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ARTICLE

What Does "Least Restrictive" or "Less Restrictive" Mean in Mental Health Law? Contradictions and Confusion in the Case of Queensland, Australia

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Abstract

Most legal systems in the West allow for involuntary treatment of mental illness, usually on the basis that without such treatment the person would be a danger to themselves or others. While historically the mental health law jurisdiction has been a protective one, it has become increasingly influenced by civil rights and international human rights law, which privilege the value of autonomy and the right to personal liberty.

In this regard, an important principle that has developed is that decisions about treatment for mental illness must be the "least restrictive alternative" available. This may mean, for example, that a person is supported to make a decision on treatment for their mental illness, according to evolving practices of "supported decision-making," so that their legal capacity is still recognized. If involuntary treatment is required, the "least restrictive" approach demands that the liberty and integrity of the person be respected to the greatest extent possible.

The Mental Health Act 2016 (Qld) ("MHAQ") prescribes that decision-making on non-consensual treatment should preferably be done according to what it calls the "less restrictive way." However, the "less restrictive way" is defined as decision-making by patients under advance directives, and also by substitute decision-makers, including by attorneys or guardians not appointed by the patient, usually a family member. The MHAQ states that these arrangements are distinguished from and prioritized over what it calls "involuntary treatment and care," where the decision for non-consensual treatment is made by the treating team.

However, we argue that these arrangements are not in fact "less restrictive" of the person's autonomy, but are less accountable forms of decision-making. Decision-making by treating teams under involuntary treatment provisions is subject to higher levels of transparency and accountability. In Australian states these decisions are reviewed regularly by a specially constituted, independent mental health tribunal. By contrast, treatment decisions made under the "less restrictive way" are not even defined as constituting involuntary treatment, and are outside the scope of the tribunal's review.

In the case of decision-making by advance directive, we acknowledge that this is widely considered to be "less restrictive" of a person's right to legal capacity and autonomy. However, in these cases, the patient may actually be refusing treatment at the time the advance directive is relied upon. This raises serious questions as to whether such "voluntary" admissions and treatment should not be subject to the same oversight and accountability as involuntary ones. Patients have a right to less restrictive forms of decision-making, but when deprived of their liberty, they also have a right to adequate safeguards established by law.

The term "less restrictive" in the MHAQ is largely misplaced and misleading. In the case of advance directives, it deflects attention from the potentially restrictive nature of the treatment and the lack of accountability. Even more problematically, the privileging of private substitute decision-making under the less restrictive way ignores the real risk of abuse and undue influence within the personal and family sphere. We argue that the "less restrictive way" under the MHAQ is a step backwards for the rights of patients, in that

it shifts power to family on the risky assumption that decision-making by these less supervised individuals is more likely to uphold human rights. We believe that this reflects a pre-feminist assumption that the informal, family, private sphere is nearly always safe. This is a contentious assumption, which nevertheless underpins much unproblematized thinking and advocacy on supported decision-making. This issue also highlights the need for further elucidation and discussion on what least restrictive means in the context of involuntary treatment for mental illness.

Keywords: mental health; guardianship; civil commitment; civil rights; least restrictive; human rights; advance directives

Introduction

Over the past forty years, the doctrine of the "least restrictive alternative" has underpinned and driven deinstitutionalization of people with mental illness in both the United States and Australia, although involuntary treatment through commitment continues. There is a common understanding that the doctrine allows for restrictions to a person's civil rights only to the extent that such restrictions further the legitimate aim of providing appropriate and effective treatment and care.[1] The critical civil rights at stake are rights to liberty and security of the person, so that less restrictive treatment is commonly understood to be that which minimizes inpatient care and avoids or minimizes physical coercion and restraint.[2]

Since the adoption by the United Nations in 2006 of the *Convention on the Rights of Persons with Disabilities* ("CRPD"),[3] the least restrictive alternative doctrine has also been applied to the right to have legal capacity recognized on an equal basis with others in article 12(2). Article 12(3) provides that people with disability should be provided with supports to exercise legal capacity and have their decisions recognized under what has become known as the law and practice of supported decision-making.[4] The use of supported decision-making together with advance health directives is frequently described as "less restrictive" of the right to legal capacity than substitute decision-making including in the form of involuntary treatment and adult guardianship ("guardianship").[5]

However, the above apparent consensus on understandings of the least restrictive doctrine belies confusion in its application.[6] This article examines the use of the terminology of "the less restrictive way"

[1]For a description and history of the doctrine, *see* short history of the doctrine in: P. Browning Hoffman & Lawrence L. Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 San Diego L. Rev. 1101-02 (1977).

[2]*See, e.g.*, Mark R. Munetz & Jeffrey L. Geller, *The Least Restrictive Alternative in the Postinstitutional Era,* 44 Hosp. & Cmty. Psychiatry 967, 967 (1993) ("..[T]he mental hospital is a more restrictive living situation…"); Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment Law: Kenra's Law as Case Study*, 9 Psychol. Pub. Pol'y & L. 183, 187 (2003) (citing factors relating to an "LRA determination" as including the environment and physical restrictions).

[3]Convention on the Rights of Persons with Disabilities*, opened for signature* Mar. 30, 2007, 2515 U.N.T.S. 15 (entered into force May 3, 2008) [hereinafter *CRPD*].

[4]*Id.* at art. 12. ("(2) States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. (3). States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity."). For some explanation of supported decision-making, *see e.g.,* Christine Bigby et al., *Delivering Decision Making Support to People with Cognitive Disability – What has been Learned from Pilot Programs in Australia from 2010 to 2015,* 52 Austl. J. Soc. Issues 222 (2017); Kristin Booth Glen, *Piloting Personhood: Reflections from the first Year of a Supported Decision-making Project,* 39 Cardozo L. Rev. 495 (2017); Christine Bigby et al., *Diversity, Dignity, Equity and Best Practice: A Framework for Supported Decision-Making* (2023), https://disability.royalcommission.gov.au/publications/diversity-dignity-equity-and-best-practice-framework-supported-decision-making [https://perma.cc/AP79-675X].

[5]*See, e.g.*, American Bar Association, Supported decision making resolution 113 to the ABA house of delegates. Prepared by the Commission on Disability Rights, Section of Civil Rights and Social Justice Section of Real Property, Trust and Estate Law, Commission on Law and Aging (2017), https://supporteddecisionmaking.com.au/wp-content/uploads/sites/4/2021/10/ABA-Resolution-113-Legal.pdf; Brenda Burgen, *Reflections on the Victorian Office of the Public Advocate Supported Decision-Making Pilot Project*, 3 Res. & Prac. Intell. Disabilities *165, 166* (2016).

[6]*See, e.g.,* Browning Hoffman & Foust, *supra* note 1, at 1107; Robert D. Miller, *The Least Restrictive Alternative: Hidden Meanings and Agendas*, 18 Cmty Mental Health J. 46 (1982); Perlin, *supra* note 2, at 187.

