Chapter 7

Involuntary mental health orders

> Because intervention comes so late, consumers and families report that once the police are involved and no matter how the police are, there is still a sense of not being treated with dignity . . . "I know when I get sick that I quickly lose insight and will resist treatment but I am sick and there I am being handcuffed by police. No other groups of people with an illness are treated like this. Why are we? Surely there can be a better way. I think it starts with me being able to say, I'm becoming unwell and clinicians taking me seriously".[1]

7.1 This inquiry is predominantly concerned with the indefinite detention of people within the forensic mental health system. However, a significant number of people with a cognitive and/or psychiatric impairment are also detained under various state and territory mental health legislation. Provisions for detention within mental health frameworks often involve less oversight and structured review than is found in the forensic system.

7.2 In addition, the goal of diverting people with cognitive and/or psychiatric impairment away from the criminal/forensic mental health system into a civil/health system, is likely to result in an increased use of controlled orders under existing state and territory mental health Acts. As such, it is important to review how those civil frameworks are currently operating.

7.3 This chapter will look at:

- the impact of the current 'risk' approach to mental health orders;
- the involvement of police during mental health crises and the use of police vehicles for transport;
- legal capacity and Advance Directives;
- mechanisms to review controlled treatment orders; and
- the framework for transitioning back to the community.

7.4 The committee notes that multiple submitters argued that mental health legislation is in itself discriminatory, in that this legislation allows for the indefinite detention of people based on their disability.

7.5 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) said:

> When a person lacks capacity and presents a significant risk they may need to be detained. People with severe psychiatric and/or cognitive impairment are not detained because of their impairments, but because of the risk and

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1 Dr Joanne Bradbury, Matt Ireland, Helen Stasa, 'Mental Health emergency transport: the pot-holed road to care', *The Medical Journal of Australia*, Volume 200, no. 6, p. 348.

> lack of capacity. This is usually secondary to the psychiatric or cognitive impairment but it is an important distinction.[2]

7.6 RANZCP also submitted that the mental health regime has, in general, moved towards greater compliance with human rights principals:

> The clear trend in recent decades has been toward greater emphasis on autonomy and a corresponding erosion in the coercive powers available to psychiatrists. This is in line with human rights legislation.[3]

7.7 However, as the committee noted in the final report of its 2015 inquiry into violence, abuse and neglect against people with disability (abuse inquiry). '[u]nder the guise of 'therapeutic treatment', people with disability can be subjected to forcible actions that could be considered assault in any other context.'[4] The issue of 'disability specific lawful violence' and how it impacts people with a cognitive or psychiatric impairment is discussed in greater detail in Chapter 9.

Risk approach to controlled orders

7.8 Evidence presented to this inquiry outlined the ethical tensions in detaining a person for involuntary mental health treatment:

> All mental health acts within Australia express a tension between the contesting values of *autonomy*, and the perceived need for coercion to prevent *danger* or *harm* (to the patient or others) (Fistein, Holland, Clare, & Gunn, 2009). This latter value is normally complemented by provisions that enable coercion to ensure patients receive vital *care* – the *need for treatment* criterion.[5]

7.9 In her submission, Dr Joanne Bradbury outlined that laws giving the state the right to detain a person with mental illness have evolved from centuries old English 'lunacy' laws, where the King has an obligation to protect the vulnerable in society and ensure they are provided for. These laws evolved, and later included the provision of treatment for persons with a 'mental incapacity'. However, as these laws are currently applied and practised in Australia, the right to personal liberty prevails and such involuntary treatment is now only imposed when a person is deemed a risk of harm to themselves or another person.[6]

> Within the Mental Health Act there is no provision for earlier interventions based on reduced mental capacity—at least no legal provisions. Carers, caseworkers and doctors are powerless to invoke the act earlier in the process at the point where they observe a decline in mental capacity but the

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2 Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Submission 17*, p. 5.

3 RANZCP, *Submission 17*, p. 6.

4 Community Affairs Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, November 2015, p. xxvi.

5 Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Submission 17*, p. 6.

