ATTACHMENT A

OFFICE OF THE PUBLIC GUARDIAN RECOMMENDATIONS - MENTAL HEALTH BILL 2015

Key issues

A. *Guardianship/Statutory Health Attorney safeguards/review mechanisms where consent is provided by a third party*

MH Bill	Comment	Recommendation
Meaning of *less restrictive way* **Clause 13** For this Act, there is a *less restrictive way* for a person to receive treatment and care for the person's mental illness if, instead of receiving involuntary treatment and care, the person is able to receive treatment and care in 1 of the following ways- (a) If the person is a minor – with the consent of the minor's parents; (b) If the person has made an advance health directive – under the advance health directive (c) If a personal guardian has been appointed for the person – with the consent of the personal guardian (d) If an attorney has been appointed by the person – with the consent of the attorney; (e) Otherwise – with the consent of the person's statutory health attorney	There are currently insufficient safeguards either within the *Mental Health Bill* or within the *Guardianship and Administration Act 2000 (*GAA) or *Powers of Attorney Act 1998* (PAA) to address issues relating to individuals who will be subject to treatment under a 'less restrictive way' as proposed by the Bill. It is noted that the GAA was intended to operate in parallel with the mental health legislation, and was not intended to cover involuntary (or third party consent) in relation to mental health. The GAA does not have provisions which are adequate or appropriate for oversight, monitoring or review of mental health treatment and care. Consent to ongoing mental health treatment and care by statutory health attorneys is potentially an inappropriate use of the statutory health care scheme under the PAA. The proposed amendments to capacity law and changes which permit involuntary treatment where capacity fluctuates under the current scheme which does not have sufficient safeguards for this purpose, may expose a patient to abuse by unconscionable statutory health attorneys who will continue to consent to long term	It is critical that provisions are included in the Bill for review, oversight and safeguards for patients where consent is provided by a third party (such as a guardian or statutory health attorney). It is completely inappropriate that such safeguards be incorporated into the GAA and PAA. Specific provisions should be devised to regulate the use of the Public Guardian as Statutory Health Attorney of last resort under the Bill. Provision should be made to ensure that only the most senior statutory health attorney who is available is consulted for approval.

ATTACHMENT A

MH Bill	Comment	Recommendation
	mental health treatment and care. There is also no provision for ensuring that there are not multiple statutory health attorneys used at differing times, particularly where treatment is ongoing for several months. Given that Statutory Health Attorneys are outlined in a hierarchy provision, provision should be made to ensure that only the most senior Statutory Health Attorney who is available is consulted for approval. There are currently no adequate rights of review for persons who have consent provided by third parties. There are no time limitations placed upon how long consent can be provided by a third party. This fails to meet obligations under Article 12(4) of the UN Convention on the Rights of Persons with Disabilities. There are also limited safeguards with respect to the consenting to restrictive practices, such as chemical restraint (which appears to be incorporated as 'treatment and care' under the Bill - see discussion below). Further, it is not clear whether a guardian will be able to consent to personal searches of the person, or what will happen in cases where a person is absent without leave if the guardian has consented to their detention in an authorised mental health service. If amendments were made to the GAA/PAA to ensure these safeguards missing from the Bill are established, it will lead to a dual mental health review system whereby certain clients are reviewed	

ATTACHMENT A

MH Bill	Comment	Recommendation
	under a Mental Health Review Tribunal, whereas other clients will be subject to the jurisdiction of the Queensland Administrative Appeals Tribunal (QCAT). This would have resource and expertise implications for government and the OPG, and would lead to inefficient duplication of process.	
Psychiatric Reports in the Mental Health Court, Mental Health Review Tribunal and Magistrates Court.	It is not clear who will pay for psychiatric reports in the Magistrates Court, Mental Health Court and Mental Health Tribunal. Under clauses 654 and 712 of the Bill – each party to a proceeding in the MHC/MHRT respectively, '*is to bear the party's own costs of the proceeding'*. Is it intended that this will include the cost of psychiatric reports? Further, under Chapter 6, Part 2, a Magistrate will be empowered at trial to discharge a person charged with an offence if the person *appears* to have been of unsound mind at the time of the alleged offence or *appears* to be unfit for trial. It is not clear how persons with intellectual disability will be identified by the expanded court liaison service (whose expertise is foremost in the field of mental illness). It is not clear who will be qualified to provide these reports to the Magistrates with respect to	Confirmation is required that these reports will be accessible to persons with mental illness, as well as intellectual disability (particularly in the Magistrates Court) and paid by the government. Provision of reports should be made wherever a person is suspected of being of unsound mind/unfit for trial, regardless of whether counsel has been appointed for the person. Clarity is required from Queensland Health with respect to how the Court Liaison service will identify, assess and provide contemporaneous reports for persons with intellectual disability in the Magistrates Court.

