11.1.11

Sub#12

Submission by

The Australian Association of Social Workers

Queensland Branch

Proposed amendments to the Queensland Mental Health Act 2000

AASW CONTACTS:

Dr Fotina Hardy, AASW Qld Branch Vice President

Email: fotina.hardy@qut.edu.au

Ms Mere Vitale, Queensland Branch Manager

Australian Association of Social Workers

(07) 3369 9818

aaswqld@aasw.asn.au

February 2013

Background to the AASW

The AASW is the key professional body representing social workers in Australia, with a membership of more than 7,000, which is about half the social work workforce. The AASW is a foundation member of Allied Health Professions Australia (AHPA), a member of the National Primary Health Care Partnership (NPHCP) and a member of the Mental Health Council of Australia and a member of the Consumers Health Forum of Australia.

Social workers and mental health

Social workers in all fields of practice work with at least some clients who experience mental health problems, often in combination with other difficulties. Social workers work with clients across all ages, and depending on the service setting, their clients may be children, adolescents, adults or older people.

Social workers are also employed in specialist mental health services, and by 2004-05, made up a third of the allied health workforce for public mental health services (Dept of Health & Ageing, 2007, p. 46). In that year, social workers comprised the fourth largest professional group in the public mental health workforce after mental health nurses, medical staff and psychologists.

In addition, around 1300 social workers are based in private practice and provide a wide range of services for individuals and non Government organisations, utilising evidence based practice.

Response to the Draft Amendments

The Social Work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. This involves subscribing to the United Nations Universal Declaration of Human and other international covenants (AASW Code of Ethics 2010: 7). *The Principles for the protection of persons with a mental illness and the improvement of mental health care* crucially affirms that people who live with a mental health illness have the same rights as other citizens. For example, Principle 20 affirms that criminal offenders with a mental illness have the same rights as other persons to the best available mental health care, they will be treated with respect and inherent dignity of the human person and there shall be no discrimination on the grounds of mental illness.

Social Work has long been involved in providing services and advocacy for people who live with a mental health illness, as well as contributing to the evidence base through research. Social Workers are employed across Queensland Hospital and Health Services (HHS), along with community based services, and have roles within in-patient, community, rehabilitation and consultation/liaison mental health teams. Social Workers have long been at the forefront in assisting clients with their recovery from mental illness. Social work has embraced reintegration and promoted social

inclusion. These values are encompassed within many of the Australian Association of Social Workers (AASW) ethical responsibilities such as respect for human dignity and worth, commitment to social justice and human rights and client self-determination.

Within mental health services, Social Workers have managed Forensic patients whilst maintaining their own ethical principles. We have also supported the commitment within Queensland mental health services to strike the right balance between the rights of the individual with some of the concerns outlined in the Butler Inquiry about public safety and victim issues. Social workers have observed the benefits for all from the subsequent amendments to the Queensland Mental Health Act (2000) and the development of the Forensic Patient Management Policy 2006.

Policy objectives and the reasons for them

From reviewing the *Explanatory notes* there were issues raised for our members about the care of mentally ill persons. These issues include mentally ill persons and their families being subject to discrimination and stigma which has "far-reaching" negative effects; social-exclusion and the significance of factors that interrupt as well as promote recovery. These issues are particularly relevant to persons who become involved in the criminal justice system.

It is considered that reducing discrimination and stigma, reducing social exclusion and promoting recovery are central to the care and treatment of mentally ill persons and also in reducing their risk to others. These priorities and directions are reflected in the *Queensland Plan for* M*ental Health 2007-2017.* In contrast, aspects of the proposed amendments to the *Mental Health Act 2000* erode the rights of persons with a mental illness, specifically, by applying restrictions to a class of patients, irrespective of individual compliance or circumstances. Such an approach is discriminatory and stigmatising, impedes recovery and thus may result in outcomes contrary to the stated aims.

