The following submission is made on behalf of the Qld Section of the Australian Psychological Society's (APS) College of Forensic Psychologists and is supported by the APS National Office.

Correspondence in regards to this submission can be forwarded to the Executive Committee of the Queensland Section of the APS College of Forensic Psychology at qldcfpcommittee@gmail.com

The authors of this document welcome the opportunity to provide feedback on the reviewed *Mental Health Act 2000*, namely the Mental Health Bill 2015. Whilst this submission focuses primarily on the Mental Health Bill 2015, review of the Mental Health (Recovery Model) Bill 2015 has also been conducted. Whilst there are fundamental issues with both documents, on balance the Qld Section of the Australian Psychological Society's (APS) College of Forensic Psychologists would support the endorsement of the Mental Health Bill 2015 over the Mental Health (Recovery Model) Bill 2015.

The purpose of the Mental Health Bill 2015 is to provide for the involuntary assessment and treatment, and protection, of persons who have a mental illness whilst safeguarding the rights and freedoms of other persons. However, it is suggested that a number of changes introduced into the Mental Health Bill 2015 move the focus of the Bill from assessment and treatment of the mentally ill to the management of risk and criminalisation of this population, which could lead to further stigmatisation and marginalisation of mentally ill people. It is also suggested that a number of the changes are inconsistent with the initial goals of the review of the *Mental Health Act 2000*, and stated objectives of the Mental Health Bill, namely: safeguard the rights of persons; and ensure the rights and liberties of a person who has a mental illness are adversely affected only to the extent required to protect the person's health and safety or to protect others; and promote the recovery of a person who has a mental illness, and the person's ability to live in the community without the need for involuntary treatment and care. Finally, a number of the changes include processes that are currently not resourced, and without significant resourcing, including staffing, training and oversight, the implementation of these changes would be problematic with severe implications for patients and patient rights.

Sections of the Mental Health Bill 2015 that are of concern are detailed below.

Chapter 1 Preliminary

Part 2 Principles for administration of the Act, section 5(g) Aboriginal people and Torres Strait Islanders

Although the second dot point in section 5(g) – Aboriginal people and Torres Strait Islanders and 5(h) – Persons from culturally and linguistically diverse backgrounds have been differentiated, it is suggested that the identical wording in the remaining parts of these sections and 5(h) does not achieve the distinction and recognition of the different histories, experiences and needs of these population groups.

Recommendation:

It is recommended that the wording of this section be reconsidered to ensure a distinction between these population groups and ensure recognition of the different histories, experiences and needs of Aboriginal and Torres Strait Islander people.

It is further recommended that the principles detailed for Aboriginal people and Torres Strait Islanders be integrated into other sections of the legislation to reinforce its practical application. This would be reflective of other legislation such as the *Child Protection Act 1999*.

Part 2 Principles for administration of the Act, section 5(i) Minors

It is suggested that having a minor's specific needs, wellbeing and safety recognised and protected is inconsistent with the notion that a minor could be treated in an adult facility if treatment separate from adults is not practicable.

Recommendation:

It is recommended that principles of the Act should be overarching and not subject to resourcing. As such minors should have the right to treatment in an appropriate facility.

Part 3 Interpretation, section 11 Meaning of involuntary patient

The definition of involuntary patient provided in this section is misleading and requires qualification. The current meaning states that any person subject to the following authorities/orders are involuntary patients; examination authority, recommendation for assessment, treatment authority, forensic order, treatment support order, judicial order, person detained under section 36, and person from interstate detained under 366(4).

This definition is of concern as a person under an examination authority and recommendation for assessment outside an authorised mental health service should not be considered an involuntary patient. It is suggested that the assessment period would need to have started prior to this definition being accurate. It is further suggested that without qualification this definition could lead to involuntary assessment outside an authorised mental health service including in a custodial environment.

Recommendations:

It is recommended that this meaning be qualified with the addition of a sentence that states that persons under an examination authority and recommendation for assessment are not considered involuntary patients until the examination period has commenced at an authorised mental health service. It is recognised that this recommendation is not in line with recommended changes to examination authority assessment practices. Concerns with regards to these recommended changes will be addressed later in this submission.

Further to remove all doubt it also recommended that a further qualifier be added that states that when in a custodial environment, persons under orders that provide for involuntary treatment **cannot** receive involuntary assessment and treatment in the custodial environment.

Chapter 2

Part 2 Examinations and recommendations for assessment, sections 32-35 Powers of doctors or authorised mental health practitioners

It is noted that the powers of doctors or authorised mental health practitioners has been increased under the Mental Health Bill and concerns with regards to individual rights are held as a result of these changes. In the *Mental Health Act 2000* a doctor or mental health practitioner could not assess a person without their consent outside an authorised mental health service unless the person was detained by the police under the *Police and Powers Responsibilities Act 2000*. Further the Justice Examination Order in neither its own right nor the assessment under the Justice Examination Order was sufficient to transfer the person without consent to an authorised mental health service as a Recommendation and Request for Assessment was required for this to occur. Finally, the *Mental Health Act 2000* only allowed an authorised person to enter a place to take a person to an

authorised mental health service if a) the occupier of the place consents; b) it is a public place and entry is made when the place is open to the public; and c) the entry is authorised by a warrant for apprehension of the patient.

The Mental Health Bill appears to allow involuntary assessment outside an authorised mental health service providing powers to authorised mental health practitioners to detain a person, transfer a person to an authorised mental health service and enter a place without consent under an examination order, powers that were previously only afforded to police officers, or under additional legislated processes (i.e., Recommendation for Assessment) or with a warrant and police presence.