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in the *Mental Health Act 2016* ("MHAQ") in the Australian state of Queensland ("Qld"), concluding that it exemplifies just such confusion.

The first part briefly explains the origins of the least restrictive alternative doctrine in U.S. civil rights law and its subsequent application to civil commitment for mental health treatment. It describes the doctrine's adoption in Australia's mental health laws, and its application to the right to legal capacity. The second part describes the civil commitment process in Queensland and how the MHAQ prescribes two alternative pathways for decision-making on treatment against the patient's will (as expressed at the time the treatment is provided). We call these the "statutory pathway" and the "preferred pathway" - the latter described in the MHAQ as the "less restrictive way." Part three analyses and compares the two pathways to conclude that the preferred pathway or "less restrictive way" is not' less restrictive' in any of the commonly held understandings of that expression. It is, however, less transparent and accountable, compromising patients' rights to adequate legal safeguards when deprived of liberty. We question why this misnomer has occurred, and its implications. Part four concludes by admonishing against uncritical acceptance of the legitimacy of references to the "least (or less) restrictive alternative" in mental health law and policy.

I. Involuntary treatment for mental illness

Most Western nations allow for involuntary treatment of mental illness authorized under processes of civil commitment.[7] Involuntary mental health treatment commonly includes coercive detention, medical treatment by pharmacological, psychological and sometimes physical methods, and (less commonly) segregation or physical restraint.[8] It is not disputed that these treatments are restrictive to a range of individual rights, chief among them the right to liberty and security of the person,[9] the right to freedom of movement, and the right to bodily integrity.[10] With the adoption by the United Nations in 2006 of the CRPD, involuntary treatment has also been recognized as restricting a person's article 12 right to legal capacity and autonomy in decision-making.[11]

The CRPD was ratified by Australia in 2008,[12] and while the U.S. Senate has failed to ratify it,[13] the convention has nevertheless been and continues to be extremely influential in the ongoing critique and reform of mental health and guardianship laws in the United States,[14] Australia[15] and internationally.[16] While article 12 has been interpreted by the United Nations and others as requiring abolition of

[7]Luke Sheridan Rains et al., *Variations in Patterns of Involuntary Hospitalization and in Legal Frameworks: An International Comparative Study*, 6 Lancet Psychiatry 403, 407-9 (2019)

[8]Wendy de Bruijn et al., *Physical and Pharmacological Restraints in Hospital Care: Protocol for a Systematic Review*, 10 Frontiers in Psychiatry at 2 (2019).

[9]*See,* CRPD, *supra* note 3, at art. 14.

[10]*See,* CRPD, *supra note 3*, at art. 17.

[11]CRPD, *supra* note 3, at art. 12.

[12]Austl L. Reform Comm'n, Equality, Capacity and Disability in Commonwealth Laws: A Final Report 36 (2014).

[13]Andrew Peterson et al., *Supported Decision Making With People at the Margins of Autonomy*, 21 Am. J. Bioethics, 4 (2020).

[14]*See, e.g.,* Tina Minkowitz, *Legal Capacity: Fundamental to the Rights of Persons with Disabilities*, 56 Int'l Rehabilitation Rev. 25 (2007); Michael L. Perlin, International Human Rights and Mental Disability Law: When the Silenced are Heard 143 (2011); Kristin Booth Glen, *Supported Decision-Making and the Human Right of Legal Capacity*, 3 Inclusion 2, 6 (2015).

[15]*See, e.g.,* Piers Gooding, A New Era for Mental Health Law and Policy: Supported Decision-making and the UN Convention on the Rights of Persons with Disabilities (2017); Sascha Callaghan & Christopher James Ryan, *An Evolving Revolution: Evaluating Australia's Compliance with the "Convention on the Rights of Persons with Disabilities" in Mental Health Law*, 39 UNS L. J. 596 (2016); Terry Carney, *Supported Decision-Making for People with Cognitive Impairments: An Australian Perspective?*, 4 Laws 37, 38 (2015).

[16]*See, e.g.*, Anna Arstein-Kerslake, Restoring Voice to People with Cognitive Disabilities: Realizing the Right to Equal Recognition before the Law (2017); Gerard Quinn & Anna Arstein-Kerslake, *Restoring the 'Human' in 'Human*

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involuntary treatment and all forms of substitute decision-making including guardianship,[17] there has also been widespread opposition to that radical interpretation, especially in the mental health sector.[18] For now, at least, (if not for the foreseeable future) Western nations including the United States and Australia continue to impose involuntary treatment for mental illness under civil commitment processes.

A . 'Least Restrictive Alternative' - Common Understandings in Mental Health Law

The least restrictive alternative doctrine was originally a general one, invoked in interpreting and applying various U.S. constitutional civil rights and freedoms, proposing "…that governmental action must not intrude upon constitutionally protected interests to a degree greater than necessary to achieve a legitimate purpose."[19] From the 1970s in the United States, the doctrine began to be applied specifically to civil commitment law to mitigate the impact of civil rights violations inflicted by involuntary treatment.[20] In 1991, mandates for "least restrictive" treatment were included in the United Nations' *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991)*[21] ("U.N. Principles") and at around the same time, the least restrictive alternative first appeared in mental health laws of the Australian states and territories.[22]

When first introduced into U.S. and Australian mental health law and policy, the least restrictive alternative doctrine drove the move to deinstitutionalization, with treatment in the community widely considered as less restrictive of individual liberty rights than inpatient treatment.[23] The U.N. Principles provide that a person with severe mental illness may be admitted to a mental health facility "in accordance with the principle of the *least restrictive alternative* [emphasis added]" in only two situations: first, where failure to admit a person to a facility "is likely to lead to a serious deterioration in his or her condition;" and second, where "appropriate treatment … can only be given by *admission to a mental health facility* [emphasis added]."[24]

Following de-institutionalization, the doctrine started to be used in the context of civil commitment itself.[25] This meant that for inpatients, coercion, detention and physical restraint were required to be

Rights': Personhood and Doctrinal Innovation in the UN Disability Convention, *in* Cambridge Companion to Human Rights Law (Costas Douzinas & C. A. Gearty eds., 2012).

[17]U. N. Committee on the Rights of Persons with Disabilities, General Comment No. 1 (2014) Article 12: Equal Recognition Before the Law CRPD/C/GC/1 (2014); *see also, e.g.*, Minkowitz, *supra* note 12, at 26; Perlin, *supra* note 12, at 144-145;)]; Anna Arstein-Kerslake, *An Empowering Dependency: Exploring Support for the Exercise of Legal Capacity*, 18 Scandinavian J. Disability Res. 77, 78 (2016).