Achievement of policy objectives

The proposed amendments are reported to be required to "enhance those measures under the Act that are designed to protect the community". This is to be achieved through two means:
1) increasing the power of the Director of Mental Health in relation to limited community treatment (LCT), treatment plans and review of procedures and protocols related to LCT, and
2) allowing for additional monitoring conditions of patients on LCT.

Discussion below will focus on how these proposed measures as amendments to the *Mental Health Act 2000* (e.g s131A or 493AC-AJ) are unlikely to lead either to improved care or greater public protection.

Alternative ways of achieving policy objectives

As will be discussed below, our view is that some of the policy objectives could be attained without recourse to the proposed amendments. Giving the Director of Mental Health more power over treatment decisions would require legislative amendment, however, this is not considered to be necessarily indicated. Whether these changes are desirable or could be addressed in other ways has been considered at only a superficial level in the *Explanatory Notes*.

Estimated cost for government implementation

Our members were concerned that costs attributed to the amendments are described as "minimal" and to be met within existing and future budget allocations. However, these assertions would appear to be a rather limited analysis of possible costs. In relation to monitoring devices for example, it is not stated how many patients might be required to wear such devices or what type of device is being considered. In addition to the cost of purchasing such devices, there will be maintenance costs as well as staff time required to undertake, record and report on the monitoring.

Questions need to be asked as to whether this is the best use of scarce funding resources and does the devotion of staff time to such activities (a) detract from providing clinical care and (b) whether such devices might impede the clinical relationship necessary for effective clinical care and risk management.

Furthermore, given Police assistance may be required, this would involve additional costs (page 13 of the *Explanatory Notes* stipulates the need for consultation with the Police Commissioner to ascertain resource implications of returning patients whose LCT has been suspended).

The other area that concerned our members was the increased workload and therefore costs would be accrued in relation to the proposed review mechanisms. Not only the Mental Health Review Tribunal, but all the parties involved (Attorney General, Legal Aid, Mental Health and Alcohol Directorate, clinicians, Mental Health Review Tribunal(MHRT) appointed patient representatives) could find themselves involved in appeals in relation to monitoring conditions as well as appeals against suspended LCT. It is likely that if LCT was suspended for a class of persons there could be a large number of appeals, which would result in either other matters being deferred, additional hearings being held or delays in matters being heard. Such unintended consequences need to be seriously considered, particularly as they ultimately relate to the recovery, wellbeing and safety of individuals who experience a mental health illness.

The above issues need further consideration regarding the impact on existing resources of these proposals.

Consistency with fundamental legislative principles

The Mental Health Act 2000 includes provisions for mentally ill persons charged with or convicted with criminal offences to be diverted from custody to hospital for assessment and treatment (Classified patients); but also provides for determining the criminal responsibility of persons who may be of unsound mind at the time of committing an offence. When a person is found to have been of unsound mind or is unfit for trial, the Mental Health Court (MHC) may place the person on a forensic order (forensic patients). Limited Community Treatment can be approved by the Mental Health Court or the Mental Heath Review Tribunal. Once LCT is approved the patient's treating psychiatrist authorises LCT, subject to various conditions.

The proposed amendments to the *Mental Health Act 2000* effectively take decision making out of the hands of the MHRT/MHC and treatment team and gives authority to suspend LCT to the Director of Mental Health, who may be directed to consider such action by the Minister of Health. This is of concern to our members.

In the *Explanatory Notes* a number of legislative principles are briefly discussed, including:

- Not breaching individual rights and liberties
- Natural justice
- A review process
- Power is used sparingly, appropriately applied after due consideration
- There is no less restrictive alternative

Yet, in each instance, the same argument is made in the *Explanatory Notes* to override these principles, i.e. the action is consistent with the purpose of the Act, and namely the action is required to ensure the balance between patients' rights and community protection.

The matters in this section therefore warrant more careful consideration.