Recommendation:

It is recommended that further consideration be given to the recommended changes to the powers of authorised mental health practitioners and doctors and the appropriateness of them having the power to enter a private residence without consent and assess a person without consent outside an authorised mental health service.

Part 2 Examinations and recommendations for assessment, section 39 Making Recommendation for Assessment

As raised in previous submissions there are ongoing concerns with the removal of the assessment criteria from the Mental Health Bill. In short it is recommended that assessment criteria are retained.

The standard that an authorised mental health practitioner or doctor complete a Recommendation for Assessment based on whether the treatment criteria may apply to the person, rather than considering specific assessment criteria, will likely see individuals who do require an assessment not receiving this intervention. This is of particular concern within the custodial environment where environmental constraints often impair one's capacity to perform an assessment equivalent to an assessment that could be provided in an inpatient setting. Removal of the assessment criteria would not be in keeping with the forensic mental health principle of *equivalence of care whereby "Prisoners and detainees have the same rights to availability, access and quality of mental health care as the general population,"* (National Statement of Principles for Forensic Mental Health 2006).

If individuals are excluded from assessment as a result of these changes opportunities for preventative mental health care will be missed, potentially having detrimental effects on individuals well-being and future recovery. These issues (lack of recovery and preventative care focus) are further complicated by the inclusion of the word imminent in the treatment criteria.

The removal of the assessment criteria is counterintuitive to clinical processes. It is argued that the more appropriate initial decision of a clinician is does this person require further assessment to determine whether the treatment criteria are met. The removal of the assessment criteria has further implications for the classified patient provisions discussed later in this submission.

Recommendation:

It is recommended that the assessment criteria are retained.

Part 3 Assessments, section 43 Making assessment, section 56 Review of treatment authority if not made by psychiatrist

The allowance of the same doctor who made the recommendation for assessment to be the doctor who conducts the assessment to determine if the treatment criteria apply in rural and remote

services is not in keeping with the important principle of equivalence of care. Individuals should be afforded the same protection of rights no matter where they reside.

Similarly, at section 56, the extension of time period for review after a treatment authority is made from 3 days to 7 days in rural and remote services does not support equivalence of care.

Recommendation:

It is recommended that the Bill not differentiate the requirements of assessment and treatment authority review for rural and remote services. The second assessment or review by a different doctor could instead occur through the use of teleconference/videoconference equipment. A provision for a face-to-face review that occurs with a specified period (within days) could also then be included for rural and remote services.

Part 3 Assessments, section 45 Where and how person may be assessed

It is inferred that the Mental Health Bill 2015 is in keeping with the appropriate standard of care set out in the *Mental Health Act 2000* whereby assessments of patients under recommendation for assessment paperwork are not to occur in custody. It is suggested that the wording of section 45(1) does not make this sufficiently explicit. It is suggested that the wording allows for the possibility of an assessment to occur in the custodial environment if deemed clinically appropriate. To allow for assessments to occur in this environment is in contradiction to the principles of equivalence of care, and as such is not in keeping with National Statement of Principles for Forensic Mental Health (Principle 5) "*These services (FMH services) should provide evidence based, multidisciplinary, continuous care, consistent with those of general mental health services."*

The principle of equivalence of care is integral in regards to the consideration of clinically appropriate places to conduct assessments. The custodial environment, (including both the prison and court watch houses) is not a suitable environment to conduct psychiatric assessments, especially when assessments are for the purpose of determining whether a patient should be placed under a treatment authority.

The custodial environment does not provide for extended periods of observation in that access to patients in the medical centre is dictated by operational movement controlled by Queensland Corrective Services. As such, assessments can be limited in timeframe, interrupted and terminated at the discretion of correctional staff due to operational issues within the centre, and at times due to various limitations within the environment, e.g., access to interview rooms, access to patients due to movement restrictions and regulations, interviews are conducted through door hatches. These assessments are not sufficient for clinical decision making, especially with regards to the need for involuntary treatment.

Further, custodial settings are not authorised mental health settings, and should never be gazetted as such for many of the reasons already detailed above as well as the following key considerations:

- The custodial environment is not a therapeutic setting and as such can have adverse implications on a persons mental state that is counter-therapeutic e.g., exposure to victimisation, and other stressors and restricted access to usual coping strategies and supports. It also has inherent risks for vulnerable persons especially if mentally unwell and/or sedated by medication to assist in the management of their mental illness.
- Assessment and treatment is complicated by a number of environmental constraints. For example health services are at the mercy of the correctional centres operational day which limits access to patients, administration time of medication, accommodation of patients and access to therapeutic approaches to management

- The custodial environment is not a safe environment to commence a number of treatments. Health centres are not hospitals and more closely resemble a community primary care service with very basic medical equipment. The Health centres are not staffed with mental health nurses and have minimal staffing after-hours. Further the majority of centres have no capacity for a patient to reside in the centre for observation by nursing staff and even in the few cases that where exists the observations are conducted by correctional officers. This means that many acutely unwell patients are already managed in detention units that resemble seclusion units staff by correctional officers whilst they await transfer to hospital.
- The correctional system and health system have competing goals (treatment/care vs security/safety). The blurring of boundaries that would inevitable occur in the application of involuntary treatment in custody would expose consumers, staff and organisations to risk via individuals working outside their professional boundaries leading to unethical and dangerous practice (beyond what would immediately inherently exist if blatant breaches of UN Human Rights principles occurred if involuntary treatment was ever allowed in custody). For example mental health treatment being used as a means of control, coercion, and failure to comply with treatment leading to punishment.

