STATE DEVELOPMENT AND REGIONAL INDUSTRIES COMMITTEE

Members present:
Mr CG Whiting MP—Chair
Mr MJ Hart MP (virtual)
Mr JE Madden MP
Mr JJ McDonald MP
Mr TJ Smith MP (virtual)

Staff present:
Ms S Galbraith—Committee Secretary
Mr Z Dadic—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE HEALTH AND OTHER LEGISLATION AMENDMENT BILL 2021

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 27 JANUARY 2022

Brisbane

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The committee met at 9.25 am.

CHAIR: Good morning. I declare open this public hearing for the committee's consideration of the Health and Other Legislation Amendment Bill 2021. My name is Chris Whiting. I am the member for Bancroft and chair of the committee. I respectfully acknowledge the traditional custodians of the land on which we meet today and the land that we represent and pay our respects to elders past and present. We are fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people whose lands, winds and waters we all share. Present with me today are Mr Jim McDonald, deputy chair and member for Lockyer, and Mr Jim Madden, member for Ipswich West. Joining us by videoconference and teleconference are Mr Michael Hart, member for Burleigh, and Mr Tom Smith, member for Bundaberg. Mr Robbie Katter, member for Traeger, is an apology for today's proceedings.

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. Finally, in line with the Queensland parliament's COVID-19 requirements, all members and visitors will be required to wear masks during today's proceedings. Members and witnesses may remove their mask while speaking. Thank you for your understanding.

BOOTH, Mr Paxton, Privacy Commissioner, Office of the Information Commissioner (via teleconference)

CHAIR: I now welcome via teleconference our first witness from the Office of the Information Commissioner, Mr Paxton Booth. Good morning and thank you for appearing before the committee today. I invite you to make an opening statement and then committee members will have questions for you.

Mr Booth: Good morning. I would like to thank the committee for the opportunity to provide a submission on the Health and Other Legislation Amendment Bill 2021 and to appear before the committee today. I would also like to thank the Queensland Department of Health for consulting with the Office of the Information Commissioner on the proposed amendments and answering a number of questions we had about its operation. The statutory functions of the Office of the Information Commissioner under the Information Privacy Act 2009 include commenting on the administration of privacy in the Queensland public sector environment. My comments today are primarily focused on the various policy and data security issues raised in our submission by the proposed amendments in the bill to the Hospital and Health Boards Act 2011 to enable a range of health professionals not registered under the national law to access the Viewer and view patient healthcare information.

I understand the purpose for the proposed amendments, as outlined in the explanatory notes, is to enable allied health professionals to have a better understanding of the care a patient has received in the acute setting, determine appropriate continuity of care and achieve better health outcomes for patients. The Office of the Information Commissioner considers this to be a legitimate purpose to improve health care to members of the Queensland community. However, legislative amendments authorising the use and disclosure of personal information need to strike an appropriate balance to ensure any impacts on privacy are reasonable, necessary and proportionate. As noted in our submission, the office has identified a number of areas where there are opportunities to improve the way in which privacy issues could be managed. There are likely to be circumstances where patients' health information may be accessed or disclosed without the consent or knowledge of the patient.

We are seeing increasing levels of sophistication and expectations from the public about how their personal information is managed by government agencies. What the public wants is to be afforded greater choices and control on how their personal information is used and disclosed. This

includes only using and disclosing their personal information with their consent. When agencies do this, it increases public confidence and trust in the agency and, consequently, increases the uptake of the services offered by the agency.

The goal of extending access to the Viewer is to improve outcomes for patients and reduce the administrative inefficiency in the current manual requests to access information. However, for these benefits to be realised, the public need to have trust that their information is being managed appropriately. That is the focus of the Office of the Information Commissioner's submissions. As demonstrated by a range of Commonwealth and state initiatives involving the handling of personal information such as My Health Record, the COVIDSafe app and more recently the Check In Qld app, the adoption and implementation of robust privacy and data security protections is critical to gain the trust and confidence of the community in the uptake of these initiatives.