[18]Wayne Martin & Sándor Gurbai, *Surveying the Geneva Impasse: Coercive Care and Human Rights*, 64 Int'l j. l. & psychiatry, 119-21 (2019); John Dawson, *A Realistic Approach to Asessing Mental Health Laws' Compliance with the UNCRPD*, 40 Int'l J. L. & Psychiatry 70 (2015); Melvyn Colin Freeman et al., *Reversing Hard Won Victories in the Name of Human Rights: A Critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities*, 2 Lancet Psychiatry 844 (2015); Malcolm Parker, *Getting the Balance Right: Conceptual Considerations Concerning Legal Capacity and Supported Decision-Making*, 13 J. Bioethical Inquiry 381, 382 (2016); Julia Duffy, Mental Capacity, Dignity and the Power of International Human Rights (2023); Katrine Del Villar, *Should Supported Decision-Making Replace Substituted Decision-Making? The Convention on the Rights of Persons with Disabilities and Coercive Treatment under Queensland's Mental Health Act 2000*, 4(2) Laws 173 (2015).

[19]Browning, Hoffman & Foust, *supra* note 1; *see also* Munetz & Geller, *supra* note 2.

[20]Perlin, *supra* note 2, at 186 *citing* Lessard v. Schmidt, 349 F. Supp. 1078 (E.D.Wis. 1972).

[21]G.A. Res. 46/119, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (Dec. 17, 1991) [hereinafter UN Principles].

[22]Like the United States, Australia has a federal system of government so that both mental health and guardianship laws fall within state and territory jurisdictions. *See,* Francesca C. Grace et al., *An Analysis of Policy Levers used to Implement Mental Health Reform in Australia 1992-2012*, 15 Bmc Health Services Res. 479 (2015).

[23]Munetz & Geller, *supra* note 2, at 967-8.

[24]UN Principles, *supra* note 19, at princ. 15(1)(b).

[25]Substance Abuse and Mental Health Services Administration, Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice 8 (2019).

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minimized and used only as a last resort or when they were the "least restrictive alternative" available.[26] For involuntary treatment of outpatients, the least restrictive alternative would be "outright release," as opposed to still being subject to a range of conditions relating to medication, follow up appointments, activities or movements. Outpatient or community treatment as regulated by mental health laws is still involuntary to the extent that failure to adhere to its conditions (including by refusing medication) may lead to treating practitioners or others seeking the patient's readmission into hospital.[27]

References to the least restrictive alternative are threaded throughout the mental health laws of Australia's states and territories, including Queensland.[28] The *Mental Health and Wellbeing Act 2022* (Vic) provides that mental health services must be provided to people "…with the least possible restriction of their rights, dignity and autonomy…"[29] and other states' and territories' mental health laws similarly provide that people be treated in the "least restrictive environment"[30] or "least restrictive setting."[31] The MHAQ provides that its objects

"….are to be achieved in a way that— (a) safeguards the rights of persons; and (b) is the *least restrictive* of the rights and liberties of a person who has a mental illness" and that:

> …a way is the *least restrictive* of the rights and liberties of a person who has a mental anrequired to protect the person's safety and welfare or the safety of others [emphasis added].[32]

All Australian mental health laws explicitly include options for involuntary treatment both in hospital and in the community.[33] In Queensland, as in most other states, the legislation expressly provides that involuntary treatment as an inpatient is justified only where there is no "less restrictive alternative,"[34] and seclusion and physical restraint of inpatients can only be used as a last resort.[35] Treatment considered to be particularly intrusive on bodily integrity such as electroconvulsive therapy and psychosurgery are much more strictly regulated, and permitted only when other available methods of treatment have been unsuccessful.[36]

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[26]*Burnett v Mental Health Tribunal* [1997] ACTSC 94 (Austl.).; Michael L. Perlin, *"Their Promises of Paradise": Will Olmstead v. L.C. Resuscitate the Constitutional "Least Restrictive Alternative" Principle in Mental Disability Law?*, 37 Houston L. Rev. 1000-1 (2000) ("[…] the use of the concept has expanded to consideration of restrictivity of conditions within an institution, adequacy of treatment (in some cases) […] a patient's right to *refuse* treatment […]").

[27]*See, e.g., Mental Health Act 2016* (Qld) s 57 (allowing for involuntary treatment to be community category to inpatient); Browning Hoffman & Foust, *supra* note 1, at 1115; Perlin, *supra* note 2, at 194 ("Yet some jurisdictions apparently force patients to choose restrictive treatment by demanding it against their wishes and by threatening recalcitrant patients with more restrictive treatment as the price of refusal.").

[28]*See, e.g., Mental Health Act 2015* (A.C.T.) s 5(c); *Mental Health Act 2016* (Qld) s 3(2)(b); *Mental Health Act 2009* (S.A.) s 7 (1)(b); *Mental Health Act 2014* (W.A.) sch 1 princ. 4.

[29]*Mental Health and Wellbeing Act 2022* (Vic) commenced September 1, 2023, replacing the *Mental Health Act 2014* (Vic.) which also referred to least restrictive, for example, s 10(b) "…a person should be assessed and treated in the least restrictive way possible with the least possible restrictions on human rights, and human dignity…".

[30]*Mental Health and Related Services Act 1998* (N.T.) ss 8(a), 9(p); *Mental Health Act 2009* (S. A.) s 7(1)(b); *Mental Health Act 2015* (A.C.T) s 85(1)(a)(iv).

[31]*Mental Health Act 2013* (Tas) s 12(d).

[32]*Mental Health Act 2016* (Qld) ss 3(2)(a)-(b), 3(3).

[33]*See, e.g., Mental Health Act 2016* (Qld) s 51; *Mental Health Act 2007* (N.S.W.) s 53(3); *Mental Health and Related Services Act 1998* (N. Terr) s 16; *Mental Health Act 2009* (S.A.) pt 4 divs 1-2; *Mental Health Act 2015* (A.C.T.) pt 5.5; *Mental Health and Wellbeing Act 2014* (Vic.) s 194; *Mental Health Act 2014* (W.A.) s 23.

[34]*Mental Health and Wellbeing Act 2014* (Vic), ss 18, 71(3); *Mental Health Act 2007* (NSW) ss 12(1), 31(4); *Mental Health Act 2015* (ACT) s 58(2)(g); *Mental Health Act 2009* (SA) ss 21(2), 25(3), 29(2); *Mental Health Act 2014* (WA) ss 25(1)(d)-(e); *Mental Health and Related Services Act 1998* (N.T.) ss 14(c), 56(d).

[35]*See, e.g., Mental Health and Wellbeing Act 2014* (Vic) s 125ff (restrictive interventions generally). For seclusion, *see, Mental Health and Related Services Act 1998* (NT) s 62(3); *Mental Health Act 2014* (WA) s 216(1)(b). For physical or mechanical restraint, *see, Mental Health and Related Services Act 1998* (NT) s 61(3); *Mental Health Act 2014* (WA) s 232(1)(b).