ATTACHMENT A

MH Bill	Comment	Recommendation
	persons with intellectual disability and within what timeframe they will be provided.	
Request for Psychiatric report **Clause 88** The following persons may ask the chief psychiatrist for a psychiatrist report about the person in relation to the serious offence – (a) The person (b) The person's lawyer, if any: (c) The person's nominated support person, if any; (d) A personal guardian authorised to make decisions for legal matters for the person under the *Guardianship and Administration Act 2000*, if any (e) An attorney authorised to make decisions for legal matters for the person under the *Powers of Attorney Act 1998,* if any.	Psychiatric reports should be able to be requested for any offence, if there are doubts regarding their soundness of mind or fitness for trial in any jurisdiction. Under Clause 88 it does not appear that provision has been made for parents/guardians to request psychiatric reports for a minor. It is also noted that the ability to request a psychiatric report is limited to a personal guardian authorised to make decisions for legal matters for the person. This is the only time that the Bill requires a guardian for legal matters, rather than personal matters. There is a risk that a person may not have been appointed for legal matters, but for general matters. The concern is that this may mean that certain individuals fall within the gaps. With the onus now placed upon the person to request a legal report, there are concerns that personal guardians may be excluded from the legal process inhibiting their ability to fulfil their duty as guardian for the person.	It is recommended that the ability to request psychiatric reports should not be limited to only serious offences, but be available for any offence. It is recommended that provision be made for parents/guardians to request psychiatric reports for a minor. It is recommended that the ability to request a psychiatric report should not be limited to guardians appointed for legal matters.

ATTACHMENT A

MH Bill	Comment	Recommendation
Who is a Nominated Support Person **Clause 231** (1) A person is a ***nominated support person*** of another person (the ***appointing person***) if – (a) The person has been appointed, by written notice, as a nominated support person by the appointing person; and (b) A record for the appointment is kept in the records system (2) The appointing person may revoke the appointment by written notice	From stakeholder discussions it appears that the appointing of a nominated support person may be arranged at the same time as the making of an advance health directive. It is not clear why a person is not encouraged to establish a power of attorney or appoint one under an advance health directive at this time, when they have capacity. Particularly as a power of attorney is authorised to make particular decisions and do particular things for another person (see section 5(1) of the *Powers of Attorney Act 1998*). (see discussion of clause 232). From stakeholder discussions it also appears that the appointing person will be required to have capacity to appoint a nominated support person. This needs to be explicit in the Bill. Revocation of the appointment can only be by written notice of the appointing person. This appears to create an onerous obligation upon a nominated support person and does not enable them to withdraw from the position. There are also no mechanisms for removing a person as a nominated support person if they abuse their position. (*see also discussion regarding Clause 232*)	It is recommended that the Clause specify that the person must have capacity in order to appoint a nominated support person. It is recommended that consideration be given to providing for a mechanism for a nominated support person to withdraw from the position and be removed from a position if they are in breach of their duties/obligations.

ATTACHMENT A

MH Bill	Comment	Recommendation
Powers of nominated support person **Clause 232** A nominated support person may, if the appointing person is or becomes an involuntary patient, do any of the following (a) Receive notices for the appointing person under this Act; (b) Receive confidential information, under the *Hospital and Health Boards Act 2011,* relating to the appointing person (c) To the extent permitted under Chapter 12 or 16 – (i) Act as the appointing person's support person in the tribunal; or (ii) Represent the appointing person in the tribunal	It appears that this role attempts to create a hybrid of a power of attorney with that of 'formal supporter'. The risk is that it may not be successful in either supporting or representing the person's interests. To this end, while the Bill provides for powers for a nominated support person, there are no fiduciary type duties placed upon the person regarding how they are to exercise this power. There is no requirement that the supporter must be free from conflict of interest or not exert undue influence upon the appointing person. Greater clarification is also required regarding what the role of 'representing' the person will entail.	It is critical that the Bill explicitly provide fiduciary type duties/responsibilities for the nominated support person for the manner in which they are to conduct themselves in representing the appointing person's interests.
Records system for advance health directives and appointments of nominated persons **Chapter 7, Part 10, Division 3**	A records system is to be established and maintained by the Chief Psychiatrist to record advance health directives and appointments of nominated support persons. It is noted that establishing a record system specifically for these appointments within the mental health system is not consistent with current government policy and practice regarding record keeping for directives and powers of attorneys. Establishing such a system	It is recommended that the keeping of a record system for advance health directives and nominated support persons be considered from a whole of government policy position to enable consistent practice regarding registration of advance health directives and powers of attorney.