It is noted in the *Explanatory Notes* that when an individual patient has caused a serious risk, then suspension of LCT is clearly indicated. Such suspension is currently available under the current legislation, albeit not directly by the Director of Mental Health. Further, treating psychiatrists are required to advise the Director of Mental Health of matters of concern. The *Explanatory Notes* then goes on to consider the application of LCT suspension to a class of "relevant patients". The scenario is discussed of patients who belong to a class of patients whose LCT is to be suspended, but who have been compliant with LCT conditions. The question is posed whether such patients are unfairly disadvantaged and whether their individual right's and liberties have been breached. Yet, this concern is summarily dismissed on the basis that there needs to be a balance between protection of the individual and protection of the community. Such an action would seem grossly unfair. It also has to be considered whether suspension of LCT for a class of patients is proportional to the identified risk.

The question has to be further asked, what "serious risk to the life, health or safety or a serious risk to public safety" (s493AC) could a class of individuals pose, especially when it includes individuals who have been compliant with LCT? An individual going absent without permission (AWOP) or committing an offence is of concern; however, it is unclear how the class of patients poses a risk. This would be akin to incarcerating all people who drink alcohol because some have committed violence. Such a broad net as a "class of patients" is clearly discriminatory because it fails to take into account individual circumstances and makes stigmatising judgments about individuals because of their mental illness. Evidence exists that mental illness is a modest risk factor for violence when compared to other factors such as alcohol abuse.

Further, the proposed s493AG(2)(d) and (3) makes provision for patients whose LCT is suspended to be returned to any designated authorised mental health service, even if it is not their usual mental health service. While this allows for flexibility in return arrangements, it could also be extremely disruptive and have a negative impact on a patient's mental health if they are returned to an unfamiliar environment or location distant from their usual supports and staff who know them.

The argument that suspension of LCT for a class of patients is required to address systematic problems, raises several issues:

1. if the issues are systemic issues why not pro-actively address these through the existing policy and audit mechanisms,
2. if the power is to be used "only sparingly and appropriately applied after due consideration" how is this to be reconciled with immediate action referred to on page 2. A set of criteria are outlined in the *Explanatory Notes* and in s. 493AD (2) of the proposed Act. Due consideration would appear to be at odds with both page 2 of the *Explanatory Notes* and the Ministers speech (November 27, 2012) which refers to the capacity to "immediately deal" with incidents. Immediate action and adequately taking into account the impact on individuals would appear completely at odds if the concept of "due consideration" is to be meaningfully applied.

Natural justice implications are dealt with under the proposed amendments by proposing the MHRT act as a body of appeal. If such suspension is proposed, the onus should be on the Director of Mental Health to make the case that such a serious risk exists and the decision should be one for the MHRT. Using the MHRT as an appeal body erodes the authority of an independent body established to make decisions regarding the approval or suspension of LCT (albeit for individuals). The powers of the Director of Mental Health (which under s492 can be delegated) or the Minister of Health blurs the separation of executive and judiciary powers.

The amendments also do not make it sufficiently clear what a systemic issue is. The onus should be upon the Director of Mental Health to establish such a case before an independent authority rather than the reverse. Under these provisions, the Director of Mental Health will have the power to suspend LCT for a class of individuals however, the appeals process will require all affected individuals to have

their appeals heard separately. The *Notes on Provisions* (page 39) makes it clear that the process to amend orders is likely to be more complex and time consuming that s493AG suggests, the implication being additional disadvantage to patients.

Our members were concerned that the issue regarding additional LCT conditions is problematic in that it is unclear what the system would be and how it would be administered, and that classes of patients may be subject to a condition such as wearing a monitoring device. While a monitoring device may be an effective means to locate an individual, no consideration has been given to the disadvantages of such devices, or evidence from other forensic mental health services regarding the efficacy and implications of using such devices. The use of such needs to be anchored in evidence based practice, which is a criterion for the introduction of new Practices across Queensland Health. It is of concern that the use of such devices for classified or s273(1)(b) patients is not considered to require a review process because they are currently without such review processes. It is also of questionable logic that if someone is receiving treatment 'voluntarily' that the patient is in effect giving consent to all forms of treatment, including monitoring devices. As stated, our concern is also that this breaches the fundamental human rights of these individuals.

