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**HEALTH AND COMMUNITY
SERVICES COMMITTEE**

Office of the Public Advocate Systems Advocacy

Submission to the Health and Community Services Committee

*For the Queensland Mental Health
Commission Bill 2012*

February 2013

Background to the submission

In November 2012, the *Queensland Mental Health Commission Bill 2012* (the Bill) was introduced to the Queensland Legislative Assembly. The draft legislation aims to facilitate whole-of-government reform towards a 'more integrated, evidence-based, recovery-oriented mental health and substance misuse system'¹ through the establishment of the Queensland Mental Health Commission (the Commission).

The Bill was referred to the Health and Community Services Committee who will deliver their report to the Queensland Parliament in March 2013. The Committee has invited submissions from individuals and organisations to inform their findings.

Interest of the Public Advocate

The Public Advocate was established by the *Guardianship and Administration Act 2000* to undertake systems advocacy on behalf of adults with impaired decision-making capacity in Queensland. The primary role of the Public Advocate is to promote and protect the rights, autonomy and participation of Queensland adults with impaired decision-making capacity (the adults) in all aspects of community life.

More specifically, the functions of the Public Advocate are:

- Promoting and protecting the rights of the adults with impaired capacity;
- Promoting the protection of the adults from neglect, exploitation or abuse;
- Encouraging the development of programs to help the adults reach their greatest practicable degree of autonomy;
- Promoting the provision of services and facilities for the adults; and
- Monitoring and reviewing the delivery of services and facilities to the adults.²

In 2010, there were approximately 110,000 Queensland adults with impaired decision-making capacity.^{3 4} This vulnerable cohort includes adults living with mental illness and adults who engage in substance misuse.

Queensland adults with impaired decision-making capacity are among the most disadvantaged people in the community. An unacceptably high level of disadvantage is experienced across a range of social and economic indicators. This disadvantage significantly reduces quality of life and increases the risk of abuse, neglect and exploitation.

Despite accessing multiple service systems, across multiple sectors (government, non-government and private organisations), people with impaired decision-making capacity have a high level of unmet need. The current combination of specialist interventions and mainstream services is failing to meet the support needs of people with impaired decision-making capacity.

As a result, there is a critical and immediate need for all levels of government, across all sectors, to invest in a sustainable social system that ensures access to social, economic, civic and specialist resources for people with impaired decision-making capacity, their families and support networks. This is a primary way to promote inclusion, protect rights and interests, and reduce risks of abuse, neglect and exploitation.

Position of the Public Advocate

While I support the intention of the *Queensland Mental Health Commission Bill 2012*, this submission offers some matters for consideration in finalising the details contained within the Bill. My submission also notes my concerns in relation to some of the proposed amendments to the *Mental Health Act 2000*.

The whole-of-government approach of the Bill is a positive step towards addressing some of the deficiencies of the Queensland system and advancing the recovery and social inclusion of people living with mental illness or who misuse substances. There are, however, broader system deficiencies that the Bill does not address.

¹ *Queensland Mental Health Commission Bill 2012*, Section 4.

² *Guardianship and Administration Act 2000*, Section 209.

³ Australian Bureau of Statistics 2012, *Microdata: Disability, Ageing and Carers, Australia 2009*, Cat No. 4430.0.30.002, Australian Bureau of Statistics, Canberra.

⁴ Australian Bureau of Statistics 2008, *Population Projections, Australia, 2006 to 2101*, cat no. 3222.0, Australian Bureau of Statistics, Canberra.

A more inclusive and outcomes-focussed approach to the delivery of human services would generate increased opportunities for improvement and integration within and across systems, thus enabling more appropriate support to be provided to vulnerable Queenslanders.

The current human services system in Queensland is fragmented and inequitable. People are channelled into different service systems primarily on the basis of their diagnosis, with many of these systems lacking the sophistication to determine and provide an appropriate mix of services to adequately respond to the needs of the person. The services that are available differ from system to system and are often premised on historical service types that do not map to contemporary understandings. In many cases, they are also provided according to rigid models of service delivery that do not give sufficient consideration for the outcomes being sought by the person nor how to create an effective network of support and services to assist the person to achieve their goals.

The shortfalls of these systems often lead to services being provided in an *ad hoc* manner that does not address the causal factors underpinning the person's circumstances. Instead the current approach centres more on the 'type' of impairment experienced by the person than the 'nature' of their impairment.

For example, people living with a mental health or substance abuse issue are directed into the mental health and substance abuse system, while people with intellectual or psychiatric disability are steered into the disability service system. This approach will continue to exacerbate the exclusion and disadvantage experienced by vulnerable Queenslanders.