The aforementioned position is supported by the 1991 United Nations Principles for the Protection of Persons with a Mental Illness and the Improvement of Mental Health Care, whereby Principle 20 declares that persons serving sentences or who are detained in the course of criminal proceedings or investigations and who are determined to have or believed to have a mental illness:

(2) All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of Principle 1.
(3) Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.

Paragraph 5 of Principle 1 states:
Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

In addition the position is supported by the National Statement of Principles for Forensic Mental Health 2006

"Prisoners and detainees have the same rights to availability, access and quality of mental health care as the general population," – Principle 1

"*Legislation should not allow coercive treatment for mental illness in a correctional facility.*"- Principle 13

<u>Recommendations:</u>

It is strongly recommended that the wording of this section be strengthened to expressly preclude involuntary assessment in the custodial environment.

Further it is strongly recommended that the Bill also include a clear statement prohibiting both involuntary assessment and treatment of people in custody, further strengthened with a statement that correctional settings **cannot** be gazetted authorised mental health services.

Part 4 Treatment authorities, section 56 Relationship with forensic order (disability)

In dealing with the relationship between a treatment authority and forensic order (disability) it is suggested that the Mental Health Bill provides for the possibility that a patient under a forensic order (disability) community category and treatment authority inpatient category (i.e., requiring inpatient care for a mental illness) could be discharged from hospital as the forensic order (disability) prevails. This is of concern as the mental health inpatient needs of the patient, based on clinical assessment should not be superseded based on administrative processes of the Bill e.g., the nature of the forensic order (disability).

Recommendations:

It is suggested that the aforementioned interpretation of the Mental Health Bill is not in keeping with its intent in this section. If this is the case it is recommended that the wording of this section be strengthened.

Alternatively, if the aforementioned interpretation is the intent of the Bill it is acknowledged that an authorised service could in these instances change the category of the forensic order (disability), it is therefore recommended that this process be supported by a policy that ensures that the clinical needs of the patient are not superseded by administrative processes.

Chapter 3

Part 2 Transport of persons in custody to authorised mental health services

The structure of this section is particular unclear and complicated and needs further consideration. It is suggested that the removal of the assessment criteria is one key factor that contributes to the confused and insufficient processes recommended in this section, the outcome of which could be patients being unable to have access to the mental health assessment and care required.

It is understood that the reworking of the classified processes in the Bill aimed at trying to distinguish between patients who are already subject to Mental Health Act orders and require involuntary assessment and/treatment in an authorised mental health service; patients who are not consenting to assessment and/or treatment and require further assessment and/or treatment in an authorised mental health service; and patients who are consenting to assessment and treatment however their treatment in custody is insufficient to meet their mental health treatment needs and they require further treatment in an authorised mental health service. The Bill also now distinguishes a further category of classified patients, namely those patients who are already in a mental health service (as a result of a court order) prior to the classified provisions being commenced. It is suggested that attempts to distinguish these groups of patients has led to confused and insufficient classified processes in the current Bill. In particular it does not recognise that patients can move between these categories and that decision making in management of patients should not be based on which group of patients they belong to but rather their clinical need.

For example, a patient may consent to transfer for assessment and treatment however on arrival may remove consent. The change in consent does not necessarily indicate a change in clinical need

as such this should not effect a transfer back to custody but instead a decision making process to determine whether there is a need for involuntary assessment and/or treatment.

Section 65, Transport for assessment

Recommendation:

It is recommended that recommendation for assessment also be listed in this section to remove all doubt that this document is also required to effect transfer. This would be in keeping with previous sections.

Section 69, Administrator consent

Recommendation:

It is recommended that just as section 69(1)a states is *subject to a recommendation for assessment* that section b and c should refer to the actual mental health act paperwork required e.g., subject to a transfer recommendation so that it is clear that this process is required to obtain administrator consent.

Further, it is recommended in line with previous concerns raised under this Chapter that restricting administrator consent for those patients who initially consent to transfer to only treatment and care should be amended so that all patients transferred from custody are transferred for the purpose of assessment as per section 64(2)a. The current distinction can lead to the confusion of the management of voluntary patients who may revoke consent yet still have inpatient assessment and treatment needs.

Section 71, Custodian consent

Recommendation:

It is again recommended as per section 69 that this section refer to the actual mental health act paperwork required e.g., subject to a transfer recommendation.

Section 84, Person stops being classified patient if mental health court makes decision on reference

It is suggested that this section does not take into consideration clinical need in dictating an administrative process. It neglects to acknowledge that just because a patient may be found of sound mind in regards to their offending it does not mean that they do not have ongoing inpatient treatment needs.

Recommendation:

It is recommended that consideration be given to rewording this section to ensure that return to custody is based on clinical decision making (that treatment and care can be provided in the custodial environment) not solely on Mental Health Court outcomes.

Chapter 4

Psychiatrist reports for serious offences.

It is acknowledged that the removal of the 238 report process is reflective of patients right to choose to participate in this process, however there is a concern that patients under a treatment authority, forensic order or treatment support order are likely to have issues of impaired capacity, and as such

the patients capacity to understand their right to request a report and make an informed decision to request the report could reasonably be impaired. The result of which could be patients receiving criminal convictions for crimes that due to unsoundness of mind they may have otherwise been found not criminally responsible for.

The addition that the chief psychiatrist can direct a report be prepared if the chief psychiatrist believes that it is in the public interest does not detail how the chief psychiatrist would be informed of cases, and further it is not clear that this power also exists to safeguard the rights of the patient.

Recommendations:

It is recommended that that section 89 state that if a person is subject to a treatment authority, forensic order or treatment support order that they must be advised of their right to request a psychiatrist report within a set time-frame. If the person is unwell and unable to understand and consent to this process then the persons support person and/or other person must be advised of the patient's rights.