While the office applauds a number of existing privacy safeguards within the Viewer supported by various departmental policies and procedures, we consider that these safeguards could be strengthened by taking up a number of additional risk mitigation strategies. Briefly, these include conducting a privacy impact assessment and public release of that assessment, and I am pleased to advise that we have received a consultation draft of the department's privacy impact assessment this week about the extension of the Viewer; secondly, a comprehensive community engagement campaign to inform the community about what health information is available on the Viewer, who can access their health information, what options they have to control it and how to find out further information about the Viewer generally; and, thirdly, providing individuals with greater control and choice over the health information that can be accessed by health professionals.

I understand that a patient can restrict access to certain categories of health professionals. However, the Viewer currently does not have the functionality to allow a patient to restrict access to specific health information or records. Many Queenslanders rely solely on the public health system to provide their health care. They do not have the ability to access private health care all the time. For that reason, all or most of their health records are likely to be held in Viewer. At times, while they want or need the services of allied health professionals to support their care, they may not want their healthcare providers to see all of their medical records, particularly if they are not relevant to the treatment they are receiving.

Other additional risk mitigation strategies are, fourthly, transitioning the existing patient consent model from opt out to opt in, as this is a much stronger model to ensure that patients are consenting to the expanded use and disclosure of their information; and, lastly, embedding privacy and security awareness training for all prescribed health professionals granted access to the Viewer. We note that the recommendations made by the Queensland Human Rights Commission in its submission are largely consistent with this office's proposals to strengthen privacy protections. I understand that agency will also be addressing the committee later today. Thank you and I am happy to take any questions the committee may have.

CHAIR: Excellent. Thank you, Mr Booth. Looking at your submission, you have outlined how the federal act, the My Health Records Amendment (Strengthening Privacy) Act 2018, has express privacy provisions, and you outlined that quite well. Are there other jurisdictions in Australia that are moving towards this model?

Mr Booth: In terms of a guiding standard in terms of this model where health information is available, I think that question was asked at the last committee meeting and my understanding was that Queensland is the first state to implement this expanded access to health information. I do not know that it has been done in other states to date.

CHAIR: I was more talking about those privacy provisions under the federal act. You outlined what they do, not in the Viewer but in My Health Record in the federal one—for example, prohibition of access for insurance and employment purposes, prohibition on releasing health information to law enforcement agencies, allowing individuals to opt in and opt out of My Health Record. Looking at that model which is contained in that federal act, is that something that other jurisdictions in Australia may want to move towards?

Mr Booth: I would say yes. I think that model, obviously because it is Commonwealth, applies across all the states in the sense that for anyone living in New South Wales who has a My Health Record those provisions are applicable to them and those protections are applicable to them in other states in Australia. We are definitely seeing other agencies getting stronger protections in this health space. As I said before, people in the community are becoming much more aware of their rights, much more sophisticated in what they are asking government departments to protect in terms of their

private information and have higher expectations on government to fold in that protection. Ultimately, it comes back to giving people the ability to make a choice and make decisions about how their information is accessed and used by agencies.

CHAIR: Thanks for that. It may be something for all of the variety of health departments throughout Australia to look at that model contained in that federal act and decide if they want to go towards that particular model. In terms of people being more sophisticated in the information they want conveyed or contained, is it more common in privacy protection regimes in health to be opt in or opt out throughout the states?

Mr Booth: As I said before, I am not sure that other states have this current capacity. Certainly the Commonwealth model is opt out. There was quite a lot of public debate at the time around the opt-out model and I think one of the things that was discussed in the public arena was an extension of time for people to make that decision as to whether they were going to opt in or opt out of that service.

CHAIR: Thanks for that.

Mr McDONALD: Thanks, Mr Booth, for joining us and thank you for your submission. Have you seen the response from the department to your submission with regard to the answer about monthly audits of access to the Viewer? Have you seen that response?

Mr Booth: No, I have not seen that response to our submission.

Mr McDONALD: Just as a really short summary, basically it says that there is an audit that happens and potentially inappropriate access can be flagged and the allied health professionals have their own legal requirements with regard to privacy and access under other acts. Could you consider that with regard to your suggestion about the risk assessment that you have suggested?

Mr Booth: A strong legal framework is certainly a good start and having a strong audit capability is also a good requirement in any database where private information is accessed. I think the limitations on that though are identifying inappropriate access. Because I have not seen the submission or the response by the department, I do not know how they intend to conduct their audits.