ATTACHMENT A

MH Bill	Comment	Recommendation
	within the mental health arena may give rise to public expectation that the state should record all advance health directives and powers of attorneys.	
Administrator to provide report **Clause 409** For a periodic review of a treatment authority under section 403(1)(c) - (a) The tribunal must consider whether the appointment of a personal guardian for the person may lead to a less restrictive way for the person to receive treatment and care for the person's mental illness; and (b) The administrator of the person's mental health service must give the tribunal a report about whether the appointment of a personal guardian for the person may result in there being a less restrictive way for the person to receive treatment and care for the person's mental illness.	The appointment of a guardian has cost and resource implications for both QCAT and the Public Guardian. It is not clear how many people are currently on involuntary treatment orders for periods of longer than 12 months and how many people this might apply to.	The Department of Health is requested to provide statistics regarding the number of people who are currently on an involuntary treatment order (ITO), and have been under the ITO for a period of longer than 12 months. It is strongly recommended that sufficient funding and resources are provided to the OPG to address this proposed increase in guardianship appointments.

ATTACHMENT A

B. *Children/Young People*

MH Bill	Comment	Recommendation
Use of restrictive practices **Chapter 8, Use of mechanical restraint, seclusion, physical restraint or other practices**	The Bill should expressly provide for limitations on the use of restrictive practices in the case of minors who are involuntary patients. For example: • clause 246(4) provides that mechanical restraints could be used on a person for up to 9 hours in a 24 hour period. • Clause 252(f) requires that a patient in seclusion be observed either continuously or at intervals of not more than 15 minutes. The Bill should expressly limit the use of mechanical restraints on minors, and ensure that minors are observed continuously if they are in seclusion. Where a restrictive practice is used on a minor, a notification should also be made to the Public Guardian.	It is recommended that the Bill expressly limits the use of mechanical restraint and seclusion in the case of minors. It is recommended that the Bill provide that minors placed in seclusion must be observed continuously. It is recommended that the Bill provide for a notification to be made to the Public Guardian when restrictive practices are used in the case of a minor.
Notice to tribunal of minor in custody becoming classified patient **Clause 71** (1) As soon as practicable after a person in custody, who is a minor becomes a classified patient, the administrator of	In order to satisfy the child advocate functions under the *Public Guardian Act 2014,* it is critical that the Public Guardian be advised as soon as a minor becomes a classified patient and upon admission or discharge from a high secure unit.	Amend **clause 71 and 81** of the Bill to provide notification must also be provided to the Public Guardian as well as the Mental Health Review Tribunal when a minor is admitted or discharged from a high secure unit.

ATTACHMENT A

MH Bill	Comment	Recommendation
the high security unit to which the minor is admitted must give the tribunal written notice that the minor has been admitted to the high security unit (2) If the minor stops being detained in a high security unit of an authorised mental health service the administrator must, as soon as practicable, give the tribunal written notice of that fact. **Clause 81** **Return of Classified patient to custody**	It is noted that under the *Mental Health Act 2000* notification was provided to the Chief Executive for Young People. It is recommended that the Bill address this gap and ensure that under **clauses 71 and 81**, notification is provided to the Public Guardian.	
Suspension of proceeding for offence **Clause 75** (1) If a person in custody becomes a classified patient, a proceeding against the person for an offence, other than an offence against the Commonwealth, is suspended **When suspension ends** **Clause 76**	In order to satisfy the child advocate functions under the *Public Guardian Act 2014*, it is critical that the Public Guardian be advised of suspension or ending of suspension of proceedings against a minor. (This should also be reflected under clause 100(3))	Amend **Clause 75** to reflect that notice should also be given by the chief executive (justice) to the Public Guardian of suspension of proceedings against a minor. Amend **Clause 76** to reflect that notice should also be given by the chief executive (justice) to the Public Guardian when the suspension of proceedings against a minor ends.
Support Person **Clause 95** (1) A person being examined for a psychiatrist report may be accompanied by a support person, including, for example, a nominated support person, lawyer, or personal guardian	It is noted that a person may be accompanied by a support person. It is recommended that it be mandatory that the opportunity to be accompanied by a support person must be offered to the person in the case of a minor.	Insert a provision that requires that that it be mandatory that the opportunity to be accompanied by a support person must be offered to the person in the case of a minor.

ATTACHMENT A

MH Bill	Comment	Recommendation
(2) A support person must not interfere with the examination		
Review of detention of minors in high security units **Chapter 12, Part 7**	It is noted that the Bill does not provide for notification to be made to the Public Guardian when there is a review of a minor's detention in a high secure unit. Notifications may be made under clause 282(5) to a parent of a minor, however, the definition of a parent of a minor includes 'a person who exercises parental responsibility for the minor, other than a person standing in the place of a parent of a minor on a temporary basis'. It is therefore noted that notification may not be received by Child Safety, and therefore also the Public Guardian for children in high secure who are also in the child safety system. This would mean that the Public Guardian would not be able to fulfil their child advocate function properly. It is therefore recommended that notification be made in all such circumstances to the Public Guardian, and also to child safety where a minor is subject to a child protection order.	It is recommended that notification be made to the Public Guardian (and where relevant the CEO of Child Safety) when there is a review of a minor's detention in a high secure unit.