[36]*See, e.g., Mental Health Act 2016* (Qld) ch 12 pt 9 divs 1-2; *Mental Health Act 2009* (SA) pt 7 divs 1-2; *Mental Health Act 2015* (ACT) ch 9.

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B. The Right to Legal Capacity and "Less Restrictive" Alternatives

Underlying all of the above calibrations of "least" and "less" restrictive is the understanding that involuntary treatment is always more restrictive than voluntary treatment because involuntary treatment impinges on the fundamental right to make decisions about our own lives. As described above, the CRPD articulates, for the first time, a right for people with disability (including those experiencing mental illness) to have their legal capacity or decision-making rights recognized on an equal basis with others. It further states that people with disability must be provided with supports to exercise legal capacity and make their own decisions.[37]

Supported decision-making is still in development, but it is agreed that supports may be in the form of mentoring, communication assistance or advocacy that assist people in making decisions and having their legal capacity recognized.[38] Supported decision-making is underpinned by the value of autonomy and the practice of ensuring that a person's will and preferences are respected and acted upon to the greatest extent possible. The MHAQ only allows for involuntary treatment when a patient lacks capacity;[39] so supported decision-making can enable a person to have their legal capacity recognized and thus avoid civil commitment.[40]

Guardianship legislation in Queensland also only allows for the appointment of a guardian if an adult lacks capacity,[41] and the *Guardianship and Administration Act 2000* (Qld) ("GAA") provides that alternatives to guardianship that are "least restrictive" of legal capacity are preferred. The context makes it clear that "least restrictive" alternatives include supported decision-making and the use of advance health directives, both of which are more respectful of an adult's autonomy.[42]

II. The Legislative Framework in Queensland for Involuntary Treatment

The short survey above is intended to reflect common understandings of how the least restrictive alternative doctrine is understood to apply in mental health and guardianship law, and yet we acknowledge that its meaning and application are contested.[43] Miller observes that: "….LRA is a concept which has as many meanings as the number of people who use it. It serves to advance and legitimize several very different, and often conflicting, viewpoints…"[44] Our aim is not to interrogate all these interpretations, but to investigate one particularly contradictory and confusing application in the MHAQ.

The MHAQ now provides two alternative pathways for decision-making on behalf of a person with mental illness. The first we refer to as the "statutory pathway" and is the traditional way in which decisions are made by a psychiatrist to authorize involuntary mental health treatment. The second, called in the MHAQ the "less restrictive way" and also referred to in this article as the "preferred pathway," is described and analyzed further below. Our analysis concludes that treatment provided under the preferred pathway does not fit squarely within any of the commonly recognized understandings of "less restrictive" alternatives.

[37]CRPD, *supra* note 3, at art 12(3). *See also,* Law Commission, Mental Capacity and Deprivation of Liberty Report No. 372 (2017) at 167 (UK) (defining supported decision-making as "the process of providing support to a person whose decision-making ability is impaired, to enable them to make their own decisions wherever possible").

[38]*See, e.g.,* Piers Gooding, *Supported Decision-Making: A Rights-Based Disability Concept and Its Implications for Mental Health Law* 20(3) Psychiatry, Psych. & L. 431, 432-39 (2013).

[39]*See Mental Health Act 2016* (Qld) s 12.

[40]*See id.* at s 14(3) ("'A person may be supported by another person in understanding…' matters required to demonstrate capacity and in '…making a decision about the treatment'").

[41]*See Guardianship and Administration Act 2000* (Qld) s 12.

[42]*See id.* at s 11B sub-s 8 ("Maximizing an adult's participation in decision-making").

[43]*See, e.g.*, Perlin, *supra* note 2, at 191-192. *E.g.* There is contention whether "forced drugging" of outpatients is always less restrictive of rights than some alternative inpatient treatments. Browning Hoffman & Foust, *supra* note 1; Perlin, *supra* note 24.

[44]Miller, *supra* note 6.

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A . The "Statutory Pathway" – Treatment Authorities

Under the statutory pathway, a decision (called a "treatment authority") is made for involuntary treatment by a clinician, usually a psychiatrist. A treatment authority is a heavily regulated decision that is also subject to review by the independent Mental Health Review Tribunal ("Tribunal").[45] A clinician can only make a treatment authority if the "treatment criteria" apply and there is no "less restrictive way" of providing treatment and care.[46] The treatment criteria require that the person has a mental illness; [47] lacks capacity to consent to be treated;[48] and if not treated, will likely cause "..imminent serious harm to the person or others…," or suffer "serious mental or physical deterioration."[49]

A treatment authority must be documented in an approved form incorporating prescribed information, including whether the person is an inpatient or in the community and "the nature and extent of the treatment and care to be provided."[50] The clinician making the decision must discuss the proposed treatment and care with the patient.[51] After making the treatment authority, the clinician must advise the patient of the decision, explain its effect and give a copy to the patient's "nominated support person" and any guardian or attorney if requested.[52] When a patient subject to a treatment authority is an outpatient in the community, the clinician must also explain the patient's obligations (e.g. to attend appointments and take medication) and provide a statutory notice summarizing that information.[53]

A patient subject to a treatment authority, whether inpatient or community, has several statutory protections. First, they can nominate someone to be their support person.[54] A nominated support person can request a psychiatrist's report and must be given prescribed notices and access to confidential information.[55] They can also act as the patient's support person or representative in Tribunal reviews (see further *infra*).[56] Second, and critically, the treatment authority is subject to legislatively mandated, ongoing clinical reviews under prescribed schedules. When a treatment authority is made by a doctor who is not a psychiatrist, then a psychiatrist must review it within three days (or seven for a remote service) and either confirm or revoke it.[57] The MHAQ prescribes regular clinical assessments for patients subject to treatment authorities, at a minimum every three months,[58] as well as at any time the clinician considers the treatment criteria may no longer apply.[59] Each assessment must be discussed with the patient, and the decision recorded in their medical records.[60]

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[45]Australian states have independent statutory mental health tribunals, constituted typically by a mix of community, legal and medical members. *See, e.g., Mental Health Act 2016* (Qld) ch 16 pt 2 (Austl.). The tribunals broadly serve the same functions as courts in U.S. state civil commitment procedures, but are inquisitorial rather than adversarial in nature and conduct proceedings with less formality. Appeals can be made from the tribunals to the state courts on questions of law only.

[46]*Id.* s 48-49.

[47]*Id.* s 10 (defined as "(1) ….a condition characterised by a clinically significant disturbance of thought, mood, perception or memory' with various exclusions from this wide definition in subsection.").