6 Dr Joanne Bradbury, *Submission 63*, pp 4–6.

> person is still a low risk of harm. They must watch and wait until the person becomes a serious risk before they can legally intervene.[7]

7.10 A submitter who described a parent's lived experience argued against early interventions to provide involuntary treatment, recommending that 'in the interests of keeping people involved in their own decision making that involuntary detention is only used as last resort when the safety of people is at risk.'[8]

7.11 However, Dr Bradbury argued that using forcible intervention only as a last resort necessitates police involvement which can be detrimental to the delivery of appropriate health care:

> Under current legislation in NSW, no one can legally intervene unless the person is considered to be a high risk of physical harm. Police and ambulance services are frustrated by this interpretation of the MHA, which seems to place them in the front line. As first responders, they are frequently called upon to attend an emergency situation where a person is behaving erratically, but not necessarily criminally, and it could be caused by mental health disorders or drug or alcohol intoxication. The scene of an incident is not the place to make diagnostic decisions about mental capacity.[9]

7.12 Dr Bradbury recommended changes to the legislation to allow for earlier intervention which may not require police involvement.[10] This is in line with the recommendations for more early intervention programs made in submissions by many medical, advocacy and service delivery organisations.[11]

7.13 The Australian Cross Disability Alliance (Disability Alliance) submitted that there is no consistency across state and territory mental health laws in assessing, or determining the level of risk of harm to self or others, or in assessing a person's ability to provide consent to treatment. The Disability Alliance wrote:

> As a result, many people with psychosocial disability and cognitive impairment experience serious breaches of their human rights and widespread abuse, neglect and exploitation within the current legislative, policy and practice framework that purports to 'protect' them.[12]

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7 Dr Bradbury, *Committee Hansard*, 23 March 2016, p. 31.

8 Name withheld, *Submission 41*, p. 6.

9 Dr Bradbury, *Submission 63*, p. 11.

10 Dr Bradbury, *Committee Hansard*, 23 March 2016, p. 31.

11 Among other submissions, see: Queensland Advocacy Inc. *Submission 7*; Australian Medical Association, *Submission 12b*; Australian College of Mental Health Nurses, *Submission 14*; NSW Council on Intellectual Disability, *Submission 40;* Office of the Public Guardian, Queensland, *Submission 56*; Office of the Public Advocate Victoria, *Submission 58*; Australian Cross Disability Alliance, *Submission 61*; Forensicare, *Submission 65;* Law Council of Australian, *Submission 72;* Aboriginal Disability Justice Campaign, *Submission 76.*

12 Australian Cross Disability Alliance, *Submission 61*, pp 12–13.

7.14 RANZCP also submitted evidence about the inconsistency in legislation and practice:

> There is a significant divergence between mental health acts as to the criteria that must be applied before involuntary treatment is enacted. Divergence is not limited to differing criteria; it finds expression in the frameworks that operate after initial assessment in a mental health facility. Processes which enable the imposition and review of compulsory treatment vary even more between states and jurisdictions than do the criteria themselves, although convergence is starting to occur on this level as well.[13]

7.15 The QLD Office of the Public Guardian (OPG-QLD) submitted evidence that even within the one jurisdiction, legislation is inconsistent in how it responds to differing impairments:

> For example, under the new mental health legislation, while provision is made for a new and less restrictive order (treatment support order) as an alternative to a forensic order, this alternative only applies to persons with a mental illness. A person who is found to be of unsound mind or unfit for trial due to an intellectual or cognitive disability can only be placed on the restrictive forensic order. No less restrictive option is available for this cohort. Under the less restrictive order, the default is that persons should be placed upon community category orders, unless it is necessary for the person to be an inpatient. The default position under a forensic order is detention unless the Mental Health Court is satisfied that there is not an unacceptable risk to the safety of the community, because of the person's mental condition, including the risk of serious harm to other persons or property. The result is that the default for people with intellectual or cognitive disability is detention.[14]

7.16 The QLD Office of the Public Advocate (Public Advocate QLD) submission also discussed the new provisions in the recently passed *Mental Health Act 2016* (QLD). The Public Advocate QLD contended that while some parts are consistent with best-practice frameworks, the framework does not go far enough in 'supporting a recovery orientation to mental health treatment when compared with other contemporary legislative approaches.'[15]

7.17 The Disability Alliance submitted that one consistency across jurisdictions, is that all laws regulating mental health treatment 'have failed to prevent, and in some cases, actively condone unacceptable practices, including the widespread use of non-consensual psychiatric medications, electroconvulsive therapy (ECT), restrictive practices, such as seclusion and restraints and arbitrary detention.'[16]

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13 RANZCP, *Submission 17*, pp 6–7.