One of the challenges is actually identifying when someone is accessing information and it is inappropriate. That can be difficult to do. I know from other work I have done in relation to the database that is available to Queensland Health that it internally has a system that does red flag checks on, for example, staff who are looking up people with the same surname as themselves. That obviously creates a flag. It does not mean that it is inappropriate access, but certainly the limitations there are the tip of the iceberg in terms of an appropriate audit. It would not, for example, pick up someone looking up a neighbour or someone else they know who does not have the same surname, so we are certainly seeing the limitations. Whilst they are really important and they do provide an overall service and they are an excellent starting point once a complaint is made, I think they have limitations in terms of identifying a breach to start with at times.

Mr McDONALD: Thanks very much for that response. Just for clarification, in your opening remarks you said that you had been consulted by the department. Was that before the draft bill?

Mr Booth: It was before. I have only been in this role for a month, so I was not present at the consultation. I think it was during the process of drafting. I would have to go back to notes and check whether it was before or after the bill had been introduced.

Mr McDONALD: Okay. Finally, with regard to the federal process of implementation of their record system, would you suggest an extension of time if the opt-out system in Queensland remained? Would you give an extension of time for people to consider that?

Mr Booth: I think it is really important that the department undertake a very extensive public education program if they are going to retain the opt-out model, particularly looking at those areas or services which people might consider to be particularly sensitive. For example, they might decide in the area of mental health that they need to be more proactive with those services and actively communicating to people who are receiving those services that this information will be available to other allied health professionals. There may be other areas as well. They might want to go through and do an analysis of certain types of information that would be considered more personal by people, things like if people are seeing a sexual health clinic or things of that nature.

Mr McDONALD: For sure. Thanks, Mr Booth. I appreciate it.

Mr MADDEN: Thanks very much for appearing today, Mr Booth. I have a question with regard to the opt-out, opt-in model as well. I note in your submission you have raised five issues that you would like the committee to consider, including this issue. With regard to the current opt-out model and the new opt-in model, you say that you base your opinion on—

An opt-in model is more likely to meet contemporary community expectations.

Is your opinion based on that premise or is it based on any case studies where there was an abuse of the opt-out model?

Mr Booth: No, I cannot say it is based on case studies but based on information that is available from research done by the Office of the Australian Information Commissioner and people saying in response to that survey that what they want is more control and decision-making about how their information is used and disseminated. We say that that is reflected better in an opt-in model than it is in an opt-out model for the obvious reason that with an opt-out model if people are unaware of what is going on they do not have the choice.

Mr MADDEN: Thanks very much, Mr Booth.

Mr HART: Mr Booth, sticking with the opt-in, opt-out conversation, I think that is probably a good thing for the committee to consider in recommendations, Chair, but I am worried about the practicality of changing from an opt-out facility to an opt in. Mr Booth, how would that work? Are you aware of anybody that has changed from an opt out to an opt-in system and are you suggesting that it should be either opt in to specific categories of information, and, if so, how would that work?

Mr Booth: Thank you for the question. It is certainly something that probably needs some further consideration. The choices would be around opting in. It could be restricted to opting in to further dissemination of the information or it could be changing the entire way information is accessed or available in the Viewer at the moment. What we are talking about is just really making sure that individuals in the community are given the choice about how their information is viewed, but the focus of our submission is that now this health information is going to be available to a lot more health professionals who are going to be providing more specific treatment and a narrower focus but they are still going to potentially have access to a wide range of information that is available in the Viewer from the public health system which they may not need to provide the service they are. Giving people the choice to opt in to that rather than it being automatic gives people more control over how their information is being used. To answer your first question as to whether I am aware of other occasions when a service has been changed from an opt out to an opt in, no I am not.

Mr HART: Do you have any particular concerns about any of the groups that the bill proposes to give access to medical records? Do you think they are too broad or not broad enough?

Mr Booth: I do not think there is any issue with the intent behind the legislation or the intent behind the bill insofar as they have tried to improve the administrative efficiency of getting information from the public system to the private system to improve that continuity of care. It is really about making sure that the information that is provided is relevant for the purpose of the treatment.