While monitoring devices are used with Dangerous Prisoner Sex Offender Act 2003(DPSOA) prisoners, there are very significant differences between these prisoners and forensic patients (e.g. forensic patients were mentally ill at the time of their offence; they may only have been charged with a minor non-violent offence and are not necessarily repeat offenders).

The current forensic provisions of the *Mental Health Act* were established precisely because there were problems managing mentally ill people in custody and the need to adequately consider the relationship between mental illness and criminal charges, by the criminal justice system. A central tenet of these provisions is that public safety is best achieved through ensuring that individuals, whose offending is associated with mental illness, receive this treatment. Placing excessive restrictions and blurring the therapeutic and security functions excessively, may in fact decrease public protection rather than enhance it.

Patients may remain on forensic orders longer than if convicted of an offence, due to their response to treatment and treatment needs. One cause for patients going AWOP is frustration at the slowness of progress through the forensic mental health system and the associated restrictions. A humane system is one that can respond promptly, consistently and proportionally to breaches of LCT.

Consistency with legislation of other jurisdictions

The information in this section only states that "security considerations" are utilised in New South Wales and Victoria. This gives the impression that similar measures are in place in other States and Territories. Certainly forensic patients in other states are not required to wear monitoring devices. Similarly, whether the Director of Mental Health in these states can suspend leave (LCT) for an individual or class of

individuals is not clear. Given the different legislations in these states it is problematic to make overly general statements suggesting the proposed Queensland amendments are consistent with interstate practice.

Summary of issues identified

1. Applying extremely restrictive processes on a class of patients, without adequate consideration of individual circumstances is discriminatory and a breach of individual liberties.
2. Issues such as additional costs and burdens to current resources and the subsequent negative implications of these proposed amendments have been given inadequate attention.
3. Persons on forensic orders and classified patients are comprised of heterogeneous individuals, many of whom will not have committed or repeated major violence. Their needs are quite different to prisoners.
4. Arbitrary social exclusion, disruption to recovery and adding to the stigma many patients already experience is likely to contribute to reduced public protection. Already alienated and stigmatised patients are likely to feel more alienated, which comprises the capacity to provide therapeutic interventions and build trust which is essential if these individuals are to be properly cared for and their risks minimised.
5. The negative impact on carers and families already struggling with issues of stigma, social exclusion and their role in supporting a family member recovering from a mental illness involved in the criminal justice system has not been adequately considered.
6. Addressing system issues and the behaviour of individuals who go Absent Without permission (AWOP) or pose a risk to others can be addressed through existing policy and legislative mechanisms.

Conclusion

As discussed, the AASW QLD is keen to contribute to the current consultation around the proposed amendments to the *Mental Health Act 2000* and our concerns have been listed. The AASW QLD would welcome more consultation with key stakeholders as consultation on these proposals has been limited or absent to date, yet this is fundamental to achieving a system that meets the complex needs of individuals who live with a mental health illness and our communities. There is a concern amongst our Social Work members that the proposed changes in legislation are contrary to the United Nations principles, which underpin the Code of Ethics of the AASW.

Furthermore, we are concerned that the proposed changes are not feasible given the current climate of tight fiscal responsibility. Yet funds need to be directed towards front-line services, as reflected in the Queensland Plan for Mental Health

2007-2017 that guides systemic reform and innovation of Queensland's Mental Health Services.

We would appreciate the opportunity for these concerns to be considered in the drawing up of proposed amendments to the current legislation and would welcome the opportunity to provide additional input and advice.