14 Office of the Public Guardian (QLD), *Submission 56*, p. 5.

15 Office of the Public Advocate (QLD), *Submission 36*, p. 11.

16 Australian Cross Disability Alliance, *Submission 61*, p. 18.

7.18 RANZCP outlined that legislative provisions outside the various state and territory mental health legislation also allow for involuntary treatment, such as disability and guardianship Acts.[17] These are also discussed in greater detail in Chapter 9.

Committee view

7.19 There is an inherent conflict in the imposition of involuntary mental health treatment: while it is intended for a person's best interest, it is both imposed against their will and often requires a deprivation of liberty. Understandably, the current system is weighted towards individual liberty, where detention is only imposed where there is deemed a significant risk to life or safety. However, this flies in the face of medical advice for most other illnesses, where early intervention is generally advised.

7.20 The committee is concerned that the mental health care system has not followed the general move in healthcare towards preventative care. The committee believes that more early intervention programs would result in fewer people being detained as a result of police being used as first responders.

7.21 The committee is also concerned with the widely differing standards of care, protection and oversight that legislation affords across the jurisdictions, and believes that more can be done to replicate best practice examples across Australia.

Transport

7.22 As discussed above, a last-resort approach to intervention in a mental health context often necessitates police involvement in situations of risk of imminent harm. This often leads to police being used to provide a de facto mental health transport service.

7.23 Evidence presented to the inquiry highlighted the frequent use of police to transport people to involuntary mental health treatment:

> The Mental Health Act had been changed in 2007 in an attempt to reduce police involvement, and police were expecting that Ambulance and Health would assume responsibility for mental health transports under the act. In fact, in the New South Wales parliamentary speech introducing the bill in 2007, the Minister Assisting the Minister for Mental Health, Paul Lynch, clearly stated the intention to transfer the burden of responsibility to Health. He said:
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> > The new provisions aim to emphasise that NSW Health will take primary new provision will the responsibility for patient transports, with requests for police involvement to be limited to where there are serious concerns about patient and/or staff safety.
>
> However, in practice, police were continuing to provide the bulk of mental health transports under the act after it had been changed.[18]

17 RANZCP, *Submission 17*, p. 7.

18 Dr Bradbury, *Committee Hansard*, 23 March 2016, p. 31.

7.24 It was submitted that this form of transport is highly inappropriate, as it not only traumatised people to be 'picked up by police' but the paddy wagon itself was described as:

> a cold, dark, plastic/metal box-like cage with no seat cushioning, nothing to hold on to, no proper windows and no proper ventilation. There is no way of monitoring someone who is in the back during the transport.[19]

Dr Bradbury further contended that the use of police vehicles, particularly paddy wagons, is not consistent with least restrictive practice.

7.25 Dr Bradbury outlined the process by which police then 'hand over' a person for assessment or treatment:

> Upon arrival at the emergency department, police (or ambulance if they were the transporters) must wait with the person until they can be triaged in turn by the nurse, who will then call the psychiatrist to come in to undertake the psychiatric assessment. The wait times in emergency are extraordinarily long and cause of a lot of time stress for police and ambulance officers, who might hear other calls coming out on their radios but are unable to attend. This process is a bottle neck for emergency services.
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> A recent Victorian study found that the time a person, who was bought [sic] in by police under mental health legislation, spends in the ED could range from 79 – 416 minutes, with a median of 156 mins (2.6 hours). These wait times may also exacerbate the condition of the person who may be waiting in the back of the paddy wagon in the driveway.[20]

7.26 A NSW Police Force initiative aims to address issues such as those raised above, by redrafting the Memorandum of Understanding between NSW Police, Health and Ambulance, with the goal to:

> …ensure that persons detained by the NSWPF under Sect 22 of the Mental Health Act are always transported to a health facility for assessment by a NSW Ambulance vehicle. The use of Police vehicles for this purpose only serves to add to the stigma surrounding mental health, whereas Ambulance facilitated transport ensures a least restrictive, dignified and clinically supervised transition into care.[21]

7.27 In rural and regional areas, it was submitted that it is common practice to use a paddy wagon, largely due to limitations in health resources such as ambulances.

> In rural and regional Australia, and particularly after-hours, travel in the back of a paddy wagon may involve long distances between regional towns, due to the fact that only the larger regional towns have a psychiatrist available to make the assessment. Apart from the extreme discomfort and distress caused to the person in the back, this can also take police and/or

19 Dr Bradbury, *Submission 63*, p. 10.

20 Dr Bradbury, *Submission 63*, p. 12.

21 NSW Police Force, *NSWPF Mental Health Intervention Team*, http://www.police.nsw.gov.au/community_issues/mental_health (accessed 16 November 2016).