It is recommended that a clear policy be put in place that guides authorised services of this process to ensure patients understand their right to request a psychiatrist report and the possible implications of making this decision. This policy should direct clinicians to consider patients capacity in making these decisions. Further it should include a reporting/documentation process whereby the administrator/relevant clinician and consumer/other person as defined by the Act signs a document to attest that they have been advised of their rights.

In addition, it is recommended that a clear policy be put in place in the implementation of this legislation that ensures that the chief psychiatrist receives relevant information, so that they may, as required utilise their power to direct that a report be prepared. Further it is recommended that the statement 'public interest' take into consideration patients' rights.

Further consideration is also required as to how authorised mental health services will identify patients who have serious charges, and if remanded in custody which service is responsible for completion of the report.

Chapter 5

Part 4 Forensic orders and treatment support orders, section 135, 139, 140

The power of the Mental Health Court to impose monitoring conditions including a tracking device has significant ethical implications and is fundamentally opposed. Support is provided by the authors of this submission for a number of submissions to the Health and Community Service Parliamentary Committee which addressed the ethical implications of the introduction of electronic monitoring in the Mental Health Commission Bill, including RANZCP, AASW, Forensic Psychologists (see reference list for more details).

The use of electronic tracking devices on mental health patients contributes to the stigmatisation of mental illness. Electronic monitoring devices were only used in Queensland for the monitoring of offenders under the Dangerous Prisoner (Sex Offenders) Act 2003 (DPSOA). Those under the DPSOA legislation are considered to be dangerous sex offenders who repeatedly offend. The suggestion of a similar level of risk for those with mental illness is stigmatising and does not recognise reduction of risk with effective treatment, or the essential principles of recovery. Rather it suggests to the general public that mental illness is something to be scared of. Further being required to wear such devices

renders patients potentially identifiable as 'dangerous' by members of the public. Individuals under the DPSOA have been through a stringent assessment process to assess their risk and eligibility criteria. The proposed process for patients is not at all comparable and as such impinges on patients rights and breaches a core principle of forensic mental health care.

"*Mentally ill offenders must have the same standard of protection that the justice system offers everyone else."* NSPFMH Principle 13

In addition monitoring devices lack an evidence base. An essential aspect of Forensic Mental Health Systems is that practice within these systems is evidence based.

"*These services (FMH services) should provide evidence based, multidisciplinary, continuous care, consistent with those of general mental health services."* NSPFMH Principle 5

A previous literature review on the use of electronic monitoring devices in mental health revealed a dearth of information regarding the use of monitoring devices in mental health settings and its potential impact in mental health settings. The existing literature on monitoring devices focuses on corrections populations. Demichele, Payne and Button (2008) indicate that even within the corrections population group there is limited robust evidence on the effectiveness of the intervention. It is considered that the evidence for the use of electronic monitoring with mental health populations (both in regards to potential benefits and hazards) is lacking and as such its implementation is not evidence based as provision of mental health care, including risk management should always be.

Further from an Aboriginal and Torres Strait Islander perspective the use of electronic monitoring can compound the impact of historical paternalistic policy approaches having an ongoing impact in communities today. Further the requirement to be contactable 24 hours a day erodes the right to privacy and basic human rights of freedom of movement. There are also a number of rural and remote regions that do not have full GPS/mobile phone coverage which would mean that a number of patients including a high proportion of Aboriginal and Torres Strait Islander patients in the state may not be able to meet basic monitoring obligations which in turn may impact on the recovery process, including approval for Limited Community Treatment and discharge home.

In summary electronic monitoring of mental health patients is unnecessarily stigmatising both in terms of community perception and patient self-perception, is not supported by an evidence base, could prove detrimental to mental state, relationships and recovery opportunities, and is unlikely to be more effective in managing risk than other existing monitoring and risk management measures.

<u>Recommendations:</u>

The capacity to monitor mental health patients with electronic tracking devices be removed from legislation.

Section 136, Recommendations about intervention programs

It is noted that the Mental Health Court has the power to make recommendations about intervention programs that authorised mental health services or forensic disability service should provide. It is suggested that the expansion of the role of the Mental Health Court into treatment is not in keeping with the purpose of the Mental Health Court and as such is beyond its remit. Further this change in legislation does not take into consideration the capacity of services to meet the recommended requirements. Whilst it is acknowledged that this section refers to recommendations it is also noted that the use of fairly strong language ("should provide"). Treating teams are best

placed to assess treatment needs as these needs unfold overtime. Additionally allowing treating teams to remain responsible for identifying and implementing treatment options for patients in a less enforced manner will likely serve to enhance patient engagement and outcome.

Recommendation:

The Mental Health Court should not be able to make recommendations with regards to treatment and intervention.

Section 137, Non-revocation period

The addition of a non-revoke period for forensic orders to the legislation is in contradiction to least restrictive practice and the promotion of recovery, core objectives of the Bill. The foundation of a forensic order is that the person is not criminally responsible for an offence committed whilst unsound of mind, and that they were deprived of their capacity due to mental illness. The implementation of a non-revoke period is akin to assigning punishment for a crime that the individual was found not to be criminally responsible for, and as such, criminalises mentally ill persons. When a finite term is imposed on a person's order, that order begins to resemble punishment, because the length of the order is no longer subject to clinical criteria, but is arbitrarily determined on the basis of the person's charges.

The determination of the length of a forensic order should be based on clinically decision making with regards to treatment need and risk. Additionally given that treatment requirements and the course of an illness bear no relationship to arbitrary tariffs based on the seriousness of a crime (punishment) it is again emphasised that this addition to the legislation is not in keeping with the stated objectives of the Bill.