ATTACHMENT A

Other Issues in Bill

MH Bill	Comment	Recommendation
Principles for administration of Act **Clause 5(b)** Matters to be considered in making decisions • 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 or care	Clause 5(b) should reflect principles acknowledging supported decision making in line with the Convention on the Rights of Persons with Disabilities, Article 12. Recognition of the principle of supported decision making is consistent with clause 14(3) of the Bill. It is also a separate issue to Clause 5(c) and the principle of recognition of support persons involved in decisions about the person's treatment and care. The principle of 'supported' decision making is currently reflected in Clause 7(e) of the *Forensic Disability Act 2011* (FDA). In the *Mental Health Act* 2000, the principles of the FDA are recognised as applying to persons with intellectual disability. It is recommended that the principles should be consistent with the FDA to ensure equal recognition of the principle for persons with mental illness as well as intellectual and cognitive disabilities.	Clause 5(b) should be amended to state 'a person is to be encouraged *and supported* to take part in making decisions'.
Application of provisions to persons with intellectual disability **Clause 8** To the extent this Act applies to a person with an intellectual disability— a) clauses 3 and 5 apply in relation to the person as if a reference in the clauses to a person who has a mental illness	The MH Bill promotes a recovery-oriented model, which is appropriate for persons with mental illness but is not appropriate for persons with intellectual or cognitive disability who may come under the Act, whether due to a dual disability or under the forensic provisions.	Include a sub-clause in clause 8 that a reference to recovery of a person who has a mental illness is a reference to 'habilitation and rehabilitation' of a person with an intellectual disability.

ATTACHMENT A

MH Bill	Comment	Recommendation
were a reference to a person with an intellectual disability; and b) a reference in the Act to treatment and care of a person means a reference to care of the person.	Although the definition of care includes the concepts of rehabilitation and habilitation, it is important to recognise that a recovery model is not appropriate for persons with intellectual or cognitive disability. It is recommended that clause 8 include recognition that a reference to 'recovery' in the context of mental illness in the Act is a reference to 'habilitation and rehabilitation' for a person with an intellectual disability. This would also enable the purpose of limited community treatment (see s.16) to reflect purposes which are relevant to persons with intellectual disability.	
Meaning of *capacity* to consent to be treated **Clause 14(1)** (1) A person has capacity to consent to treatment if the person— (a) recognises the person has a mental illness; and (b) is capable of understanding, in general terms— i. the nature and purpose of the treatment for the mental illness; and ii. the benefits and risks of the treatment, and alternatives to the treatment; and iii. the consequences of not receiving the treatment; and	It is noted that the 'capacity to consent to treatment' criteria has changed from the *Mental Health Act 2000* and is inconsistent with the definition of 'capacity' under the *Guardianship and Administration Act 2000* (GAA). This is likely to create confusion. The capacity to consent criteria has introduced a new criterion that the person must *'recognise [they have] a mental illness*' in clause 14(1)(a). The new definition appears to set a different and higher and inconsistent standard of capacity than that required to give informed consent to treatment regulated under the Bill (see cl.221(2)). This criteria has potential to impact upon individuals who refuse to acknowledge their condition as an illness, (possibly due to stigmatization), but may recognise the symptoms of the illness. The new	It is recommended that the new criteria in clause 14(1)(a) be: (1) omitted; or (2) The criteria be amended to 'recognition of the symptoms of mental illness'

ATTACHMENT A

MH Bill	Comment	Recommendation
(c) is capable of making a decision about the treatment and communicating the decision in some way.	definition may place such a person in a 'catch 22' situation. If the person does not acknowledge their illness, then they are at risk of being deemed unable to accept or understand the consequences of their illness. In a key Canadian case, *Starson v Swayze* (2003) (Supreme Court of Canada) the Canadian equivalent of the Mental Health Review Tribunal, decided that because Starson (the patient) lacked capacity because he refused to acknowledge that he had a mental illness. His refusal to acknowledge his mental illness led the Tribunal to conclude Mr Starson was unable to understand or appreciate the risks and the benefits of treatment. This matter was then appealed to the Supreme Court of Canada.The Supreme Court decision found that the patient, Mr Starson *did* have capacity. Although Mr Starson refused to recognise he had a mental illness, he recognised that he was not 'normal' and could 'recognise the symptoms'. The court considered that this understanding was sufficient to allow him to demonstrate capacity, rather than be forced to acknowledge that he had a mental illness and the stigma that went with the 'label'. It is therefore recommended that to avoid further stigmatisation of a patient by requiring them to recognise mental illness in order to prove their capacity, and in order to be consistent with other consent provisions within the Bill and other legislation, the criteria under clause.14(1)(a) should be omitted. Alternatively, wording should be	