[48]*Id.* s 14 (defined as "[a] person has capacity to consent to be treated if the person— (a) is capable of understanding, in general terms— (i) that the person has an illness, or symptoms of an illness, that affects the person's mental health and wellbeing; and (ii) the nature and purpose of the treatment for the illness; and (iii) the benefits and risks of the treatment, and alternatives to the treatment; and (iv) the consequences of not receiving the treatment; and (b) is capable of making a decision about the treatment and communicating the decision in some way.").

[49]*Id.* s 12.

[50]*Id.* s 50.

[51]*Mental Health Act 2016* (Qld) s 53 (Austl.). If a clinician makes a treatment authority overriding wishes in an advance health directive, they must explain to the patient the reason why, *id.* s 54(2)(a).

[52]*Id.* s 55.

[53]*Id.* s 220. *See also* Verere Bateren et al., *Improving Human Rights in Mental Health Takes More than Just Changing the Law: An Audit of Medical Assessments in Regional Community Patients in Queensland*, 30 Australasian Psychiatry 19, 198 (2022) (suggesting doctors frequently don't comply with record keeping requirements).

[54]*Mental Health Act 2016* (Qld) s 223 (Austl.).

[55]Queensland Health, Role of Nominated Support Persons at 1 (2016).

[56]*Id.* s 223-24.

[57]*Id.* s 56.

[58]*Id.* s 59. The assessment is made under *id.* s 205.

[59]*Id.* s 205(3).

[60]*Id.* s 205(4).

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Third, treatment authorities are subject to formal and regular external review by the Tribunal. Reviews must occur within twenty-eight days of a treatment authority being made; within six months of the first review; within six months of the second review, and then at least every twelve months.[61] Additional reviews can also be requested by: the patient; their nominated support person; any other person with "…a sufficient interest in the person;"[62] the Chief Psychiatrist,[63] or by the Tribunal itself.[64] The "Chief Psychiatrist" is an independent statutory officer[65] responsible for the "proper and efficient administration" of the Act.[66] A Tribunal review of a treatment authority is a review on the merits, which means that all relevant information is reviewed and a determination made on whether the decision should continue in effect or should be varied or revoked. The Tribunal must consider all the person's circumstances, their mental state and their response to treatment,[67] and must provide written reasons for its decision on request.[68]

In summary, treatment authorities are subject to extensive statutory criteria for treatment, are regularly reviewed by the clinical decision-maker and are subject to reassessment and external review by the Tribunal.

B . The Preferred Pathway – The "Less Restrictive Way"

A treatment authority can only be made if there is "no less restrictive way" for the person to receive treatment and care for their mental illness.[69] In comparison with a treatment authority, decision-making under the preferred pathway – the "less restrictive way" – is subject to scant regulation or external oversight.

Section 13(1) of the MHAQ provides that under the less restrictive way, treatment can be authorized in order of priority, by:

a) an adult parent (for a minor);
b) an advance health directive;
c) a personal guardian;
d) an attorney appointed by the person under an advance health directive or enduring power of attorney; or
e) a statutory health attorney.[70]

Two of these methods – an advance health directive and an attorney appointed by the person – involve the person's own choices. But crucially, three of them – a parent, a personal guardian and a statutory health attorney – allow substitute decision-makers not appointed by the person to make decisions authorizing treatment. These substitute decision makers can authorize treatment against a person's current wishes (what would typically be described as "involuntary" treatment), in preference to a clinician making a treatment authority.

[61] *Id.* s 413(1).
[62] *Id.* s 413(2) ("interested person" defined in *id.* sch 3).
[63] The "Chief Psychiatrist" is an independent statutory officer responsible for the "proper and efficient administration" of the Act: *id.* s 301(c).
[64] *Id.* s 411.
[65] *Id.* ch 10.
[66] *Id.* s 301(c).
[67] *Id.* sch 3. Definition "relevant circumstances," includes mental state and psychiatric history; any intellectual disability; social circumstances; response to and willingness to receive treatment and care; response to any previous community treatment.
[68] *Id.* 294-95.
[69] *Id.* s 13(2). The obligation to consider the "less restrictive way" is ongoing, even if a patient's treatment is commenced under a treatment authority. *Id.* ss 50, 421(1)(b).
[70] *See Powers of Attorney Act 1998* (Qld) s 63(1) and *infra.*

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Despite the naming of the preferred pathway as the "less restrictive way," in our view at least three of the allowed decision-making methods are not less restrictive of rights, in any of the commonly understood meanings of the doctrine. Two of the decision-making methods under the preferred pathway – advance health directive and durable power of attorney – are commonly considered "less restrictive" of the article 12 right to legal capacity. However, even these methods do not necessarily lead to treatment that is less restrictive of rights to liberty and security of the person. Understanding this conclusion requires further explanation of the decision-making methods included under the preferred pathway.

1. Decision-Makers under the Preferred Pathway

The first decision-maker under the preferred pathway is a parent of a child under eighteen years old. For general health care, Queensland law provides that, except for mature minors who are "Gillick competent," parents can make decisions for their children in their "best interests."[71] Prior to passage of the MHAQ, an exception to this rule had been for mental health treatment, where minors could only be treated involuntarily under the then equivalent of the statutory pathway. The inclusion of this "less restrictive way" in the MHAQ extends parental authority, allowing them to consent to mental health treatment in their child's best interests, potentially in the face of the young person's objection.

The second option under the preferred pathway is where an advance health directive executed by the patient under the *Powers of Attorney Act 1998* (Qld) ("POAA") authorizes treatment.[72] The POAA provides that a doctor "can restrain, move or manage a person" to administer treatment if the advance health directive specifically authorizes this.'[73] Providing treatment according to a patient's wishes set out in an advance health directive is generally considered less restrictive of the person's article 12 decision-making rights.[74]

The third option under the preferred pathway is for a decision to be made by a personal guardian. Under the GAA the Queensland Civil and Administrative Tribunal ("QCAT") can appoint a person as guardian to make decisions on personal matters (including health care) for an adult with impaired capacity.[75] QCAT has wide discretion whom to appoint as guardian, but usually it is a family member or unpaid carer, or where no one else is available or suitable, the Public Guardian may be appointed as a "last resort."[76] Prior to the passage of the MHAQ, guardians had no power to consent to mental health treatment and care.[77]

The fourth avenue for authorization under the "less restrictive way" is by an attorney chosen and appointed by the person themselves, either under an advance health directive, or an "enduring power of attorney for personal matters."[78] These are formal legal documents executed by an adult with capacity, to take effect at a future time when they have impaired capacity. Usually, the attorney would be someone close to the person, either a trusted family member or friend, but a person may also appoint the Public

[71]A minor will be Gillick competent if they possess "…sufficient understanding and intelligence to enable him or her to understand fully what is proposed;" Lord Scarman in *Gillick v. West Norfolk and Wisbech Area Health Authority* [1986] AC 1122 (HL) 188-9, *cited in* Ben Matthews & Malcolm Smith, *Children and Consent to Medical Treatment*, *in* Health Law in Australia 161, (Ben White et al., eds., 2018).