In support of the need to address the shortfalls of the current system, I commend the Bill for its focus on developing an evidence base that may assist in promoting and facilitating systems change.

Guiding principles and functions of the Commission

I am firmly committed to ensuring that Australia's responsibility under the United Nations Convention on the Rights of Persons with Disabilities is upheld. In accordance with this, I support the Guiding Principles of the Bill [Part 1, Division 2, Section 5].

I also support the stated objective of the Bill, which speaks to the promotion of the best interests of people with mental health or substance abuse issues, their families, carers and support network; the pursuit of innovation and best practice through knowledge sharing and a robust evidence base; and the focus on prevention and early intervention strategies [Part 1, Division 2, Section 4].

A robust evidence-base should form the cornerstone of the Commission's decision-making and be used to advance best practice service delivery and positive, meaningful outcomes for people living with mental health and/or substance abuse issues. The Commission's research agenda should complement (and not duplicate) existing research projects as well as pursuing new research. I encourage the Commission to consider research partnership opportunities and to be transparent with respect to its research agenda and research findings. Furthermore, I encourage the Commission to take a strategic approach to the application of research findings and identify ways in which the findings may be used to benefit other cohorts who experience similar disadvantage.

The Strategic Plan should be developed in such a way that it ensures an increasing focus on research into contemporary approaches to prevention and early intervention. This research will develop an evidence base with which to facilitate practice change and pursue improved outcomes. These outcomes may include enhanced behavioural and mental health outcomes; reductions in the incidence of offending behaviours; reduced recidivism; reduced time that individuals are subject to an Involuntary Treatment Order and/or detained in an authorised mental health facility; and increased likelihood of remaining well supported by, and/or successfully transitioning back into, the community.

I strongly agree with the Guiding Principle which acknowledges that an effective mental health and substance misuse system is the shared responsibility of the government and non-government sectors and that it requires a coordinated and integrated approach. Notwithstanding this, a major weakness of the Bill is its narrow focus. As mentioned previously, a more inclusive and outcomes-focussed approach to the delivery of human services is needed to ensure the efficient and effective provision of appropriate support.

I commend the acknowledgement of Aboriginal and Torres Strait Islander people in the Guiding Principles. The treatment and support provided to a person with an Indigenous or other cultural background must be adequate and culturally appropriate. Mental illness, substance and alcohol abuse and acquired brain injury are likely contributors to increased risk of impaired decision-making among Indigenous Queenslanders.⁵

Furthermore, the Commission's functions and activities should not only take into account the views and needs of Aboriginal and Torres Strait Islander people, but also those of culturally and linguistically diverse communities and other vulnerable groups at risk of marginalisation, including people with impaired decision-making capacity.

I note that a review of the Commission and Act is scheduled for three years after its commencement, however neither the conduct nor outcomes of these reviews are identified as potential triggers for a review of the Whole-of-Government Strategic Plan. It is reasonable to expect that a review of the Whole-of-Government Strategic Plan be conducted immediately following the completion of the review of the Commission and the Act to ensure the ongoing currency and applicability of the Strategic Plan.

Engagement of the mental health sector

The Bill provides a legal foundation for the cooperation of government and human service agencies [Part 4, Section 34]. Of equal importance is the acquisition of commitment and practical cooperation from human service agencies. The achievement of real results through the Whole-of-Government Strategic Plan will rely on the engagement and support of the mental health sector.

I note that while the Commission can make recommendations to agencies, it has no authority to require action. This may hinder the achievement of real change in circumstances where the Commission identifies a significant risk or issue. In addition, the Bill does not outline the grounds on which a refusal to take action would be considered reasonable. Consideration should be given to using Service Level Agreements to direct or initiate action in response to identified issues, particularly where these highlight a situation of significant risk.

Special and ordinary reports

The Bill enables the Commission to prepare and present special and ordinary reports, including reports relating to people living with mental health or substance abuse issues and any systemic issues affecting them. I support this activity.

The Bill currently includes a provision that requires the Commission to provide a copy of an ordinary report to any agencies to which it relates [Part 3, Section 31]. I propose that the legislation be expanded and clearly mandate that any report relating to the cohort of a particular agency, not just a report relating to the agency itself, be provided to that agency. As Public Advocate, I would expect to receive a copy of any ordinary reports relating to people with impaired-decision making capacity, as well as reports relating to the systemic issues impacting them.