ATTACHMENT A

MH Bill	Comment	Recommendation
	amended to replace 'recognition of a mental illness', with 'recognition of symptoms'.	
Purpose of limited community treatment **Clause 16** The purpose of limited community treatment is to support a patient's recovery by transitioning the patient to living in the community with appropriate treatment and care	If the Mental Health Court is able to order limited community treatment for a person on a Forensic Order (disability) then an appropriate definition should reflect that the purpose of limited community treatment for a person with intellectual disability is to 'support a patient's *habilitation and rehabilitation'* and not 'recovery'.	Insert a definition of limited community treatment that reflects 'rehabilitation and habilitation' is the purpose of limited community treatment for persons with intellectual disability.
Treatment and care of patients **Clause 23** (2) A person subject to a treatment authority must be regularly assessed to decide if the treatment authority should continue	In light of the fact that consent can be provided by a third party (eg., attorney, guardian), it is strongly recommended that this provision be amended to reflect a broader category of persons beyond just those on treatment authorities. Namely, that 'a person who does not have capacity to consent to be treated' must be regularly assessed to decide if the treatment should continue.	Amend Clause 23(2) to reflect that: 'A person subject to a treatment authority *or who has consent provided by a third party,* must be regularly assessed to decide *if they have capacity to consent to treatment'*.
Mental Health Review Tribunal **Clause 28** (1) The Mental Health Review Tribunal reviews the following – (a) Treatment authorities; (b) Forensic orders (c) Court treatment orders; (d) The fitness for trial of particular persons (e) The detention of minors in high secure units (2) The Mental Health Review Tribunal also hears applications for the following –	The Mental Health Review Tribunal (MHRT) is not provided with the jurisdiction to review patient treatment and care consented to by third parties. It has been intimated at stakeholder meetings that the GAA or PAA will need to be amended for review of their treatment and care, or use of restrictive practices. This will effectively create a dual system for the review of mental health treatment and care. It is therefore recommended that provisions be made within the Bill to ensure that reviews for treatment consented to by third party can be reviewed by the MHRT.	Amend clause 28 to extend the jurisdiction of the MHRT to review treatment and care of persons for whom consent has been provided by a third party, on an equivalent basis as that provided for persons subject to an involuntary treatment authority.

ATTACHMENT A

MH Bill	Comment	Recommendation
(a) Examination authorities (b) The approval of regulated treatment (c) The transfer of particular patients into and out of Queensland		
Notice of making recommendation for assessment **clause 37(1)** (1) As soon as practicable after deciding to make the recommendation for assessment, the doctor or authorised mental health practitioner must— a) tell the person of the decision; and b) explain to the person the effect of the recommendation; and c) if asked by the person—give a copy of the recommendation to the person.	If a person is suspected of lacking capacity to consent to treatment, it is questionable as to how the person will have the capacity to request a copy of the recommendation for assessment. Clarity is required in the legislation to specify that the doctor or authorised mental health practitioner is required to tell the person that they are able to obtain a copy of the recommendation. It is recommended that a copy of the recommendation be provided to the person as an automatic right under clause 37(1), unless there are legitimate medical reasons as to why the person should not be provided with a copy of the recommendation eg., it may cause serious and imminent deterioration of their mental health.	It is recommended that clause 37(1)(c) be amended to omit the words 'if asked by the person –'
Revocation **Clause 39** (1) A doctor or authorised mental health practitioner who makes a recommendation for assessment may revoke the recommendation at any time before the start of the assessment period for the person subject to the recommendation	It is considered that a least restrictive option wherein a third party can consent to treatment and care is still a substantial imposition on a person's human right to liberty and security, and requires a full assessment by a psychiatrist that the treatment criteria apply. In addition to this, treatment may require the prescription of psychotropic drugs. It is not appropriate that a doctor (who is not an authorised doctor under the Bill) or authorised	It is recommended that Clause 39 be amended to reflect that consent to treatment and care provided by a third party (such as a guardian or statutory health attorney) can only be made upon the assessment of a psychiatrist/authorised doctor.

ATTACHMENT A

MH Bill	Comment	Recommendation
(2) The doctor or authorised mental health practitioner may act under subsection (1) only if the doctor or health practitioner is no longer satisfied that on making an assessment of the person under part 3 an authorised doctor may form the view that – (a) The treatment criteria apply to the person; or (b) There is no less restrictive way for the person to receive treatment and care for the person's mental illness	mental health practitioner make such a recommendation to a guardian or statutory health attorney for consent to treatment, prior to a full assessment having been conducted by a psychiatrist/authorised doctor.	
Notice of particular decision on assessment **Clause 44** If the authorised doctor decides the treatment criteria do not apply to the person or there is a less restrictive way for the person to receive treatment and care for the person's mental illness, the authorised doctor must— (a) tell the person of the decision; and (b) explain its effect to the person.	It is not clear what documentation will be available to the person to allow them to freely leave the place where they have been involuntarily detained for the purpose of an assessment, and identify to others that they are free to leave, and retain as a record for their personal understanding. This is of particular importance for a patient's rights where there are locked acute care wards, and provisions regarding absent persons. Further, a person should be provided written information in a communication style appropriate to the person, particularly where consent is provided for their treatment and care by a third party (eg., guardian/statutory health attorney). A copy of the decision on assessment should be provided to the person as an automatic right.	It is recommended that clause 44 be amended to include the words 'and give a copy of the decision to the person'.