> ambulance resources away from small regional centers for long periods of time.[22]

7.28 Dr Bradbury presented evidence that the use of video conferencing for psychiatric assessment reduced long distance transport by 20 per cent over a 20 month period, and argued this type of program should be further explored to reduce the use of transport by paddy wagon of people experiencing mental health episodes.[23]

Committee view

7.29 It is clear that the current mental health system relies on waiting for a crisis to occur before involuntary treatment orders are invoked, and this in turn significantly increases the chances of police involvement due to risk of harm to the individual or others. The result is that people when at their most vulnerable during a mental health episode, are transported to a health facility in an inappropriate way that does not accommodate their needs.

7.30 The committee believes that a key way to address this issue, in addition to increased funding for health transport services particularly in regional and rural regions, is to increase early interventions in mental health, rather than wait for a crisis to occur before taking action. The committee strongly supports a move to early intervention in mental health care as a better model of health service delivery.

Legal capacity and Advance Directives

7.31 The committee heard evidence from a range of submitters that a loss of legal capacity for decision making for a person with a mental health condition is often temporary or episodic, and linked to a periodic mental health crisis. However, during times of mental health stability, the person may be quite capable of demonstrating legal capacity. Broader issues of legal capacity and guardianship are discussed in greater detail in Chapter 9.

7.32 In an article for the Medical Journal of Australia, Dr Bradbury has noted the important role that a legal mechanism could play for people with periodic mental incompetence in pre-determining agreed trigger points for non-consensual assessment and treatment during times of a mental health crisis:

> A legal mechanism for non-consensual assessment based on decisional capacity could be explored. People living with mental illness could be supported, during periods of capacity, to identify indicators of diminished capacity as key intervention points, and doctors making clinical assessments in chronic and potential first-episode psychosis could give serious consideration to capacity. Thinking about capacity at an earlier intervention point may reduce the number of people requiring an emergency response.
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> Ideally, people living with mental illness should be able to access quality mental health services voluntarily, long before non-consensual intervention

22 Dr Bradbury, *Submission 63*, p. 12.

23 Dr Joanne Bradbury, *Submission 63*, p. 13.

> is required. Once voluntary options have been exhausted, the point at which a person loses decisional capacity may represent an earlier, more benevolent juncture for non-consensual intervention. Reaching the point of emergency services intervention in a mental health incident should be the *last* option along the pot-holed road to care.[24]

7.33 One such mechanism presented to this inquiry is an Advance Directive or Advanced Care Directive.[25] These are legally binding documents prepared by an individual to indicate their health care assessment and treatment preferences, and preferred advocate in the circumstance that they are temporarily or permanently unable to make their own decisions. Typically, these are used by someone with a terminal illness to provide clear direction on their healthcare; however, these directives are now being used by those with mental or psychiatric illnesses that temporarily incapacitate a person's decision making functions.[26]

7.34 A 2008 paper aptly summarises the role that an Advance Directive plays:

> In a sense, the Advance Directive becomes the voice of the person at a time when they may not be able to convey their preferences. An Advance Directive can articulate the person's preferences or nominate another person to make particular decisions. The document may state the negative effects of particular treatments and the reasons that other medications are preferred. Advance Directives for people with a mental illness aim to extend beyond medical treatment to all aspects of the person's life.[27]

7.35 The Public Advocate QLD described how Advance Directives function in QLD:

> The *Powers of Attorney Act 1998* (Qld) allows people to make decisions and/or arrangements for decision-making that can be implemented in the future. These arrangements are primarily made through an advance health directive or an enduring power of attorney, and enable people to have a voice in their future health care should they later develop a condition that prevents them from consenting to treatment.[28]

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24 Dr Bradbury et al, 'Mental Health emergency transport: the pot-holed road to care', pp 350–351. See also: V. Topp, M. Thomas, 'Advance Directives for Mental Health', *The Australian Journal on Psychosocial Rehabilitation*, Autumn 2008, pp 51–55, http://www.communitylaw.org.au/mhlc/cb_pages/files/advance%20directivesnew%20paradigm-1(2).pdf (accessed 7 March 2016).