The implementation of tariffs (punishment) has no place in mental health legislation. The inclusion of this provision is a key example of how this Bill has moved from its core purpose (civil legislation for the assessment and treatment of the mentally ill) towards criminalisation of the mentally ill. It is suggested that such moves are more inclined to further perpetuate the stigmatisation of the mentally ill whilst having a detrimental impact on patient recovery. There are a number of alternate evidenced based and ethical strategies that can be implemented to instil community confidence in mental health systems.

Recommendation:

The removal of non-revoke periods from the legislation.

Chapter 6

Part 2 Magistrates Courts

The inclusion of new powers to the Magistrates Courts can have significant implications for patients and services. Whilst a number of benefits of this new approach are acknowledged including timely decision making with regards to unsoundness and unfitness for patients with summary offences a number of areas of concern are not sufficiently addressed by the legislation. Further the inclusion of these new powers will have a number of practical implications and without appropriate resourcing and processes could be highly detrimental to patients and significantly impact mental health and disability service provision.

With regards to gaps in the legislation it is noted that the legislation does not stipulate that Magistrates should be bound by (or even required to seek) the opinion of a mental health

professional in exercising their powers. It is in the scope of mental health practitioners to provide advice on the presence of mental illness and relevant capacities the lack of legal requirement for mental health practitioners to provide advice to inform the Magistrates decision could lead to these powers being used inappropriately.

Principle 12 of the National Statement of Principles for Forensic Mental Health (NSPFMH) proposes:

> *"Decisions to detain, release or transfer mentally ill individuals found not guilty or unfit for trial because of a mental illness or intellectual impairment should be made by courts or independent statutory bodies of competent jurisdiction, not by a political process or the Governor/Administrator in Council."*
>
> *"These decisions should only be made in accordance with the applicable legislation and legal principles, on the advice of suitably qualified mental health practitioners and in accordance with best practice principles contained in this statement".*

With regards to practical implications that must be considered if implementation of the current model was to be successful the following are highlighted:

- The provision of information to Magistrates on the issues of fitness for trial and unsoundness of mind is imperative for informed decision making. This would result in a significant expansion of the scope of the Queensland Forensic Mental Health Service Court Liaison Service. There would need to be a significant increase in staffing levels and the implementation of training, supervision and accreditation in the assessment of unsoundness and unfitness to ensure a standardised and transparent approach across the state.
- Regular training of Magistrates would be required to reduce the potential misapplication of the legislation as detailed above.
- The issue of identification of intellectually disability is a complex one and the role of disability services is not clearly articulated throughout the draft Bill. Further it is noted that there is a disparity in the disposition of mentally ill individuals and intellectually disabled individuals within the draft Bill.
- As previously stated there are significant resource issues associated with this new model, including issues with regards to equality of access for patients in remote and rural areas.
- There will be circumstances where definitive assessment may not be possible on the day (e.g., environmental and time constraints, complexity of presentation, lack of access to relevant collateral). There is a concern that in these instances vulnerable people may be remanded in custody for the purpose of mental health assessment. Further if an adjournment for assessment is to occur it is not clear who would be responsible for these assessments, particularly is the patient is to be remanded in custody. If other services are to also be responsible for conducting assessments outside the Court/watch houses then the aforementioned increase in staffing, training and accreditation would also be required for these other services e.g., Prison Mental Health Services.

<u>Recommendation:</u>
Much more extensive consideration is required with regards to the issues of implementation and capacity to implement this section of the Bill. This should include further consultation with the Queensland Forensic Mental Health Service due to the service implications. Unless implementation issues are considered and addressed prior to finalisation of this Bill it is envisaged that significant issues will arise at the time of implementation both for services and consumers.

Section 180, Admissibility of examination report

The utility and appropriateness of an old clinical report being admissible as evidence in future criminal proceedings is not clear and as such the admissibility of an examination report raises concerns. The examination report functions to determine whether a patient at one point in time to determine whether they meet the criteria for involuntary treatment and/or whether other treatment and care recommendations are appropriate. In essence the clinical information in this report would be the same as for a person not before the Court being assessed by a mental health service.

Recommendations:

Further clarification is required in this section with regards to the intent of using these reports in future proceedings.

It is suggested that the same right to confidentiality and right to information processes should exist for all person assessed by mental health clinicians and that clinical information is only admissible via consent or subpoena.

Chapter 7

Part 4 Patients subject to forensic orders

The Mental Health Bill 2015 proposes to remove the legislated 'Special Notification Forensic Patient' (SNFP) category that currently operates under the *Mental Health Act 2000*. Despite removing this category, the Bill continues to require a Chief Psychiatrist policy for patients subject to 'prescribed offences', similarly to the current requirement for SNFPs.

It is important to note that the creation of the SNFP category of forensic patients (those patients who have committed very serious offences) provides a clear legislative mechanism for this cohort to be clearly distinguished and a clear link with the policy requirements of the Chief Psychiatrist.

It should also be noted that the creation of a clearly defined and specific category of forensic patient (the SNFP category) has been recommended in two prior reviews of the *Mental Health Act 2000*. The Mullen Chettleburgh review in 2002 identified that an additional category was required "to ensure more intensive treatment and risk management processes are in place for individuals that have committed serious violent offences" (Butler Review). This category was created through an administrative process.

In 2006, the Butler review reiterated the importance of having a separate SNFP category and identified that maintaining adherence to administrative policy is difficult without legislative mandate. This is particularly relevant within the current Queensland public health system which is managed across 16 Hospital and Health Services. The Butler review specifically recommended that the administrative category equivalent to SNFP be legislated under the Mental Health Act.