At the moment, if a person has an injury to their leg and they require surgery in a public health system and then require ongoing care outside of that, if they are in the system, all their health records would be provided. For example, if that patient had also received, completely unrelated to the leg injury, mental health care or treatment, that information would be available to the other health professional.

I am not suggesting that health professionals will necessarily go out of their way to look at that information, but people often want to put controls around want information is available to other people they are seeing and may not want those full records available, particularly where it is not relevant to their treatment.

Mr HART: Do you see that the decision on what information can be accessed should be purely left to the person whose medical records that are being looked at, or should there be some general rules around this sort of thing?

Mr Booth: That is certainly the starting position, from our point of view; that it is about consent. It really should be up to the individual to decide what information they want disclosed to the health professionals. They may not want information around other treatments that they have received at other public systems available to set practitioners. That is certainly something we have come across before where we have had complaints about restricting or making sure that the least information is communicated as possible—only to provide the service that is needed.

Mr HART: I am wondering if that then leads to somebody hiding information that a medical practitioner may need access to. I think there are a whole lot of issues here that we need to consider.

Mr Booth: There certainly are a number of things that need to be considered. We would say it is up to the individual to decide what information they want to disclose, particularly where the information is not directly relevant to their current treatment.

Mr SMITH: My question is around opt in, opt out. The way I read it is that there is an opt out, if this all goes ahead, which means that a patient's Viewer will only be viewed by a health professional when that person becomes a patient of theirs. Is your concern that there are going to be health professionals randomly searching patients, or they know someone and they want to do a check-up? What is the real concern there about a health professional searching a Viewer record of someone who is not their patient? Is that a reality? Is that going to be something that will occur?

Mr Booth: It is a possibility. I know that there are certain controls in the Viewer at the moment, as far as I am aware, where you cannot just go in, if you are outside Queensland Health, and search people by name. You need other identifying information. For example, I believe you need their Medicare number or other particulars. If you knew the name of your neighbour, for example, you cannot go in and search the name of your neighbour; there are other controls in place at the moment to limit that abuse of the system.

What I am more concerned is about is that you go to see a health professional about a particular treatment and there is information in your health records which are unrelated to that treatment which you may not want the person to look at or to be able to access. You may have a diagnosis for something you do not want them to know about—it is quite personal; it may be about your family, your wife and your kids—and it is about giving those individuals who need treatment control over their health records so that they are not accessed by people who are, out of curiosity, just looking something up.

I am not trying to focus in on health professionals. Like anyone who works in the public sector and the Public Service, most of the people do the right thing. It is just that small minority of people who, for a whole variety of reasons, as I said in my submission—sometimes it is pure curiosity—they look up confidential information or personal information when it is not directly related to a service or the work that they are doing.

Mr SMITH: You need particular details to be able to then access the patient's Viewer. When that patient has been told, 'You need to go and see a physiotherapist,' that is where the option is, 'By the way, when you go there, the physiotherapist will able to access your health records. Would you like them to view it? Yes or no?' and that is where the opt-out option comes. Can you perhaps put forward why we need to shift to an opt-in when the option to opt out—I am not saying that it seems easier. The fact that the Viewer is there, it can be seen. 'Hey, patient X, you are going to see health professional Y. Would you like health professional Y to see your records through the Viewer?' To opt out sounds like an easier model than opt in does.

Mr Booth: That comes back to whether the person knows. I can say from a personal level that because this model has been in place with other health practitioners for some time, I was certainly unaware until I came to work here. In terms of communication to the wider community, I really doubt that the greater community is aware of the capability. The limitation with the opt-out model is that it assumes that everyone knows and is aware of what is going on and their rights to opt out. Unless that is communicated very well to the community so that everyone is made aware of it, then you run the risk that people's information will be available to others, without their knowledge.

CHAIR: There being no further questions, we will close this session. We do not have any questions on notice for Mr Booth. Thank you very much, Mr Booth, for being a part of this today. We appreciate the work you have done on it.

PHILLIPS, Dr Emma, Deputy Chair, Human Rights and Public Law Committee, Queensland Law Society

THOMPSON, Dr Brooke, Policy Solicitor, Queensland Law Society

WILLIAMS, Ms Karen, Deputy Chair, Health and Disability Law Committee, Queensland Law Society

CHAIR: I welcome representatives from the Queensland Law Society. Thank you very much for appearing before the committee today. Good morning to you all. I now invite you to make an opening statement after which committee members will have some questions for you.