ATTACHMENT A

MH Bill	Comment	Recommendation
Notice about review of treatment authority **Clause 53** (1) On making a decision under clause 52 on the review of a treatment authority for a person, the authorised psychiatrist must— (a) tell the person of the decision; and (b) explain its effect to the person.	It is not clear what documentation will be available to the person to allow them to freely leave the place where they have been involuntarily treated under a treatment authority and how they will identify to others that they are free to leave. This is of particular importance for a patient's rights where there are locked patient wards, and provisions regarding absent persons. It is recommended that a copy of the decision revoking a treatment authority be provided to the person contemporaneously with the revoking of their treatment authority under s.52 (not within 7 days).	It is recommended that clause 53(1) be amended to include the words 'and where the authority is revoked, give a copy of the decision to the person'.
Recommendation for Transport clause 62 (1) A doctor or authorised mental health practitioner may make a recommendation in the approved form (a ***transfer recommendation***) to transport a person in custody from the person's place of custody to an inpatient unit of an authorised mental health service for treatment and care for the person's mental illness. (3) As soon as practicable after making the transfer recommendation, the doctor or authorised mental health practitioner must— (a) tell the person of the making of the transfer recommendation; and (b) explain its effect to the person; and (c) if asked by the person—give a copy of it to the person.	If a person is suspected of lacking capacity to consent to treatment, it is questionable as to how the person will have the capacity to request a copy of the transfer recommendation. Clarity is required in the legislation to specify that the doctor or authorised mental health practitioner is required to tell the person that they are able to obtain a copy of the transfer recommendation. It is recommended that a copy of the transfer recommendation be provided to the person as an automatic right under clause 62(3).	It is recommended that clause 62(3) be amended to omit the words 'if asked by the person –'

ATTACHMENT A

MH Bill	Comment	Recommendation
Making of forensic order **Clause 138** (1) The court must make an order (a **forensic order (mental condition)** or **forensic order (disability**) for the person if the court considers, after having regard to the matters mentioned in subsection (2), that a forensic order is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property. (2) The court must have regard to the following— (a) the relevant circumstances of the person; (b) any victim impact statement produced by the prosecuting authority for the offence; *Note—* See part 5, division 3 in relation to victim impact statements. (c) any policies or practice guidelines made by the chief psychiatrist under clause 294 that relate to persons subject to forensic orders.	There is concern that in the making of a forensic order (mental condition) or forensic order (disability), consideration is given only in cl.138(2)(c) to policies and practice guidelines made by the Chief Psychiatrist and not to any equivalent policies made by the director of forensic disability. It is recommended that a similar provision as that of clause 105 be included for Chapter 5, to make Chapter 5 applicable to the needs of persons with Intellectual disability. Further it is inappropriate that the Mental Health Court **must** have regard to policies of an administrative officer (such as the Chief Psychiatrist) in making a forensic order. It is recommended there be a strict separation of judicial power from administrative action.	It is recommended that a provision be inserted recognising that a reference to the chief psychiatrist is a reference to the director of forensic disability. Amend clause 138(2) to omit the word 'must' and insert the word 'may'.
Making of court treatment order **Clause 139** (1) The Mental Health Court must make an order (a ***court treatment order***) for the person if the court considers, after having regard to the matters mentioned in subsection (2), that a	Provision is made for a less restrictive 'court treatment order' for persons who may be found of unsound mind or unfit for trial, but have a mental illness. There is no equivalent 'lesser' order for persons with a sole diagnosis of intellectual disability. The only option available for persons with a sole diagnosis of	Insert a provision to provide for a less restrictive court order for persons with intellectual disability, equivalent to a 'court treatment order' for persons with mental illness. Amend clause 139(2) to omit the word 'must' and insert the word 'may'

ATTACHMENT A

MH Bill	Comment	Recommendation
court treatment order, but not a forensic order, is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property. (2) The court must have regard to the following – (a) The relevant circumstances of the person; (b) Any victim impact statement produced by the prosecuting authority for the offence; (c) Any policies or practice guidelines made by the chief psychiatrist under section 296 that relate to persons subject to court treatment orders	Intellectual disability is a forensic order. This is imbalanced and inappropriate. Provision should be made for an equivalent 'lesser' order for persons with intellectual disability. Further it is inappropriate breach of separation of powers that the Mental Health Court **must** have regard to administrative policies of the Chief Psychiatrist in making a court treatment order. It is recommended there be a strict separation of judicial power from administrative action.	
Authorised doctor may revoke treatment authority after assessment **clause 207** (3) However, the authorised doctor is not required to revoke the treatment authority if the authorised doctor considers that the patient's capacity to consent to be treated for the patient's mental illness is not stable. *Examples of when a patient's capacity to consent to be treated is not stable—* • the patient gains and loses capacity to consent to be treated during a short time period	Clause 207(3) gives cause for concern that this clause extends the boundaries of established capacity law (both in legislation and at common law) exclusively in the field of mental health. It enables treatment of a person involuntarily or by consent provided by a third party – even if the person has capacity (albeit fluctuating capacity). Enabling treatment when a person's capacity is 'not stable' is too ambiguous and open to widely different interpretations by treating doctors. It is also inconsistent that a third party provide consent to medical treatment and care under a 'least	It is recommended that either: (i) this provision be removed, or (ii) safeguards be included in the Act, such as ensuring that a support person must be present (eg., guardian/carer/ representative of the person) during the interview process, unless refused by the individual and that the person has a right for this to be immediately reviewed by a second psychiatrist if requested.