It is noted that offence-type is a crude mechanism for identifying risks, however providing a clear legislative basis for this cohort of patients allows for targeted management of forensic patients within limited resources as well as providing transparency for the community, consumers and patients by clearly, and legislatively, identifying this cohort.

The Butler review identified that a "statutory classification should give the public and victims greater confidence that community safety considerations will be given proper weight in decisions about matters such as LCT" (Butler Review). Continuing the requirement for a specific policy for

patients who have allegedly committed a prescribed offence, without continuing the specific legislative category erodes the transparency that currently exists.

Recommendation:

The SNFP category is retained.

Chapter 9

Part 5 Independent patient rights advisors

The Bill stipulates that patient rights advisors are to be independent. It is however questioned how truly independent the position can be. It is also noted that a number of functions of this position should be conducted by the treating team as part of sound clinical and ethical practice.

It is acknowledged that patient rights advisors will hold an important role and that all involuntary patients should have access to these positions. However the role for patient rights advisors for patients under the mental health act in custody has not been made clear within the legislation. It is argued that patients in custody under treatment authorities and forensic orders (whilst not able to enforced in the custodial environment) should have access to patient rights advisors, particularly with regards to tribunal hearings.

Recommendations:

Consideration to be given to the reporting structure for patient rights advisors and whether central oversight via the office of the Chief Psychiatrist is appropriate.

Patients in custody under the mental health act right of access to patient rights advisors should be clearly articulated within the legislation and policy developed during implementation that identifies the service responsible for meeting this need, being mindful that patients can be placed in correctional settings outside the geographical region covered by the authorised mental health service that holds the order.

Chapter 10

Part 5 Serious risks to persons or public safety, section 311, Action chief psychiatrist may take

The actions that the chief psychiatrist has been empowered to take under this section of the draft Bill raises significant concerns when imposed on a 'class' of forensic patients due to the failure to recognise individual rights and individual treatment needs and the potential breach of the principle of least restrictive environment.

The proposed powers for review and suspension when applied to a class of patients (312(2)b) is of concern as it implies that individuals, with individual treatment needs, individual risk considerations, and individual rights can be responded to as a collective, homogeneous group. It is considered that this legislative change fails to recognise a core principle of sound mental health treatment: namely that it is individualised and responsive to needs. Further it potentially violates a number of principles pertinent to the rights of the individual. For example:

> *"Forensic mental health services should meet the changing needs of an individual, taking into account the entirety of their biological, psychological, social, cultural and spiritual context."*
>
> *"Individualised care implies facilitated access, comprehensive assessment, unimpeded treatment, regular review and recognition of the humanity of the person…."*

NSPFMH Principle 9

"The right of all clients to respect for individual human worth, dignity and privacy is not waived by any circumstance, regardless of an individual's history of offending or their status as a forensic mental health client or a prisoner/young offender."

"All persons accessing mental health services…. Are entitled to the protection of their civil and human rights and freedom from abuse consistent with the United Nations Principles on the Protection of People with a Mental Illness…."

NSPFMH Principle 7

"The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff."

Principle 9 (2) UNPPMI

"The treatment of every patient shall be directed towards preserving and enhancing personal autonomy."

Principle 9 (4) UNPPMI

"Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:

(a) Recognition everywhere as a person before the law;…"
(b) Principle 13 (1) UNPPMI

Further there is a risk of the potential breach of the principle of least restrictive environment via the implementation of group-based decision making which does not consider individual needs and risks.

"Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others." Principle 9 (1) UNPPMI

It is acknowledged that the draft Bill provides for a patient to appeal the decision to the Mental Health Review Tribunal, however, given the current frequency of MHRT hearings and the number of referrals, it is likely that even if a patient were to request an early hearing they would be waiting at least a month for this to occur (potentially longer if a large 'class' of patients have been impacted by a decision). This relatively long waiting period is more than enough for patients who may have been doing very well, have been compliant with treatment, and living as functional members of the community to lose jobs, lose housing, and more importantly lose their sense of progress, hope and self esteem. Such discouraging outcomes for patients may in the longer term serve to increase risk due to decreased trust in the mental health system that is meant to support them.

Recommendation:

The powers to impose restrictions on a class of patients be removed from the legislation.

Chapter 11

Part 2 Establishment of authorised mental health services

As articulated previously in this submission the authors are fundamentally opposed to the involuntary assessment and treatment of patients in custodial settings.

Recommendations:

It is emphatically recommended that the Act explicitly states that health centres in custodial settings **cannot** be declared an authorised mental health service.

Chapter 12

Section 411, When reviews are conducted

The proposed timeframe of 12 months for patient's on a treatment authority is of concern when considering the realities of the progression of mental health recovery. It is suggested that an individuals clinical picture and risk profile can significantly change in this time-frame. The provision for the request of an earlier review whilst important places an unfair burden on patients and is likely unrealistic based on current timeframes for review.

Recommendation:

It is recommended that the timeframe for review be decreased.

Part 8 Applications for examination authorities, section 500

Support is provided for the continued inclusion of a process that mirrors the Justice Examination Orders under the *Mental Health Act 2000*. Such a process is recognised as imperative to ensure some individuals who require assessment and/or treatment for mental illness are able to be assessed. Further support is provided for the requirement for feedback from a mental health professional which will hopefully minimise the use of such orders for vexation purposes. However the Bill is not clear what form this feedback is to be provided in e.g., completion of a section of the authorised paperwork or verbal feedback to the applicant that is documented by the applicant. It would be essential that any process implemented is both not complicated nor could result in a delay in having a person assessed.