25 For further discussion of advance care directives, see: *Submission 36*, *Submission 58* and *Submission 63*.

26 South Australian Government, *Advance Care Directives*, http://www.advancecaredirectives.sa.gov.au/about (accessed 29 February 2016). These can also be known as Ulysses pacts/contracts/agreements, in that they are designed and intended to bind oneself in the future.

27 Vivienne Topp, Martin Thomas, 'Advance Directives for Mental Health', *The Australian Journal on Psychosocial Rehabilitation*, Autumn 2008, p. 51.

28 Office of the Public Advocate (QLD), *Submission 36*, p. 16.

7.36 The Office of the Public Advocate Victoria (Public Advocate Victoria) outlined how Advance Directives are included in Victorian legislation:

> The Mental Health Act in Victoria provides a model for consideration in the way clinical oversight and review mechanisms are provided, with access to a second opinion, legal aid assistance, the opportunity to appoint a nominated person and provisions for a patient advance statement to be considered by the authorised psychiatrist.[29]

7.37 However, the Mental Health Legal Centre highlights some of the practical complications that exist in the current health service delivery environment:

> In Victoria common law regarding Advance Directives suggests that when a person is deemed to be 'competent', their Advance Directive will be respected. However, once a person is defined as 'incompetent' the Advance Directive holds a much weaker position. This causes considerable problems because what consumers think they're doing when making an Advance Directive is putting in place something that will be there for them if they do become very distressed and ill later on.[30]

Committee view

7.38 Increasing the use of supported decision-making was recommended by this committee in the final report of the 2015 abuse inquiry.[31] This current inquiry has received more evidence to affirm the committees view formed during the abuse inquiry, and the committee continues to recommend increased use of supported decision making models across the jurisdictions.

7.39 For people with a mental health condition that involves periodic loss of legal capacity, the committee notes that Advance Directives appear to offer a way to increase their autonomy and involvement in decisions about their health care. The committee notes the need to enact legislative change to address the issue of Advance Directives being ignored.

Review mechanisms

7.40 Chapter 7 outlined the various state and territory involuntary mental health order review mechanisms. This section will look broadly at some of the problems highlighted by submitters, which include the need for time limited detention, differing standards for review across jurisdictions and the difficulty detained people have in meeting the safety standards required for release.

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29 Office of the Public Advocate (VIC), *Submission 58*, p. 18.

30 Mental Health Legal Centre, *Advance Directives—Maximising consumers autonomy dignity and control*, http://www.communitylaw.org.au/mentalhealth/cb_pages/living_wills.php (accessed 7 March 2016).

31 See Community Affairs Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, recommendations 10–12, November 2015, p. xviii.

Time limited detention

7.41 A key issue discussed by multiple submitters in regards both the forensic and civil mental health systems, is the lack of statutory time limits on the period of detention. The Disability Alliance recommended that 'State and territory laws should provide for limits on the period of detention of a person who has been found unfit to stand trial, and for regular periodic review of other detention orders.'[32]

7.42 The Australian Law Reform Commission recommended that, in their view, the most fundamental change that should happen to the regime around the detention of people with cognitive and/or psychiatric impairment, is the imposition of limits on the period of detention as well as regular periodic review.[33]

7.43 The Public Advocate QLD made a similar recommendation:

> In instances where indefinite detention is effected, it must be employed as a transitional strategy and be subject to strict time-limitations.[34]

7.44 However, Victoria Legal Aid submitted that even where time limited detention exists, the system of review can render this, in effect, indefinite detention:

> Whilst an ITO can only be made for 6 months, this order can be renewed indefinitely where a person continues to meet the ITO criteria under the Mental Health Act as further applications may be made prior to the expiry of each order. There are people who have been continually detained in the same hospital for many years under an ITO. Our advocacy work focusses on representation at hearings where the primary issue for the decision maker is whether a person continues to meet the criteria under the Mental Health Act. Unlike the best practice framework for STO's, the Mental Health Act does not require consideration of planning for future reduction of interventions, or for leveraging of supports to transition to a less restrictive environment.[35]

7.45 The Disability Alliance submitted similar evidence, stating 'people under involuntary treatment orders can reside in secure accommodation with no release date, or with the possibility that their treatment order will be continually extended prior to expiry.'[36]

7.46 Ms Karly Warner, Executive Officer of the National Aboriginal and Torres Strait Islander Legal Services, recommended that to address this failing in the review process, an additional level of review is created:

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32 Australian Cross Disability Alliance, *Submission 61*, p. 24.