The Bill proposes that the Commission must notify the Minister in writing prior to preparing an ordinary report. The current wording of the Bill allows for the perception that the Minister may have the authority to influence or endorse the decision to prepare an ordinary report. Such political influence, or the perception of same, would damage the credibility of the Commission. The Commission must be able to independently report on issues. I recommend consideration be given to changing the wording in Part 3, Section 29 (2) in light of this.

I am similarly concerned that allowing the Minister to table an ordinary report in the Legislative Assembly 'as soon as practicable' after receiving it [Part 3, Section 30 (2)], also provides scope for political influence, or again, the perception of same. I propose a time period be applied to the tabling of an ordinary report, similar to the one applied to reports prepared by the Public Advocate, which is 5 sitting days after the Minister receives a report. Refer to the *Guardianship and Administration Act 2000* [Chapter 9, Part 1, Section 209A (4)].

⁵ Australian Institute of Health and Welfare 2011, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander People: An Overview 2011*, Cat No. AIHW 42, Australian Institute of Health and Welfare, Canberra.

Queensland Mental Health and Drug Advisory Council

The establishment of the Queensland Mental Health and Drug Advisory Council (the Council) is an important inclusion in the Bill. I support the Council's ability to provide advice to the Commission on its own initiative so that it is not restricted to only acting in response to the Commission. The legislated requirement that the Commission must respond to recommendations of the Council will help ensure the Commission is fulfilling its functions, adhering to the Guiding Principles in the Bill, is accountable and remains in touch with people living with mental health or substance abuse issues.

It is important that the membership of the Council reflects the Queensland community and that the Council members have appropriate skills, knowledge and experience in relation to mental health and substance abuse issues. I support the inclusion of regional and remote members, those from Indigenous and culturally diverse backgrounds and representation from service providers, service users, their families and carers.

It is, however, disappointing that the scope of the Council is limited to mental health and substance abuse issues. Similarly to the scope of the entire Bill, greater advancements could be made if the focus was broadened to an inclusive and outcomes-focussed approach to the delivery of human services.

Linkage to the Mental Health Statement of Rights and Responsibilities

It is expected that the Mental Health Statement of Rights and Responsibilities also underpins the functions of the Commission and Council. I would like to see practical initiatives to improve the interaction between service users and service providers regarding the delivery of support services, particularly as this relates to decision-making for treatment, care and rehabilitation.

The right to interact with service providers is a fundamental consumer right under the Mental Health Statement of Rights and Responsibilities. However, interactions with service providers in relation to decision-making are challenging for those who do not have capacity to make decisions.

In accordance with this, provisions must be made to ensure that appropriate decision-making support is provided to service users and their families/carers, when required. This is particularly relevant given that service providers are not able to act as decision-makers for service users and, in many cases, the quality and/or timeliness of their service responses may be compromised if decision-making support is not available to the person.

Amendments to the *Mental Health Act 2000*

The Bill includes a number of proposed amendments to the *Mental Health Act 2000*, including a new provision whereby the Minister may command the Director, Mental Health to investigate a matter and consider taking appropriate action [Part 9, Section 73]. As this only applies to situations where there is serious risk to a person or public safety, it is reasonable to assume that such action will only be required periodically. Consideration should be given to the resourcing issues associated with such investigations if it is anticipated that they may occur on a more frequent basis.

I propose an additional amendment to Section 493AC of the *Mental Health Act 2000* [Part 9, Section 73], requiring the Director, Mental Health to provide a written copy of the findings relating to any systemic issue involving people with impaired decision-making capacity to the Public Advocate (after the Director has reported back to the Minister).

The Bill proposes an amendment to the *Mental Health Act 2000* regarding the monitoring of limited community treatment (LCT) patients [Part 9, Section 62]. I am not aware of the current use of tracking devices used for LCT patients in Australia and am concerned about their introduction in Queensland.

To my knowledge, tracking devices are only used to monitor high-risk prisoners with repeat sexual offences (under the *Dangerous Prisoner (Sexual Offender) Act 2003*). As a result, members of the community recognise and associate tracking devices with high risk criminals who have committed multiple sexual offences.

There is a high likelihood that community members will mistakenly identify a LCT patient wearing a tracking device as being a high-risk criminal. This stigma may hinder the LCT program, which is designed to facilitate a gradual reintegration into the community. Successful reintegration is contingent not only on the activities of the person themselves but also on society's acceptance of the person. The use of tracking devices may limit the effectiveness of the outcome it is purporting to support.