ATTACHMENT A

MH Bill	Comment	Recommendation
• the patient makes different decisions based on the same facts during a short time period (5) An authorised doctor must tell a patient of a revocation of the patient's treatment authority under this clause as soon as practicable after the revocation. (6) The administrator of the authorised mental health service must give written notice of the revocation to the patient, and the tribunal, within 7 days after the revocation.	restrictive option', when under other legislation and common law the person would be considered to have capacity to consent to (non-mental) health treatment. (Note a similar provision to clause 207(3) is also at clause 410(2) and what the MHRT may consider in revoking a treatment authority). Further, an individual with dual diagnosis who is open to suggestions, acquiescence and confabulation, may be influenced by the suggestions of authority figures. Therefore due to an intellectual disability (and not a mental illness) they may be determined to have fluctuating capacity and unfairly kept on a treatment authority or be subject to consent to their treatment by a third party (under a least restrictive measure). It is recommended that safeguards (eg.,nature of review person is subject to, opportunity for a second opinion) be included in the Act to ensure this situation does not eventuate. Alternatively, this provision should be removed. It is also recommended that a copy of the decision revoking a treatment authority be provided to the person contemporaneously with the revoking of their treatment authority, not within 7 days.	It is also recommended that clause 207(5) be amended to include the words 'and give a copy of the revocation to the person'.
Meaning of *medication* **Clause 266** ***Medication*** of an involuntary patient, includes sedation of the patient. **Offence** **Clause 267**	It is of concern that treatment and care includes the use of chemical restraint for the purpose of sedation and managing risk. It is recommended that chemical restraint be separated from treatment and care and recognised	It is recommended that the Bill provide for the use and regulation of chemical restraint for the purpose of sedation (eg., for transportation) and managing risk, separately from treatment and care.

ATTACHMENT A

MH Bill	Comment	Recommendation
(1) a person must not give medication to an involuntary patient unless the medication is clinically necessary for the patient's treatment and care (2) to remove any doubt, it is declared that for subsection (1), a patient's treatment and care includes preventing imminent serious harm to the patient or others	as restraint, and regulated accordingly within the act.	
Display of signs **Clause 274** (1) The administrator of an authorised mental health service must display signs in prominent positions in the service stating that a copy of the statement of rights is available on request. (2) The signs must be easily visible to patients and nominated support persons, family, carers and other support persons.	The actual statement of rights should be clearly displayed in the authorised mental health service, as well as signs stating that copies can be requested. This would be the clearest means of ensuring that people and families/carers/support persons are aware of the patient's rights. It is an additional obstacle to overcome if the people seeking care are required to request a statement that they have a right to know, and it is accessibly displayed.	Amend clause 274 to require display of the actual statement of rights.
Written notices to be given to nominated support persons and others **Clause 282** (1) This clause applies if— (a) a provision of this Act requires any 1 of the following to give a written notice to a patient— (i) an authorised doctor; (ii) an administrator of an authorised mental health service; (iii) the chief psychiatrist; (iv) the tribunal; or	It is noted that no provision is made for notification where a written notice is required to be given to a patient by the Mental Health Court. This would mean that personal guardians and other key persons may not be informed of relevant issues. This is **a critical issue** for guardians so that they are able to receive notices from the Mental Health Court and participate in supporting the person through Mental Health Court proceedings, and fulfil their duties as guardians. Failure to provide for notification	Amend clause 282(1) to include notification from the Mental Health Court where written notices are required to be given to the patient, and ensure that the Mental Health Court provide notifications to personal guardians. Amend clause 282(5) to include notification to a guardian where appointed for a minor.