33 Prof. Rosalind Croucher, President, Australian Law Reform Commission, *Committee Hansard*, Melbourne, 29 April 2016, p. 35.

34 Office of the Public Advocate (QLD), *Submission 36*, p. 19.

35 Victoria Legal Aid, *Submission 71*, p. 9.

36 Australian Cross Disability Alliance, *Submission 61*, p. 12.

> [W]e recommend that determinations about release of mentally impaired accused from custody or community release orders should be made by the relevant board, with an annual right of review before the Supreme Court.[37]

Different standards for review

7.47 The RANZCP raised the issue of differing mechanisms for review across the various regimes used for the imposition of compulsory treatment orders, which results in different levels of protection for individuals:

> [T]he review mechanisms and protections for the individual vary widely depending on what legislation is used. For example, under the Mental Health Act involuntary treatment is reviewed by a Tribunal with psychiatrist, lawyer and public member. No such review is undertaken under the Guardian and Administration Act and the decision rests with guardian. This means that people receiving involuntary treatment can have wildly different standards of care and protection.[38]

7.48 Mr Povey from Victoria Legal Aid went further, and submitted to the committee that this absence of a really consistent and clear framework for the detention of people with cognitive or psychiatric impairment was not simply difficult to navigate, but could itself 'create an environment for abuse.'[39]

Safety triggers for release

7.49 The NSW Government outlined the review provisions of the *Mental Health Act 2007* (NSW) (NSW Mental Health Act) in its submission, stating that where the Mental Health Review Tribunal orders detention, it must 'review that decision every three months during the first year of a person's detention and every six months thereafter' and also states that the NSW Mental Health Act directs that a detained person must be released as soon as an authorised medical officer no longer considers them to be mentally ill' or that there is alternative appropriate community-based accommodation.[40]

7.50 However, as discussed in Chapter 3, this essentially reverses the onus of decision-making from one which requires a justification for detention, to one which requires a justification for release. In order to meet the trigger for release, a person is entirely reliant on the actions of external parties: for example, they require the provision of therapeutic interventions to improve their mental health and/or the provision of appropriate community based accommodation.

7.51 The Public Advocate Victoria raised this issue, stating that despite existing safeguards in the Victorian regime, people continue to be detained beyond the period required for treatment:

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37 Ms Karly Warner, Executive Officer, National Aboriginal and Torres Strait Islander Legal Services, *Committee Hansard*, 29 April 2016, p. 23.

38 RANZCP, *Submission 17*, p. 7.

39 Mr Chris Povey, Victoria Legal Aid, *Committee Hansard*, Melbourne, 29 April 2016, p.4.

40 NSW Government, *Submission 66*, p. 2.

> The Mental Health Act in Victoria provides a model for consideration in the way clinical oversight and review mechanisms are provided, with access to a second opinion, legal aid assistance, the opportunity to appoint a nominated person and provisions for a patient advance statement to be considered by the authorised psychiatrist. In this way, accountability and safeguards are contained in the Mental Health Act.
>
> Despite these safeguards, some people subject to detention and treatment under the Mental Health Act at least, continue to be detained beyond the time when they need treatment in a clinical mental health unit.[41]

7.52 The OPG-QLD contends in its submission that '[i]n Queensland, once a person enters the system as an involuntary mental health patient, there can be significant challenges and obstacles for those with serious mental illness to exit the system, regardless of whether there are regular reviews by the Mental Health Review Tribunal (MHRT).'[42]

7.53 Queensland Advocacy Inc. concurred with this view of how the system operates in QLD:

> The Mental Health Review Tribunal tends to take a conservative approach to its assessment of risk and will renew orders by default. This is particularly problematic because the more time that passes without satisfying the risk test, the more difficult it then becomes to demonstrate the ability to successfully reintegrate into the community, which increases the institutionalisation and further erodes a person's ability to live independently. It is quite a vicious circle.[43]

7.54 Mental Health and Wellbeing Consumer Advisory Group, Being, submitted that a lack of adequate communication led to patients feeling as though they were being indefinitely detained:

> Too often, mental health consumers are not informed about when they will be discharged from the hospital. Consumers tell us that they are also not informed about when they can see a doctor to discuss these issues. Some consumers told us that even when they are told when they will see the doctor, this may not necessarily happen, and they may have to wait much longer than promised. These factors make people feel like they are being held in the hospital indefinitely.[44]

7.55 Being further submitted that people in mental health in-patient units perceive doctors and staff as having power over what happens to them, including making them stay longer as punishment.[45]

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41 Office of the Public Advocate (VIC), *Submission 58*, p. 18.