Dr Thompson: Thank you for inviting the Queensland Law Society to appear at the public hearing on the Health and Other Legislation Amendment Bill. In opening, we would like to acknowledge the traditional owners and custodians of the land on which we are meeting, the Turrbal and Jagera people, and pay our respects to elders past, present and emerging. We would also like to commend Queensland Health and the government for the manner in which you have engaged and consulted with stakeholders in the formation of this bill. While our comments on the bill are limited to the provisions that amend the Mental Health Act, it is our view that this process has led to a workable piece of legislation. Notwithstanding this support, we have raised three additional measures in our submission for consideration in this suite of reforms.

Firstly, we consider that allowance in the Mental Health Act for an administrative process for adjournments would substantially alleviate the burden on the tribunal's time and resources, as well as reduce unnecessary stress on patients who must attend a tribunal hearing to seek an adjournment.

Secondly, we would like to highlight an issue in the appeals process to the Mental Health Court, specifically where a client lacks capacity to instruct and their lawyer is acting in a best-interests capacity, neither the client nor their lawyer has standing to appeal a decision of the Mental Health Review Tribunal to the Mental Health Court. Accordingly, we seek amendment to schedule 2, column 2 of the Mental Health Act to allow legal practitioners acting in a best-interests capacity to initiate an appeal to the Mental Health Court.

Finally, it has been the society's long-held view that electronic recording and availability of transcripts to relevant parties across all Queensland courts and tribunals is a fundamental element of conducting proceedings, so we strongly recommend the urgent introduction of a system of electronic recording and availability of transcripts in the Mental Health Review Tribunal. We also consider that reasons for decisions ought to be provided as a matter of course so that persons appearing before the tribunal, their treating team, support person or legal representative can fully understand the legal implications of the process which will affect their future treatment and possibly facilitate their release from an order.

As discussed I am joined today by Karen Williams and Dr Emma Phillips who are able to elaborate further on the matters raised in our submission. We welcome any questions that the committee may have. Thank you.

CHAIR: My first question is on the issue of appeal rights. You are recommending section 539 of the Mental Health Act, schedule 2, column 2 be amended so that a legal practitioner, acting in the best interests of the patient, be allowed to initiate an appeal. I note that an interested person, as defined in schedule 3, that a guardian or a nominated person can initiate that appeal. By changing schedule 2, column 2 to give that similar powers, how would you define a legal practitioner acting in the best interests? Is that something that the legal practitioner or the person would initiate? I am looking to see how to precisely define that so you do not have competing people trying to initiate in an action.

Dr Phillips: We would certainly support that the way in which that is defined as the legal practitioner when acting in a best-interests capacity, so when they are appointed in that capacity. That is different to when they are acting on instructions, and it would obviously be the client's instructions to initiate the appeal.

We do appreciate that this is different to other jurisdictions where lawyers do not have standing, but it is a very unique jurisdiction and at the moment the definition of' 'interested persons' with standing to initiate an appeal does extend well beyond the usual parties to an appeal. We think there are some really strong arguments in terms of access to justice to ensure that those appeals, particularly where there are areas identified or a lack of procedural fairness or other issues that would

found a valid appeal, we think that it is really important that there is that opportunity. Once an appeal is on foot, it no longer becomes an issue. It is about initiating that appeal. We think that that is also important in terms of the development of the case law in this area, not only in terms of the outcomes for the clients, although that remains our primary concern.

Ms Williams: I would add that not everyone who lacks capacity to instruct would necessarily have a guardian or any other interested person. The person's inability to instruct might be short term because of a severe but episodic mental illness and the time period might run out before the person is well enough to be able to seek instructions from them. In that case, they probably would not have had a guardian appointed. I think you are thinking there might be double-ups, but there are definitely gaps, and it is often vulnerable people who may have even a mild mental illness but have an intellectual disability, preventing them on a more permanent basis from being able to instruct a lawyer and then the lawyer having standing to bring an appeal about concerns on errors of law et cetera that Emma has mentioned.