[72]A valid advance health directive must comply with execution requirements and the directions must be "ordinary, reasonable and appropriate." Katrine Del Villar & Christopher J Ryan, *Self-Binding Directives for Mental Health Treatment: When Advance Consent is not Effective Consent*, 212 Med. J. Austl. 208, 209 (2020) (quoting *Messiha v South East Health* (2004) NSWSC 1061 (Austl.)).

[73]*Powers of Attorney Act 1998* (Qld)s 35(2)(c).

[74]*Mental Health Act 2016* (Qld) s 54. *See also* Sascha Callaghan & Christopher James Ryan, *supra* note 15, at 618.

[75]*Guardianship and Administration Act 2000* (Qld) s 12.

[76]*Id.* s 14; *Public Guardian Act 2014* (Qld). The Public Guardian is a statutory officer in charge of Queensland's Office of the Public Guardian, whose main function is making decisions as personal guardian for adults with impaired decision-making capacity.

[77]*See* repealed *Mental Health Act 2000* (Qld) ss 13(3), 14(2).

[78]*Mental Health Act 2016* (Qld) sch 3 Dictionary. An "enduring" power of attorney is similar to a "durable" power of attorney in the United States.

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Guardian. Having decisions for mental health treatment made by a person's chosen attorney is commonly considered less restrictive of the person's autonomy and freedom of choice than having decisions made by a clinician (see further *infra*). However, once again, before the passage of the MHAQ, attorneys had no power to make decisions on mental health treatment.[79]

The fifth possible avenue for authorization under the preferred pathway is by a "statutory health attorney." This term refers to an individual or entity who has decision-making power for a person with impaired capacity on health matters, but is not formally appointed either by the person, or by a tribunal or a court (unlike a personal guardian). The role is created by section 63 POAA, which states that if there is no advance health directive in place, no appointed guardian and no attorney, decision-making power is conferred on individuals in certain roles in order of priority. The first is the person's spouse in cases where they have a "close and continuing relationship;" followed by an unpaid carer, then a close friend or relative, and then the Public Guardian in cases of last resort. The "statutory health attorney" is the first person on the list who is available and willing to act.

2. Oversight of Preferred Pathway

There is significantly less oversight of decisions made under the preferred pathway than under the statutory pathway. Clinicians are not statutorily required to discuss treatment decisions with the patient, nor to explain the nature and effect of the treatment being provided.[80] The statutory requirement for three monthly clinical reviews does not apply to patients under the preferred pathway, nor are record keeping requirements as prescriptive. We note that some practices considered more restrictive of civil rights, *i.e.*, emergency electroconvulsive therapy and mechanical restraint, cannot be practiced under the preferred pathway.[81] However, decisions can still be made for either community or inpatient treatment and for pharmacotherapy, against the patient's current wishes.

The Chief Psychiatrist has issued a policy ("the Policy") which mandates an initial clinical review after fourteen days, if an attorney, guardian, or statutory health attorney has consented to a person being treated as an inpatient.[82] At that review, a clinician must consider whether the person should remain an inpatient, or whether community treatment is more appropriate. If the decision is being made by a statutory health attorney, the clinician must consider whether a treatment authority is preferable, the Policy acknowledging the greater protections and oversight under the statutory pathway.[83] While the Policy mandates ongoing clinical reviews, no time frames are prescribed.[84] Further, the initial fourteen day review period only applies to the decision for inpatient treatment, not to decisions for community treatment, for which no reviews are mandated. Similarly, there is no prescribed schedule for reviews to assess whether a patient has regained capacity to make their own decisions. Most notably, the Tribunal has no role in reviewing decisions for treatment and care made under the preferred pathway.

The POAA and the GAA provide scant oversight of decision-makers under the preferred pathway. Appointment of attorneys is not reviewed under the POAA unless the appointor or other "interested person," applies to QCAT for revocation.[85] The appointment of a guardian must be reviewed only every

[79] *See* the now repealed *Mental Health Act 2000* (Qld) ss 13(3), 14(2)

[80] *Cf.* the requirements for clinicians, pt 2.1 *supra*.

[81] *Mental Health Act* 2016 (Qld) ss 237 (emergency ECT), s 246 (mechanical restraint), s 256 (seclusion).

[82] Queensland Health, Chief Psychiatrist Policy - Treatment criteria, assessment of capacity, less restrictive way and advance health directives (2020) [hereinafter *Chief Psychiatrist Policy*]. This policy is legislatively required to be complied with: *Mental Health Act 2016* (Qld) s 13(2)(b); Queensland Health, Less Restrictive Way Guidelines at 23-25, https://www.health.qld.gov.au/__data/assets/pdf_file/0025/860542/LRW_Guidelines.pdf, (last visited Dec. 16, 2022) [hereinafter *Chief Psychiatrist Policy*]. The guidelines reiterate the fourteen day review period in this report as well.

[83] *Chief Psychiatrist Policy, supra* note 82, at 1.

[84] *Id.*

[85] For example, this may happen when a person believes an attorney has misused their powers: *Powers of Attorney Act 1998* (Qld) ss 109A, 116.

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five years,[86] unless a shorter period is specified by QCAT.[87] For more frequent reviews, or to seek a declaration of capacity, [88] or for an order for directions to a guardian or attorney, the onus is on the person subject to treatment (or other interested person) to apply to QCAT.[89] In short, the oversight mechanisms under the GAA and POAA for guardians, attorneys and statutory health attorneys are considerably more limited than those governing clinicians under the statutory pathway, and the MHAQ itself offers very little oversight of the preferred pathway.

III. Analysis and Comparison of the Two Pathways

As explained above, the purpose of the "least restrictive alternative" principle is to prohibit intrusion by the state into personal life to any greater extent than necessary to pursue a legitimate aim. Given this, prescribing the "less restrictive way" as the preferred pathway for decision-making under the MHAQ appears to be a legislative misnomer. Apart from provision of emergency electroconvulsive therapy and application of mechanical restraints and seclusion, treatment under the preferred pathway may be just as restrictive as under the statutory pathway. Under both pathways, treatment can still involve detention, physical restraint and pharmacotherapy, and can occur either in a facility or in the community, thereby restricting rights to liberty and security of the person. Queensland Health, the government department responsible for administering the MHAQ, has issued Guidelines on the "Less Restrictive Way." These Guidelines acknowledge that the term "less restrictive" in this context does not refer to fewer physical restrictions but only to methods of decision-making for treatment:

> These guidelines are not focused on the reduction and elimination of restrictive practices that are used under the MHA2016, such as physical restraint, acute sedation and seclusion. Whilst reduction of restrictive practices is wholly supported, these practices are only mentioned as they pertain to issues of consent and providing care under substitute decision makers.[90]

The preferred pathway is clearly intended to be "less restrictive" of the right to legal capacity.

