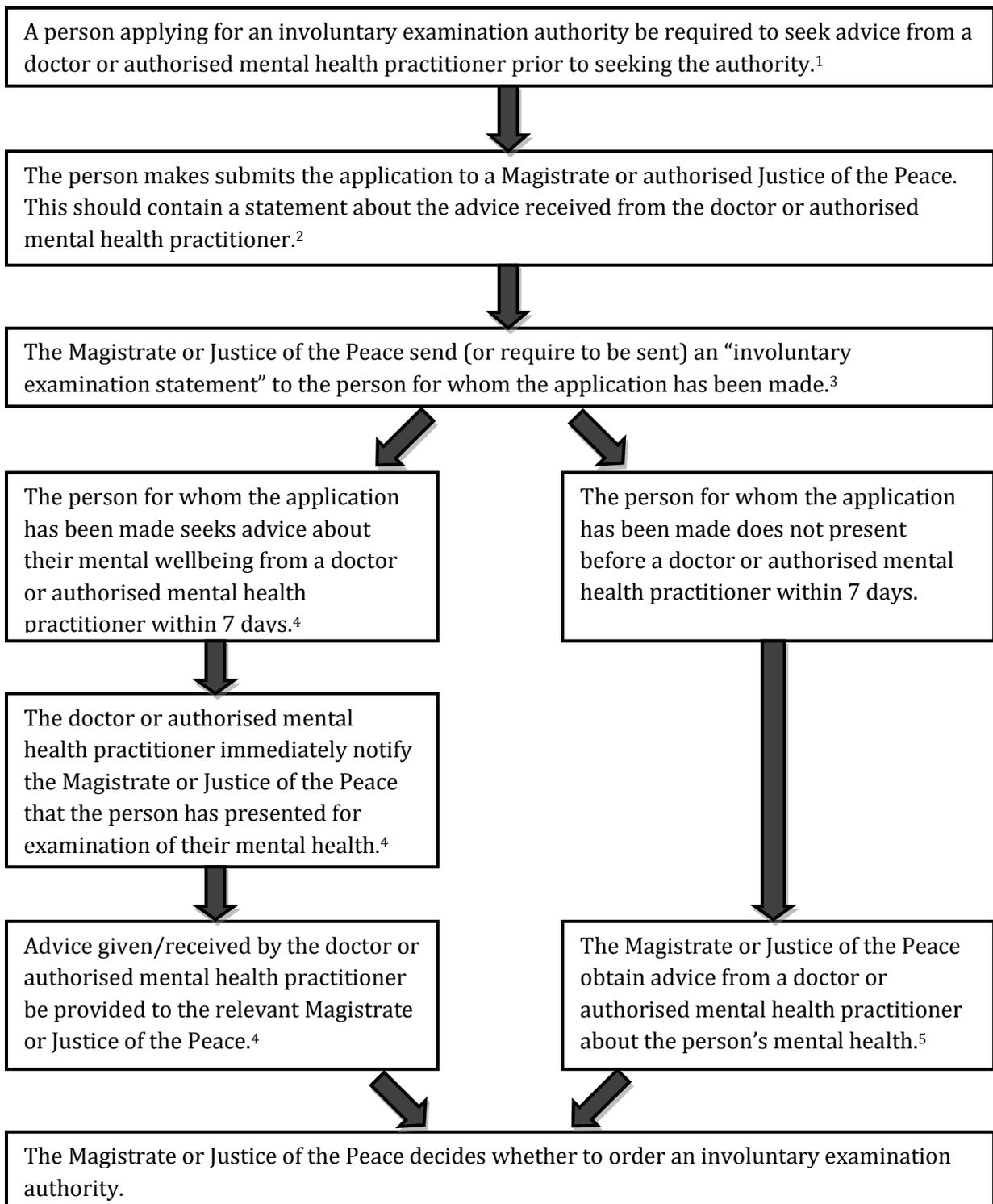
The function of an involuntary patient's advocate is to help the patient to represent the patient's views, wishes and interests relating to the patient's assessment, detention, treatment and care under this Act.

¹¹⁷ Queensland Health, above n 14, 25, recommendation 7.8.

By recognising the role of advocates in the Act, health professionals may be more willing to engage with advocates in discussions about the patient's ITO and treatment. Better communication between health professionals and advocates will lead to greater involvement of the person under the ITO in treatment decisions. This is consistent with the recovery framework.

We are only aware of a small number of advocacy services available in Queensland for people on an ITO. Some other jurisdictions that recognise the role of advocates have one advocacy agency to which referrals are made. In the absence of a central advocacy agency in the State, it would be an appropriate responsibility of the Independent Patient Companion to maintain a list of suitable advocacy services to which referrals can be made.

Appendix A – Proposed Approach to Making of Involuntary Examination Authority



Glossary

TERM	DEFINITION
Background Paper	<i>Review of the Mental Health Act 2000 Discussion Paper (2014)</i>
Discussion Paper	<i>Review of the Mental Health Act 2000 Background Paper (2014)</i>
ECT	Electroconvulsive therapy
EEO	Emergency Examination Order
IPC	Independent Patient Companion
ITO	Involuntary Treatment Order
JEO	Justices Examination Order
JP	Justice of the Peace
MHLP	Mental Health Law Practice
NSW	New South Wales
NT	Northern Territory
POA Act	<i>Powers of Attorney Act 1989 (Qld)</i>
QPILCH	Queensland Public Interest Law Clearing House
SOR	Statement of reasons
The Act	<i>Mental Health Act 2000 (Qld)</i>
The Charter	Queensland Health Public Patients' Charter
The Director	Director of Mental Health
The Guide	<i>The National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers</i>
The MHA Resource Guide	<i>The Mental Health Act 2000 (Qld) Resource Guide</i>
The Policy	<i>The Health Information: Disclosure and Access Policy (February 2005)</i>
The Rule	<i>Mental Health Review Tribunal Rule 2009</i>
The Standards	Australian National Standards for Mental Health Services
The Tribunal	Mental Health Review Tribunal
The Victorian Act	<i>Mental Health Act 1986 (Vic)</i>
The WA Bill	Mental Health Bill 2012 (WA)
Treatment criteria	As set out in section 14 of the <i>Mental Health Act 2000 (Qld)</i>