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Queensland Advocacy Incorporated

Systems and Legal Advocacy for vulnerable people with Disability

Submission on the Queensland Mental Health Commission Bill 2012

4 February 2013

Thank you for this opportunity to make submissions on the Queensland Mental Health Commission Bill 2012 **(the Bill)**.

QAI's Mental Health Legal Service has been in operation since January 2010. In that time we have provided legal advice and assistance to more than 500 clients receiving treatment under the *Mental Health Act 2000* **(MHA)** and have attended 309 Mental Health Review Tribunal **(MHRT)** hearings. Of those clients, 16% were subject to forensic orders.

1. Establishment of the Queensland Mental Health Commission (QMHC)

Clause 15 - In New South Wales, the *Mental Health Commission Act 2012* (NSW) provides that at least one of the Commissioners or deputy Commissioners should also be a person with lived experience. We recommend a similar requirement or, at the very least, that when considering applications for appointment of a Commissioner, preference should be given to applicants with a lived experience of a mental health condition.

Clause 39 – This provision should be more prescriptive in the constitution of the Queensland Mental Health and Advisory Council **(the Council)** to ensure a representative number of people with lived experience as a patient, family member, carer and support person.

This is in line with Article 4(3) of the *UN Convention on the Rights of Persons with Disabilities* which provides:

> "In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, State Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organisations"

Article 1 of the Convention clearly states that people with mental illness are within the scope of the Convention.

We note that the *Mental Health Commission Act 2012* (NSW) guarantees a diverse mix of people on its advisory council, including people with lived experience. Canada's Advisory Committees to the Mental Health Commissioner are also comprised of both experts and people with lived experience.

We recommend that the following words in clause 39(2)(b):

> "that members have appropriate skills, knowledge or experience, for example, skills,

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knowledge or experience of mental health and substance misuse issues in relation to the following"

be substituted with:

"that members have appropriate skills, knowledge or experience and *includes representatives of the following groups*"

Clause 48 – This provision should explicitly ensure that the Council is adequately resourced.

To the existing words:

"The commission must support the council in performing its functions by providing information to the council about the performance by the commission of its functions—..."

we recommend the addition of

"and by providing reasonable financial and staff resources."

Clauses 50 and 51 – Under these provisions, the Commission must respond to the Council's recommendations and any action taken reported in the Commission's annual report. If the Commission decides not to take action in relation to a recommendation, it must provide the Council with the reasons for this decision.

We recommend that Council's voice be strengthened by enabling them to resubmit any recommendations previously rejected by the Commission after a specified period of time (for example, 3 months). If the Commission's response is the same, then the reasons for that decision must also be provided to Parliament for public scrutiny.

2. Amendment to the Mental Health Act – Part 9

The purpose of the MHA as set out in s 4 is to, among other things,

- safeguard the rights and freedoms of people with mental illness; while
- balancing their rights and freedoms with the rights and freedoms of other persons.

In our opinion, many of the amendments proposed by the Bill unjustifiably erode the rights and freedoms of people with mental illness, with little public benefit.

Relevant patient, unless otherwise stated, is used to mean a classified patient, a forensic patient, or a patient for whom the Mental Health Court has made an order under s 273(1)(b).

2.1 Power to enable monitoring of forensic patients granted LCT – proposed s 131A

Electronic monitoring of relevant patients while they are on LCT is wholly inappropriate.

The only other category of persons who are subject to electronic monitoring in Queensland that we are aware of are high risk sex offenders. In those cases, electronic monitoring can only be ordered by the Court, following the filing of written evidence and a hearing (*Dangerous Prisoners (Sexual Offenders) Act 2003*, s 16).

Relevant patients are not criminals. They are people who have been found to be too unwell to be criminally responsible for their action or are yet to have their criminal charges heard. Only a small number of classified patients are also serving a sentence of imprisonment for a criminal conviction.

Yet the notion that relevant patients could be subject to electronic monitoring, criminalises their behaviour and stigmatises people with mental illness. The fact that such a condition could be required by the Director of Mental Health without evidence, hearing or reasons affords forensic patients even less rights than sexual offenders. Electronic monitoring could also have significant and serious adverse impact on a patient's mental state and recovery.

Director-made monitoring conditions are unnecessary. LCT is already carefully monitored and controlled under the current regime. For forensic orders, a treating team must have a comprehensive LCT plan, which is reviewed by an LCT review committee and is again checked by the MHRT at review hearings, who may only approve LCT having reference to the strict test set out in s 204(1) MHA. Treating teams regularly use the conditions envisaged by the Bill, such as reporting in to the mental health service by telephone or only accessing leave with a particular purpose. It is unclear how the involvement of the Director, who has no direct contact or knowledge of the patient, would enhance the safety of the public. Classified patients already may only access leave with the Director's approval, who may impose *reasonable* conditions on LCT (s 129(2)(b)). Section 273(1)(b) patients must be escorted while undertaking LCT (s 132 MHA).