It is commonly agreed that allowing treatment decisions to be made under an advance health directive or by a self-appointed attorney is less restrictive of a person's legal capacity. The CRPD Committee refers to advance health directives as a type of supported decision-making because their use respects a patient's autonomy in allowing their will and preferences to be followed.[91] Callaghan and Ryan write that in mental health "..advance directives are likely to become one of the central features of supported decision-making models as envisaged by the CRPD…"[92] In the case of an attorney, the patient's autonomy is respected to the extent that they have chosen who will act in that role. Callaghan and Ryan write of attorneys that:

> Allowing patients control over who their proxy decision-maker is, and the conditions under which decisions can be made by that person (through the terms of a grant of power of attorney, for example), is an important development in mental health law and a more concrete step towards the supported decision-making model envisaged in the CRPD.[93]

[86] *Guardianship and Administration Act 2000* s 28(1) (Austl.).
[87] *Id.* s 28(1)(a).
[88] *Id.* s 146.
[89] *Id.* ss 28-9, s 115.
[90] Chief Psychiatrist Policy, *supra* note 82, at 3.
[91] Del Villar & Ryan, *supra* note 72, at 29 ("Clinically appropriate instructions" in an advance health directive "should generally be followed by medical practitioners in preference to giving treatment involuntarily under mental health laws").
[92] Callaghan & Ryan, *supra* note 15, at 619.
[93] *Id.* at 617.

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However, the three remaining decision-making methods under the preferred "less restrictive way" –i.e., by a parent, a guardian, or a statutory health attorney – clearly constitute substitute decision-making, with its accompanying denial of legal capacity. In our view, these three methods are not "less restrictive" of the right to legal capacity than decisions made by clinicians under treatment authorities, because they still require substitute decisions to be imposed upon a person, potentially against their will. In that sense, the language of "less restrictive" is therefore inaccurate and misleading.[94]

Further, of concern for all five decision-making methods under the preferred pathway is a relative lack of transparency, accountability, and oversight of decision-making. Even in the case of advance health directives, the patient may be refusing treatment at the time it is given, suggesting that some statutory oversight is needed. The Tribunal process may not be without fault,[95] but it provides an opportunity for the appropriateness of involuntary treatment to be challenged, and for the patient to present their case to an independent third party. These issues of lack of transparency, and especially the lack of Tribunal oversight, were raised prior to passing of the MHAQ by both the Office of the Public Guardian[96] and Queensland's Office of the Public Advocate.[97] Criticism was also levelled by health law academics, that the new "less restrictive way" was a step "backwards" in allowing for coercive mental health treatment without appropriate safeguards.[98] The Government responded to criticisms by asserting that there were "extensive safeguards" for patients subject to the "less restrictive way," including the Community Visitors Program, and advised that it would review the provisions' "effectiveness" within two years.[99]

The Community Visitors Program is run by the Office of the Public Guardian, and its officers visit mental health facilities on a regular basis to advocate for patients.[100] In this way, it operates as a safeguard (for inpatients only), but the independence of this function has been compromised now that the Public Guardian also acts as a decision-maker under the less restrictive way.[101] The Government did initiate a review of the "less restrictive way" one year after implementation,[102] followed by a review of the whole Act, to assess how well the MHAQ was meeting its objectives "..with particular regard to the use of less

[94]*See* Neeraj S. Gill & Kathryn Turner, *How the Statutory Health Attorney Provision in Mental Health Act 2016 (Qld) is Incompatible with Human Rights*, 29 Australasian Psychiatry 72, 72 (2021) (concluding that decision-making by a statutory health attorney under the less restrictive way is "not based on the will and preferences of the individual" and is not compliant with article 12 CRPD); *see also*, Off. of the Pub. Advoc. (Queensl.), Better Pathways: Improving Queensland's Delivery of Acute Mental Health Services 39-40 (2022). We acknowledge that the GAA was amended in 2019 to make it more compliant with article 12 CRPD, to remove references to "best interests" decision-making and prioritize "substituted judgment" principles that take into account what the adult's preferences would have been at the time they had capacity: GAA ss 11B, 11C. However, the effects of these changes in practice (if any) are as yet untested, and are not referred to or relied upon in any of the Chief Psychiatrist's or Queensland Health documents on the "less restrictive way." For a comparison of U.S. with Queensland guardianship law, see Julia Duffy, *What if Britney Spears Lived in Australia? Disrupting the Binary Framing of Supported Versus Substitute Decision-Making*, 30 Transnational L. & Contemporary Problems (forthcoming, 2023).

[95]Sam Boyle et al., *A Study into the Operation of the Queensland Mental Health Review Tribunal*, 29 Med. L. Rev. 106-127 (2021).

[96]The Office of the Public Guardian not only has an interest as a decision-maker under the less restrictive way, but also is responsible for community education on how the guardianship and attorney system works: *Public Guardian Act 2014* (Qld) s 12(1)(j).

[97]The *Guardianship and Administration Act 2010* (Qld) establishes an independent Office of the Public Advocate to advocate at a systemic level for "the rights of adults with impaired capacity for matters."

[98]Ben White et al., *As Australia Reforms its Laws to Protect Those with Mental Illness, is Queensland Going Backwards?*, The Conversation (Dec. 13 2016) [https://perma.cc/K8ZG-3W6B].

[99]Report No. 9, Mental Health Bill and the Mental Health (Recovery Model) Bill 2015 (Qld) 47.

[100]*Public Guardian Act 2014* (Qld) ch. 3 pt 6.

[101]When the bill for the Mental Health Act was debated in Parliament, the bill's explanatory notes described how the Community Visitor Program's independence (from Queensland Health) was key to its accountability. Explanatory Notes, *Mental Health Bill 2000* (Qld) 13.

[102]The 'Less Restrictive Ways Project': John Allan & Amber Manwaring, *Queensland's New Physical Restraint Framework*, *in* Restrictive Practices in Health Care and Disability Settings Legal, Policy and Practical Responses 169, 181 (Bernadette McSherry & Yvette Maker eds., 2021); Queensland Health, Evaluation of the Mental Health Act 2016 Implementation–Evaluation Report 11 (2019).

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restrictive ways (including the use of advance health directives and substitute decision-making processes)…".[103] The evaluation report published in 2019 was mainly inconclusive, because "[i]nformation about how and whether treating teams were relying upon less restrictive ways was not readily available."[104]

A further concern is that the MHAQ misleadingly excludes treatment provided under the less restrictive way from the definition of "involuntary" treatment, even though consent (except in the case of advance health directives) has not been given by the patient.[105] The implication that treatment under this pathway is "voluntary" shrouds the very real need for oversight of decisions made under this preferred pathway, where treatment is in fact provided involuntarily.