With regards to the risk of delays it is noted that upon receipt of an application for an examination authority the Mental Health Review Tribunal must provide written notice to the applicant at least three days prior to the hearing. It is suggested that this delay in acting on the application is inconsistent with the criteria that must be met in order for an examination authority to be issued e.g., "there is, or may be, an imminent risk, because of the person's mental illness, of (i) serious harm to the person or someone else; or (ii) the person suffering serious mental or physical deterioration."

When considering policies for the implementation of examination orders it is recommended that consideration be given to recommendations from prior coronial inquests including the inquest into the death of Mr Gear in 2008. The inquest addressed the failing of the Justices Examination Order process under the *Mental Health Act 2000*, whilst also highlighting the importance of the community having access to such orders. Recommendations from the inquest included that assessment decisions under the Act "*include mechanisms for supervision or overview so that whenever someone other than a psychiatrist decides:-*

- *not to order a psychiatric assessment following an examination pursuant to a Justices Examination Order; or*

- *not to admit as an inpatient following an examination pursuant to an Emergency Assessment Order; or*
- *to discharge a patient previously assessed as suffering from mental illness warranting involuntary treatment;*

that decision be reviewed by a psychiatrist as soon as possible."

Whilst a concern exists in the timeliness of the process to obtain an Examination Authority there is an additional concern with regards to the criteria. In order for the Mental Health Review Tribunal to grant an Examination Authority, the MHRT needs to be satisfied that the person has, or may have, a mental illness and there is imminent risk because of the person's mental illness (s471). It is suggested that if someone met this criteria a more immediate action would need to be taken and that clinicians providing advice to applicants (as per the recommended process) would feel a duty of care to notify police and/or ambulance so that an emergency examination authority, under the Public Health Act could be actioned. With the removal of the assessment criteria from the Mental Health Bill and the reliance on the use of the treatment criteria in decision making with regards to the need for assessment, unwell people will likely be excluded from assessment, treatment and care and a further burden may be placed on emergency services at the point of crisis as opposed to appropriate early intervention by mental health services.

Recommendations:

As it is only 1 member who is a lawyer who is required for a hearing on an application for an examination authority it is recommended that there is a mechanism for review if an order is not granted.

It is further recommended that the MHRT is sufficiently resourced to provide a timely response to applications.

Further it is recommended that policy include the requirement that community mental health services actively engage people in mental health services for assessment under a preventative care paradigm to ensure mental health needs are addressed in a timely manner.

As previously recommended the assessment criteria should be retained. If this does not occur further consideration with regards to the use of the treatment criteria as the level for decision making with regards to assessment orders needs to occur.

Chapter 16, Part 1 Mental Health Court, Division 5 Assisting clinicians, section 650 Appointment

The College welcomes the recommendation under s650 of the Bill that the Governor in Council may appoint, *"a person with expertise in the care of persons who have an intellectual disability"*, to assist the Mental Health Court.

However, it is respectfully submitted that forensic psychologists be appointed across all functions of the Assisting Clinician role in the Queensland Mental Health Court, rather than just matters where intellectual disability is at issue. Psychologists with forensic training and expertise have been active in the deliberations of forensic mental health matters across both national and international jurisdictions, and there has been increasing opportunity and demand for forensic trained psychologists to assist the Mental Health Court in Queensland. The introduction of Forensic Disability Services (and associated legislation) has been prominent in the increased use of psychologists' expert testimony. However contributions are made in other areas; for example, psychologists may undertake expert reports for voluntary referrals to the Mental Health Court and conduct specific psychological assessment (e.g. regarding fitness for trial) to assist the court in its

determination. Forensic Psychologists have the appropriate level of training and expertise with which to assist the Mental Health Court in deliberations regarding soundness of mind and fitness for trial across both mental health and disability sectors.

To clarify, Forensic Psychologists practice psychology at the interface of the legal and justice systems. Endorsement as a Forensic Psychologist with the Psychology Board of Australia requires eight years of academic training, supervised practice and continued professional development. The period of supervised practice in forensic psychology requires psychologists to demonstrate competency in the provision of expert psychological evidence (e.g. written reports and/or oral evidence) in courts (e.g. civil, criminal, family, coroner and others) and other tribunals (e.g. guardianship boards, parole boards, administrative appeals tribunals). Specifically, forensic psychologists who practice in the forensic mental health field can be expected to have expertise in areas of mental illness, intellectual impairment and offending behaviour with skills in a range of psychological assessment tools developed for the forensic context.

In addition to the broad acceptance of forensic trained psychologists in other jurisdictions (e.g. Victoria, U.S.A, Hawaii), evidence for the positive contribution that Forensic Psychologists can make to the Mental Health Court, exists in the research literature. For example, when members of judiciary were asked to rate the content of expert reports, while blind to the discipline of the evaluator, expert forensic reports by psychologists with forensic training were considered to be similar or higher quality (i.e. considered thorough and legally relevant) to that of their psychiatry trained peers (Petrella & Poythress, 1983). Similarly reviews of several thousand forensic evaluations in the U.S.A. revealed that, when conducting assessments of soundness of mind, psychologist reports were comparable to psychiatrist reports and, on the assessment of trial competence, psychologists were considered to provide robust opinions, with the inclusion of psychological assessment considered helpful to the Court (Warren et al 2006a; 2006b). Further, forensic trained psychologists and psychiatrists tend to be consistent in opinion when the content of expert reports are compared (Robinson and Acklin, 2010). Finally, in a study that compared the quality of risk evaluations by psychologists with and without forensic training, it was found that reports by forensic psychologist were particularly helpful (Tolman & Mullendore, 2003). Specifically, their forensic training (e.g., regarding rules of evidence) meant they were more likely to provide relevant information and target their assessment to the legal issues in order to assist triers of fact in making important decisions. Overall, it is considered that forensic psychologists who practice in the forensic mental health field have the necessary expertise, based on training and experience, to make a positive contribution to the Court, and it is therefore, submitted that the role of assisting clinician is expanded accordingly to include Forensic Psychologists across all functions of the Mental Health Court and their involvement as expert witnesses be recognised within the Bill.