ATTACHMENT A

MH Bill	Comment	Recommendation
(b) any of the following events (each a ***significant event***) happens to a patient— (i) admission as a classified patient; (ii) transfer to another entity. (5) If the patient is a minor, the person may give the required written notice to the minor's parent instead of to the minor if— (a) the minor may not understand or benefit from receiving the notice; and (b) giving the notice to the parent appears to be in the minor's best interests; and (c) the minor has not asked for communication with the parent not to happen.	will result in restricting and inhibiting the guardians ability to fulfil their obligations and duties. It is noted that provision is made for notification to a minor's parents, but no provision is made for notification to be made to a minor's guardian if they have one.	
Decision on Review **Clause 468** (1) On a review of the minor's detention in the high security unit, the tribunal must decide whether the minor— (a) should continue to be detained in the high security unit; or (b) should be transferred from the high security unit to an authorised mental health service that is not a high security unit. (2) In deciding the review, the tribunal must have regard to the following— (a) the minor's mental state and psychiatric history;	In reviewing a minor's detention in a high security unit, the Tribunal should also take into consideration personal and social issues such as disabilities and vulnerabilities from neglect, abuse or exploitation that a minor may have experienced.	It is recommended that clause 465(2) be amended in include that the Tribunal must also have regard to 'a minor's disability (physical or intellectual)'. It is also recommended that consideration must also be given to a minor's 'personal and psychiatric history'.

ATTACHMENT A

MH Bill	Comment	Recommendation
(b) the minor's treatment and care needs; (c) the minor's security requirements.		
Decision on application **Clause 476** (1) In deciding the application, the tribunal must give, or refuse to give, approval for electroconvulsive therapy to be performed on the person. (2) In deciding whether to give, or refuse to give, the approval, the tribunal must have regard to— (a) if the application relates to an adult who is unable to give informed consent to the therapy—any views, wishes or references the adult has expressed about the therapy in an advance health directive; or (b) if the application relates to a minor— (i) the views of the minor's parents; and (ii) if the minor has capacity to consent to be treated—the views of the minor. *Note—* See clause 14(4) in relation to the capacity of a minor to consent to be treated.	Electroconvulsive therapy (ECT) (as a regulated and more intrusive treatment) should only be performed on minors who are able to give informed consent. Consent should not be able to be given by any other person, including parents, on their behalf. It is also not clear if ECT is limited by age. It is considered that children with Gillick competency only, should be able to consent to ECT.	It is recommended clause 476(2) be amended to reflect that ECT may only be performed on a minor with their informed consent.
Constitution **Clause 597** (1) the Mental Health Court is constituted by a member of the court sitting alone. (2) In exercising jurisdiction under this Act, the court must be assisted by 2 assisting clinicians.	The Mental Health Court should treat persons with mental illness and intellectual disability equally. It is inappropriate that there *must* be a psychiatrist with expertise in mental health, but that it is not also mandatory for expertise in intellectual disability.	It is strongly recommended that clause 597 be amended to omit sub-clause 597(3)(b)(i). Insert a provision equivalent to clause 677(2) be included so that in relation to a minor, the Mental Health Court should also be constituted by at least 1 assisting clinician with expertise in child psychiatry/ intellectual disability

ATTACHMENT A

MH Bill	Comment	Recommendation
(3) The assisting clinicians for a hearing must be – (a) For a hearing other than a hearing relating to a person who has an intellectual disability – 2 psychiatrists; or (b) For a hearing relating to a person who has an intellectual disability (i) 2 psychiatrists, or (ii) 1 psychiatrist and 1 person with expertise in the care of persons who have an intellectual disability (4) However, if the persons mentioned in subsection (3) are not available to assist the court in the hearing of the matter and the member of the court hearing the matter is satisfied it is necessary to hear the matter in the interests of justice, the court may be assisted by- (a) For a hearing other than a hearing relating to a person who has an intellectual disability – 1 psychiatrist, or (b) For a hearing relating to a person who has an intellectual disability – (i) 1 psychiatrist, or (ii) 1 person with expertise in the care of persons who have an intellectual disability	Provision is already made in subsection (4) regarding what should occur if an expert is not available. The Tribunal also provides for the expertise of a person in child psychiatry. It is recommended that an equivalent provision to clause 677(2) be included so that in relation to a minor, the Mental Health Court should be constituted by at least 1 assisting clinician with expertise in child psychiatry/ intellectual disability.	depending on the nature of the primary disability.

ATTACHMENT A

MH Bill	Comment	Recommendation
Definition of parent ***parent***, of a minor, includes— (a) a person who exercises parental responsibility for the minor, other than a person standing in the place of a parent of a minor on a temporary basis; and (b) for an Aboriginal minor—a person who, under Aboriginal tradition, is regarded as a parent of the child; and (c) for a Torres Strait Islander minor—a person who, under Island custom, is regarded as a parent of the minor.	The definition of parent similar to that of s.159 of the *Health Act 2005* should be incorporated in the Bill to enable notifications to the chief executive (child safety) in circumstances where a minor is in the custody or guardianship of child safety. However, a narrow definition of parent should apply in cases of consent to treatment (including electroconvulsive therapy under Chapter 7, Part 8) (pending consideration of the recommendation regarding clause 476 above).	That the definition of parent be included similar to that of s.159 of the *Public Health Act 2005* for the purpose of notifications, to include a guardian appointed under the *Child Protection Act 1999*, namely: *'a child who is in the custody or guardianship of the chief executive (child safety) under the Child Protection Act 1999, the chief executive (child safety),* except in the case of regulated treatments under Chapter 7, Part 8.