A final concern is that some of the most significant safeguards for a person receiving treatment under the preferred pathway are contained in policy, not mandated in legislation. It is concerning that for what is in fact involuntary and potentially coercive treatment, this protection is not contained in legislation. Under human rights principles "…any deprivation of liberty must be necessary and proportionate…. [and] must be accompanied by adequate procedural and substantive safeguards established by law."[106] The Office of the Public Guardian submitted that the criteria for choosing the less restrictive way should be stated in the legislation, rather than depend on administrative policy.[107]

Overall, we conclude that decision-making under the preferred pathway – the "less restrictive" way – lacks transparency and sufficient oversight, despite it being introduced in the context of a putative furthering of the rights of people with mental illness. This leads us to question what unspoken premises may lie behind the framing of decision-making by a parent, guardian or statutory health attorney in particular, as "less restrictive." On the one hand, there is a statutory pathway under which decisions are made by clinicians according to specified criteria, documented in approved forms and reviewed regularly by a government tribunal. On the other hand, under the preferred pathway most decision-makers (with the exception of the Public Guardian) are in close personal relationships with the patient – parents, relatives, carers and close friends. It may be that there is an assumption that decisions made by people in close relationships very much in the private, personal sphere, are somehow safer and therefore require less supervision than those in the public sphere of health services and government. Indeed, we recall that the philosophy behind the "least restrictive alternative" is to limit state intrusion into the personal sphere to the least extent necessary to achieve a legitimate purpose.[108]

Yet the consequences of these private decisions are significant, and potentially dire, for the patient. In our view, external oversight by government should not be misconstrued as illegitimate state intrusion. Where significant power to authorize non-consensual and potentially coercive treatment is conferred on a person, transparent criteria and strong systems of oversight are essential. Although this is not always (or indeed, often) the case, historically, there have been numerous instances where relatives have sought involuntary treatment that has led to abuse of people with mental illness and other disabilities.[109] It is also well-known and reported that currently, people with disability are disproportionately subject to abuse and violence, often in the domestic, private sphere of family and friends.[110]

[103]Allan & Manwaring, *supra* note 102, at 180.

[104]*Id.* at 182. To the authors' knowledge, there are still no systems in place to capture this data.

[105]*Mental Health Act 2016* (Qld) s 11.

[106]Chen Bo, *Controversy and Consensus: Does the UN Convention on the Rights of Persons with Disabilities Prohibit Mental Health Detention and Involuntary Treatment?*, 1 Found. L. & Int'l Aff. Rev. 39, 56-67 (2020) *citing* Hum. Rts. Comm., Gen. Comment No. 35 Article 9, Liberty and Security of the Person, U.N. Doc. CCPR/C/GC/35 (2014). *See also Human Rights Act 2019* (Qld) ss. 29, 30 'Right to liberty and security of person'.

[107]Office of the Public Guardian (Qld), Queensland Parliament Health and Ambulance Services Committee: Submission on the Mental Health Bill 2015 8 (October 2015).

[108]*See* Browning et al., *supra* note 1, at 1101.

[109]*See e.g.*, Kate Morton, The Woman they Could not Silence (2021); Lucy Series, Deprivation of Liberty in the shadows of the institution (2022) 36.

[110]Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Violence and Abuse of People with Disability at Home Issues Paper (2020); Office of the Public Advocate (Vic), 'I'm Too

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The question of when oversight becomes too intrusive and interventionist, so as to become an actual infringement of rights, is one which has been frequently raised in the literature on supported decision-making, but remains unresolved in both law and policy.[111] In view of the significance of the impact of these decisions on fundamental rights, assumptions that decisions made by family and friends will always serve the best interests of a person with mental illness are insufficient justification for the different and less rigorous oversight framework provided for the preferred pathway.

IV. Conclusion

Browning, Hoffmann and Foust wrote in 1977 that:

> The shortcomings of the doctrine of the least restrictive alternative as it is now applied to treatment of the mentally ill lie not in its well-intentioned purposes but rather in its naïve optimism that its goals can be attained by mere rhetoric without critical analysis.[112]

The above quote is more than forty years old, but it resonates today, as illustrated in our analysis of the MHAQ. In 1980, Morris also criticized the potential use of guardianship to achieve a so-called "least restrictive alternative" for people with mental illness – that is, as an alternative to institutionalization. He wrote of the increased pressure at that time to use guardianship as "voluntary" civil commitment that it "is indeed unfortunate that the propriety of this civil commitment safety valve has not been adequately scrutinized."[113] The same can be said of the less restrictive way under the MHAQ.

The overall goal of achieving the least restrictions on civil rights possible while ensuring adequate and appropriate treatment for those with mental illness is one with which few of us would disagree. In its initial application in the context of de-institutionalization, the aim of the "least restrictive alternative" doctrine may have been relatively clear: that is, to end abuses inflicted behind closed doors, and enable people with cognitive disabilities to live as independent and autonomous a life as possible. But Miller writes of the "least restrictive alternative" that "[s]uch a surface consensus of opinion often serves to obscure hidden motives and agendas upon which little consensus exists …"[114] A recent report reviewing the operation of the *Mental Health Act 2014* (Vic) states that: "core concepts in the legislative objectives and mental health principles—such as […] least restrictive treatment—are yet to be routinely embedded in treatment, care and support."[115] Statements like this, which endorse the application of the least restrictive alternative as a goal of our mental health systems, incorrectly assume that we have a clear, logical, workable consensus on what it actually means; in reality, achieving this in itself needs to be recognized as an ongoing challenge.

Scared to Come out of My Room': Preventing and Responding to Violence and Abuse between Co-Residents in Group Homes (2019).

[111] *See, e.g.*, Peter Bartlett, *At the Interface Between Paradigms: English Mental Capacity Law and the CRPD*, 11 Frontiers Psychiatry 1, 10 (2020) (on legislative safeguarding for supported decision-making, "how it is to be done is at best unclear, without the development of a system that is both unwieldy and intrusive".); Nina A. Kohn et al., *Supported Decision-Making: A Viable Alternative to Guardianship? (Capacity, Conflict and Change: Elder Law and Estate Planning Themes in an Aging World)*, 117(4) Penn St. L. Rev. 1111, 1137 (2013) ("Indeed, when we turn to more informal arrangements such as supported decision-making, which may occur in private and with less accountability, the potential for financial or other abuse likely increases").

[112] Browning et al., *supra* note 1, at 1152.

[113] Grant H. Morris, *The Use of Guardianships to Achieve - Or to Avoid - the Least Restrictive Alternative*, 3 Int'l. J. L. & Psychiatry, 104 (1980).

[114] Miller, *supra* note 6.

[115] Royal Commission into Victoria's Mental Health System, Final Report Volume 4: The Fundamentals for Enduring Reform 32 (Victorian Government Printer, 2021).

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