<u>Recommendation:</u>

Forensic psychologists are appointed to the role of *assisting clinician* across all functions of the Mental Health Court.

Forensic psychologists be recognised as expert witnesses under the Bill.

Chapter 17

Part 3 Permitted use and disclosure, section 781

The provision under section 781 for the disclosure of information relating to classified patients is a direct contravention of the principle of equivalence to care, whereby classified patients have

different protections with regards to confidentiality than other patients, including other forensic patients.

> *"The right of confidentiality of information concerning all persons to whom the present Principles apply shall be respected."*
>
> Principle 6 UNPPMI
>
> *"Every patient in a mental health facility shall, in particular, have the right to full respect for his or her:*
>
> *(c) Privacy… etc"*
>
> Principle 13 (1) UNPPMI

It is understood that the Bill provides for the disclosure of information to victims of crime via an information notice for patients under a forensic order or treatment support order. In order to receive a notice a victim of a crime or interested person must make an application to the chief psychiatrist. The Bill provides for a number of safeguards and provisions for the sharing of information, including in deciding whether a person has a sufficient personal interest in receiving information under the notice (s317(3)), *"the chief psychiatrist must have regard to the following matters*

a) *whether the relevant patient is a risk to the safety and welfare of the person;*
b) *whether it is likely the relevant patient will come into contact with the person;*
c) *the nature of the relevant unlawful act in relation to the relevant patient's forensic order or treatment support order."*

This process is not included for the disclosure of information about classified patients. It is important to note that patients under a forensic order have committed a crime for which they have been found of unsound mind and/unfit for trial and have also been assessed as requiring a forensic order due to the assessed risk the person is to themselves and/or others. Further this determination has been made after a court process.

Conversely classified patients can include patients that have been remanded in custody who have not progressed through the justice system to the extent that they have been found responsible for committing a crime. Further there has not been a Court process that has examined and assessed their level of risk in order to make an order under the Mental Health Act.

Under the new provisions of the Mental Health Bill patients in custody are not being afforded the same rights and protections as other patients. It is possible that under these provisions that information could be shared about an individual who later is found not responsible for the crime with which they are charged. Further the majority of patients who are transferred to hospital under the classified provisions do not end up before the Mental Health Court or under a forensic order.

It is recognised that the *Mental Health Act 2000* provides for the disclosure of information about classified patients under a classified patient information order. These orders were reflective of the forensic and treatment support order information notices and provided the required processes to safeguard this decision making.

<u>Recommendation:</u>

It is recommended that further consideration be given to this section of the Bill, to ensure that all patients are afforded the same protections.

References

Australian Association of Social Workers, Qld Branch: http://www.parliament.qld.gov.au/documents/committees/HCSC/2012/QldMtlHlthComBil2012/submissions/012.pdf

Butler Review https://www.health.qld.gov.au/mentalhealth/docs/Promoting_balance.pdf

Demichele, Matthew, Payne, Brian K & Button, Deeanna M. (2008). Electronic Monitoring of Sex Offenders: Identifying Unanticipated Consequences and Implications. *Probation and Parole: Curre nt Issues, pp. 119-135*

Dr R Doley and Associates (Forensic Psychologists): http://www.parliament.qld.gov.au/documents/committees/HCSC/2012/QldMtlHlthComBil2012/submissions/016.pdf

National Statement of Principles for Forensic Mental Health

Petrella, R.C. & Poythress, N.G. (1983). The quality of forensic evaluations: An interdisciplinary study. *Journal of Consulting and Clinical Psychology*, Vol 51(1), 76-85. http://dx.doi.org/10.1037/0022-006X.51.1.76

Robinson, R. & Acklin, M.W. (2010). Fitness in paradise: Quality of forensic reports submitted to the Hawaii judiciary. *International Journal of Law and Psychiatry* 33(3): 131-136.

The Royal Australian and New Zealand College of Psychiatrists, Qld Branch (Forensic Faculty): http://www.parliament.qld.gov.au/documents/committees/HCSC/2012/QldMtlHlthComBil2012/submissions/025.pdf

Tolman, A.O. & Mullendore, K.B. (2003). Risk evaluations for the courts: Is service quality a function of specialization? *Professional Psychology: Research and Practice*, 34(3), 225-232. http://dx.doi.org/10.1037/0735-7028.34.3.225

UNITED NATIONS (1992) United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI principles). NewYork: UN General Assembly Resolution 46/119.

Warren, J. I., Murrie, D. C., Stejskal, W., Colwell, L. H., Morris, J., Chauhan, P. and Dietz, P. (2006a), Opinion formation in evaluating the adjudicative competence and restorability of criminal defendants: a review of 8,000 evaluations. *Behaviour, Science & Law,* 24: 113–132. doi: 10.1002/bsl.699

Warren, J. I., Murrie, D. C., Chauhan, P., Dietz, P. and Morris, J. (2006b), Opinion formation in evaluating sanity at the time of the offense: an examination of 5175 pre-trial evaluations. *Behaviour, Science & Law*, 24: 113–132. doi: 10.1002/bsl.559