42 Office of the Public Guardian (QLD), *Submission 56*, p. 4.

43 Dr Emma Phillips, Systems Advocate, Queensland Advocacy Inc., *Committee Hansard*, Brisbane, 23 March 2016, p. 9.

44 Being, *Submission 49*, p. 9.

45 Being, *Submission 49*, p. 10.

7.56 Challenges impeding a person's transition to the community are discussed in greater detail in the next section.

Transition back to community

7.57 RANZCP highlighted that where a person has been detained because their mental impairment puts them or others at risk, there is a moral obligation to provide therapeutic treatment to address the impairment. RANZCP submitted that '[c]urtailment of individual liberties should be matched by providing adequate interventions and resources to assist in rehabilitation/long term care.'[46]

7.58 Evidence presented to the inquiry suggests that indefinitely detained people are not being provided with the treatment that is a necessary part of their future release: people must improve in their mental state so they are no longer a danger to themselves or others, which is largely impossible without adequate therapeutic assistance.

Therapeutic treatment

7.59 It its submission, the OPG-QLD stated that programs and interventions designed to assist people to live in the community often fail to deliver and there are 'little if any repercussions upon the system that fails to deliver services.' The OPG-QLD highlighted that 'a set of nationally-endorsed public standards and monitoring of these systems with power to enforce the standards, may assist to bring pressure to bear on these systems and provide incentives for them to transition people from detention to community living.'[47]

7.60 Victoria Legal Aid echoed this view, and stated that the current strong emphasis on preventing people from entering the indefinite detention system, must be matched with an equally strong emphasis on getting people out once they are in.[48]

7.61 The Public Advocate Victoria outlined positive aspects of the *Mental Health Act 2014* (Vic) which incorporates some of the standards recommended by the OPG-QLD:

> The Mental Health Act in Victoria provides a model for consideration in the way clinical oversight and review mechanisms are provided, with access to a second opinion, legal aid assistance, the opportunity to appoint a nominated person and provisions for a patient advance statement to be considered by the authorised psychiatrist. In this way, accountability and safeguards are contained in the Mental Health Act.[49]

7.62 However the Public Advocate Victoria did acknowledge that even with these safeguards, some people are detained within the mental health system for longer than

46 RANZCP, *Submission 17*, p. 4.

47 Office of the Public Guardian (QLD), *Submission 56*, p. 4.

48 Mr Povey, Victoria Legal Aid, *Committee Hansard*, Melbourne, 29 April 2016, p. 4.

49 Office of the Public Advocate (Victoria), *Submission 58*, p. 18.

they need to be.[50] During a hearing for the inquiry, the Public Advocate Victoria discussed a recent research study which found that of 99 long-stay mental health patients in secure facilities, 75 were detained because there was no alternative accommodation for them.[51]

7.63 Victoria Legal Aid submitted similar evidence on the regime in Victoria, and stated that a lack of statutory requirements to provide treatment has the effect of prolonging detention for individuals:

> In our advocacy work for people under the CMIA [Crimes (Mental Impairment and Unfitness to be Tried) Act 1997] or those subject to inpatient treatment order ("ITO") under the Mental Health Act we see many instances of prolonged, indefinite detention where there is insufficient impetus or structural supports to enable the person to progress and receive treatment in an environment that would be less restrictive of their freedom.[52]

7.64 The Public Advocate QLD submitted that to address this issue, formal requirements for treatment plans should be incorporated into legislation:

> The instigation of appropriate planning and review processes is an essential safeguard for people who are detained in authorised facilities for the purpose of treatment and/or behaviour support. Formal plans hold facilities to account by requiring staff to work according to specific objectives and standards, establishing outcomes against which agency practice can be measured, and documenting progress against these benchmarks. Provisions for treatment plans based on a recovery framework, positive behaviour support plans, and/or transition plans should, therefore, be incorporated into relevant legislation.[53]

7.65 The Public Advocate Victoria has submitted that an increase in in-patient therapeutic services has resulted in a reduction in long-stay patients:

> The reduction in long stay patients in Victoria has been assisted by a range of policy and funding factors. These include the provision of intensive in-reach for long-stay patients (funded originally through the Intensive Rehabilitation Recovery Care Project; then through the SECU diversion project and the Intensive Home Based Outreach Service). Together these projects have helped to divert people from SECU units and provide intensive support for their recovery and transition into the community.[54]

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50 Office of the Public Advocate (Victoria), *Submission 58*, p. 18.