We also note that:

- (proposed s 131A) A patient's treating team is best placed to consider what monitoring requirements, if any, are needed. However, they have no involvement in the exercise of this power by the Director.
- (proposed s 131A(3)) While there are example scenarios of where a monitoring condition may be appropriate, there is no test or criteria to be applied by the Director and no reasons for decision given. This could lead to arbitrary decision making, without consideration of important factors such as the seriousness of the index offence or treatment needs. In contrast, the MHA sets out a test and relevant considerations for the Director in deciding whether to approve LCT for a classified patient. (s 129 MHA)
- The lack of framework for the Director's decision places the MHRT in a difficult position in reviewing these monitoring conditions.
- For forensic patients, proposed section 204(1)(c) effectively requires the patient to prove that the monitoring condition should <u>not</u> continue, rather than requiring proof that it should. This is a heavy burden to discharge on patients who are generally unrepresented before the MHRT.

<u>2.2 Power to suspend limited community treatment - proposed s 493AE</u>

According to the first reading speech of the Bill, the proposed amendments to the MHA have been in response to two instances of forensic patients absconding from The Park high security program while on limited community treatment.

It is difficult to see how suspension of LCT for a *class* of relevant patient would help to mitigate this risk. If anything, such an order is likely to frustrate the affected patients who have abided by all the terms of their LCT, adversely impact on their mental state and recovery, and create further drains on an already exhausted mental health service. Consultation with the treating team on these issues (proposed s 493AD(2)) does not adequately address these concerns. **In other words, suspension of LCT for a class of relevant patient unfairly and disproportionately affects a number of people without meaningfully improving public safety.**

Suspension of LCT is a serious matter. Article 9 of the *International Covenant on Civil and Political Rights* sets out the right of every person to liberty and freedom from arbitrary detention. Anyone deprived of their liberty is entitled to have their case promptly heard before a court. Article 14 of the Convention on the Rights of Persons with Disabilities expands on this right, by providing that "the existence of a disability shall in no case justify a deprivation of liberty".

A suspension order does not give affected patients access to a fair hearing or natural justice. The Director is not required to give reasons for his suspension order. He is not required to identify what the significant matter is or the related risk. He is not required to identify what matters he took into account in making the order. Identification of the significant matter may in fact be in breach of another patient's privacy. While a right of appeal against a suspension order exists, it is difficult to see how such an order can be meaningfully appealed, let alone how the MHRT would decide such an appeal.

We also note that:

- (proposed s 493AF(2)(c)) There should be a limitation on how long a suspension order can remain in force.
- (proposed s 493AD(2)(a)(iii)) Suspension of LCT is a suspension of treatment. It is therefore imperative that the director consult about the best interest and needs of all patients subject of a proposed suspension order, not just children.
- (proposed s 493AG(b)) The Director should be compelled by the MHA to end the suspension order as soon as the significant matter or related risk ceases to exist. This is in line with the principles of the MHA, particularly s 9.
- (proposed s 493AH(1)(b)) In our view, this provision is ambiguous. The provision should be redrafted to clearly reflect the intention of Parliament, which appears at page 39 of the Explanatory Memorandum to be that a suspension order can be appealed on the ground that the Director "erred in including the patient the subject of the appeal in the order".
- There should be a right to written reasons from the MHRT on appeal.
- Given that a suspension order is effectively a change to approved LCT, there is no reason why an appeal should not be available to the Mental Health Court from a decision of the MHRT.

2.3 Publication of private information – proposed s 526 (3) and (4)

Privacy is of particular importance to mental health patients due to the stigma and stereotyping attached to people with mental illness. Time and again, the media refer to forensic patients in the same breath as convicted prisoners, and there are numerous examples of police using disproportionate force against people flagged as mental health patients.

Of particular concern is the justification for the proposed amendment:

> *Finally, the bill eases a current prohibition on publishing identifying information about a forensic patient, which inhibit the police's ability to advise the community or receive assistance from the community to locate the recent two patients that absconded."* [Hon LJ Springborg, First Reading of the Queensland Mental Health Commission Bill, 27 Nov 2012 at p 2756]

Publication of a person's name for these reasons merely reinforces the stereotype and perpetuates the myth that people with mental illness are dangerous and unpredictable. It has the potential to inspire overreaction from the public, leading to poor outcomes for patients, their recovery and their ability to eventually reintegrate back into society.

Sufficient mechanisms already exist for the timely apprehension of AWOP mental health patients without this amendment.

It is noted that the proposed amendment does not only apply to forensic patients, but to any person who has been a party to an MHRT or Mental Health Court proceeding.

If you have any questions about this submission, please do not hesitate to contact myself or Rebekah Leong on 3844 4200.

Yours faithfully

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