I also have ethical concerns regarding the use of tracking devices. The use of tracking devices may be contrary to a number of conventions and national standards including the United Nations Principles for the Protection of People with Mental Illness; the United Nations Convention on the Rights of Persons with Disabilities; the National Standards for Mental Health Services 2010; the National Statement of Principle for Forensic Mental Health Services; and the Mental Health Statement of Rights and Responsibilities.

I acknowledge that there may be situations where there is a need to monitor a person while participating in LCT. The method in which the person is monitored must always be the least intrusive option, supportive of (and not harmful to) their recovery, and appropriate to the circumstances of the individual. The use of an unethical tracking method that is lacking in clinical efficacy, such as a tracking device, does not appear to be warranted considering the extremely low incident rate of LCT patients being absent without permission.

I also have significant concerns around the proposed ability of the Director, Mental Health to order the suspension of LCT for a 'class of relevant patient' [Part 9, Section 73]. Decisions around the planning, implementation or restriction of a treatment plan should always be based on the assessed needs, risks and individual circumstances of a person. Decisions, including those to suspend LCT, should never be made for a group, or 'class', of patients.

I do not support the proposed suspension of LCT to a 'class of relevant patient' without the conduct of individual risk assessments as a minimum determination of appropriateness. An across-the-board decision to suspend LCT for a 'class of relevant patient' is discriminatory and likely to result in increased risks for some people while hindering the recovery of others.

An individual assessment of a person must be undertaken before altering or suspending any aspect of their treatment in order to determine if the alteration or suspension is appropriate. This is also a necessary action in upholding the rights of the person.

The proposed ability to suspend LCT treatment for a 'class of relevant patient' is in conflict with several aspects of the Mental Health Statement of Rights and Responsibilities; the National Standards for Mental Health Services 2010; the United Nations Principles for the Protection of People with Mental Illness; and the United Nations Convention on the Rights of Persons with Disabilities.

Regardless of whether the decision to suspend LCT is made at an individual or 'class' level, there is a need for clear indicators and criteria for the removal of a suspension and subsequent recommencement of LCT. These indicators should take into account the person's individual needs, risks and circumstances. It is acknowledged that there may be a need to monitor the person during their first LCT following a suspension.

In support of my comments in regarding the proposed use of tracking devices and the proposed ability to enact a suspension of LCT for a 'class of relevant patient', I refer the Committee to the following standards and conventions for further information in relation to why these proposed activities should not be legislated:

1. Australian Government 2010, *National Standards for Mental Health Services 2010*, Commonwealth of Australia, Canberra.
2. Australian Health Ministers' Advisory Council 2006, *National Statement of Principle for Forensic Mental Health Services*, Australian Health Ministers' Advisory Council, Canberra.
3. Mental Health Consumer Outcomes Task Force 2000, *Mental Health Statement of Rights and Responsibilities*, Australian Government, Canberra.
4. United Nations 2006, *United Nations Convention on the Rights of Persons with Disabilities*, United Nations, viewed 31 January 2013, <http://www.un.org/disabilities/convention/conventionfull.shtml>.
5. United Nations General Assembly 1992, *Resolution on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, United Nations, Geneva.

General support for the Bill

It is the submission of the Public Advocate that the *Queensland Mental Health Commission Bill 2012* will advance the social inclusion of people living with mental health and substance abuse issues in Queensland. The whole-of-government approach will lead to an improved understanding of this cohort across government and improved recognition of mental health and substance abuse in policies and programs.

People living with mental health and substance abuse issues have the right to access appropriate services and support. I support enhancements to the current system that afford people living with mental health and substance abuse issues improved access to appropriate services and support, greater social inclusion and the ability to live independently and meaningfully in their community.

However I do not support the introduction of the proposed amendments to the *Mental Health Act 2000* relating to the use of tracking devices and the suspension of limited community treatment for a 'class of relevant patient'. These proposed amendments contravene numerous conventions and standards, infringe upon the rights of the people to whom they will be applied and are counterintuitive to achieving the outcomes that they purport to support.

Notwithstanding the intention of the Bill, the delivery of human services to vulnerable Queenslanders remains fragmented and inequitable and I do not believe the Bill will necessarily change this. Significant change will only occur when the approach and delivery of human services takes an outcomes-focussed approach that considers the causal factors underpinning individual circumstances, rather than designing systems and responses around narrowly defined cohorts.

Once established, I look forward to developing a close relationship with the Commission in light of our common focus on systemic issues and promoting enhanced outcomes for this vulnerable and marginalised cohort, particularly those within the cohort who have impaired decision-making capacity.



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