51 Dr John Chesterman, Director of Strategy, Office of the Public Advocate (Victoria), *Committee Hansard*, 29 April 2016, p. 15.

52 Victoria Legal Aid, *Submission 71*, p. 9.

53 Office of the Public Advocate (QLD), *Submission 36*, p. 21.

54 Office of the Public Advocate (Victoria), *Submission 58*, p. 19.

Appropriate facilities and accommodation

7.66 Evidence presented to the inquiry has shown there is a dearth of appropriate facilities, both within the mental health detention system, as well as supported accommodation in the community to allow for gradual release.

7.67 The lack of facilities for people who require involuntary treatment often results in people being held under higher security than is actually required, such as in prisons (see Chapter 4), or being held in facilities which do not lend themselves to assist in therapeutic care.

7.68 The Public Advocate Victoria submitted that across all states and territories, there is a lack of less restrictive facilities to allow people on supervision orders to 'step down' levels of restriction, and noted a report from the Victorian Law Reform Commission found this could result in a mismatch between the supervision required and the supervision order that is actually made.[55]

7.69 Many submitters discussed a serious lack of community-based accommodation and support services which would allow people to be released from detention. The Public Advocate Victoria submitted that while there has been a closure of psychiatric facilities over the last three decades, there has not been a corresponding increase in community-based accommodation and support. The Public Advocate Victoria argued this compromised the ability of the mental health system to meet its human rights obligations.[56]

7.70 The Disability Alliance submitted a case study to support a similar assertion on the lack of community-based options:

> Ms A. was homeless when she was placed under an involuntary treatment order in 2010. Despite reviews of her involuntary treatment order, it was deemed to be in her 'best interests' to continually detain Ms A. in a psychiatric unit as she was considered to be a risk to herself, and there was a view that there were no community mental health supports that could be tailored to her specific needs. This detention lasted for six years, until advocacy support successfully negotiated her release to appropriate community accommodation and support.[57]

7.71 Submitters also raised evidence that many existing community-based service providers were reluctant to take on clients where managing complex behaviours or risk was involved:

> The OPG has also observed that as the complexity of disability needs increases; the availability in choice of services, supports and accommodation decreases. There are therefore limited accommodation choices for people with high and complex needs.[58]

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55 Office of the Public Advocate (Victoria), *Submission 58*, p. 24.

56 Office of the Public Advocate (Victoria), *Submission 58*, p. 18.

57 Australian Cross Disability Alliance, *Submission 61*, pp 12–13.

58 Office of the Public Guardian (QLD), *Submission 56*, p. 8.

7.72 RANZCP also raised the issue of people with long-term behaviours which continue to put themselves and others at risk, and called for a secure model of care which can deliver a range of services in-house, without which ' people in this situation often remain incarcerated in inappropriate settings such as prison, mental health facilities and in restricted residential settings.'[59] RANZCP further submitted that a general principle across all forms of treatment should be applied, where treatment ' should be in the least restrictive environment appropriate, consistent with individual circumstances and consideration for the safety of the community. [60]

7.73 The OPG-QLD argued that without increasing the availability of community-based accommodation, the problem of indefinite detention is likely to continue.[61]

Committee view

7.74 The committee strongly agrees with the principle set out by RANZCP and other submitters, that where the state deprives a person of their liberty due to the risk factors associated with a cognitive or psychiatric impairment, the state has an obligation to provide therapeutic treatment for that impairment. It is clear to the committee from the evidence presented, that for a range of reasons such treatment is not always delivered. The situation is critical enough to require legislated mandatory requirements for service delivery and oversight of time-limited care plans with a clear goal of release from detention.

7.75 The evidence has also clearly shown there is a shortage of accommodation. This includes secure accommodation that is an appropriate environment to deliver therapeutic treatment while addressing risk factors. More importantly, there is a dire shortage of appropriate community-based accommodation to allow people to step down from secure treatment environments back into the community. This accommodation shortage is resulting in increased rates of indefinite detention.

59 RANZCP, *Submission 17*, p. 9.

60 RANZCP, *Submission 17*, p. 13.

61 Office of the Public Guardian (QLD), *Submission 56*, p. 8.