Dr Phillips: I will add one final point to that: obviously there is potentially the opportunity to appoint a litigation guardian, but in practice that is quite challenging in this space so it is not something that is a workable, practical solution. That is why we are making that proposal.

CHAIR: I am looking at the difference between a solicitor who is instructed and one that is acting in the best legal interests. Am I talking about the same definition there, or is there a difference between those two? For those who are looking at the transcript or listening, they probably need that explained a little bit more.

Ms Williams: I will start and if Emma could look up the provisions so that I can quote. The Mental Health Act quite usefully already has the facility for lawyers to act in the best interests of their client in order that before the tribunal, if they are unable to gain instructions from the client—and I am not sure—it is provision 739(3)—

A person who represents the person at the hearing of the proceeding must—

(a) to the extent the person is able to express the person's views, wishes and preferences—represent the person's views, wishes and preferences; and—

That is the human rights element—

(b) to the extent the person is unable to express the person's views, wishes and preferences—represent the person's best interests.

It is attaching to that 739(3)(b) provision that then enables to further the person's legal rights if necessary in consideration of an appeal.

CHAIR: Under the response from Queensland Health to this, to the point you have raised, they have said a solicitor could be appointed under the Guardianship and Administration Act 2000. Is that possible? Is that workable? Has that been done often?

Ms Williams: To pick up from Emma's comments about litigation guardian or a legal guardian, I do have a fair bit of experience with that in that QCAT receives referrals from Magistrates Courts, from child protection matters and from the Mental Health Court sometimes. QCAT is extraordinarily overwhelmed with cases. They run at about a four to six-month wait in terms of having a case set down for a hearing, and there would be a hearing and then if it was considered warranted, the appointment of a legal guardian, the Public Guardian may well be appointed, and then they would have to be appraised of the case. That is possibly a six-month process.

CHAIR: Is that what happens under the Guardianship and Administration Act, that it is referred every time to QCAT or possibly could be referred to QCAT which six months down the track you get a decision?

Ms Williams: You have to look at who is going to initiate the actual concern. For example, I just use child protection matters where a magistrate might become aware that the person lacks capacity to instruct a lawyer and so reports have to be gained—the person has to go for assessment and the like. It is a process. It is a process that takes a lot of time—it takes several months—and it is not clear to many of the parties what the process is about capacity to instruct and getting relevant reports for someone—there is not an obvious place that is funded to provide these specific capacity assessments. It is all quite a difficult process.

CHAIR: Appointing a solicitor under the Guardianship and Administration Act can be quite lengthy?

Ms Williams: That is correct.

Dr Phillips: If I can add to that, as the decision maker of last resort, often we see the Public Guardian, a statutory body, appointed to make decisions, including for legal matters. They will be appointed as a guardian for legal matters. I think it is well recognised that the system of QCAT and

the guardianship system more broadly is really in a state of stress. There are some significant resourcing issues that are leading to some significant backlogs, both in how matters are travelling through QCAT and also in terms of the Public Guardian's case load and ability to actually prioritise this particular issue for this particular guardianship client, that is to even be aware of that issue or be able to be in a position to action it and within the time that is available.

CHAIR: I will go to the Deputy Chair for further questions.

Mr McDONALD: I would like to continue that theme if you do not mind. I am not sure whether you would have seen the department's hearing with us or advice to us in briefing with us; we had quite a lengthy discussion about the best interests. Did you see that at all?

Dr Phillips: No.

Mr McDONALD: It does not matter, but it does highlight the fact of what is the best interests of the client. We agreed—or in my mind we agreed—that every case is different. With that theme, could you expand on two things—one: how many people do fall through the cracks? Are we talking about one or two over the 10-year period, or is this a regular occurrence? Two: can you give us some examples of how the Guardianship and Administration Act provisions now do not support people?

Ms Williams: I probably would not be able to assist with the idea of numbers. In terms of appeal, I would not be aware of how many that would be. I do not know if Emma—

Dr Phillips: No, I would not be able to provide any sort of statistics. I can tell you that my day job is as one of the principal solicitors for Queensland Advocacy Incorporated. We are a community legal centre, a specialist centre for people with disability and mental illness, and we do a lot of work in the Mental Health Review Tribunal. From memory, over the last few months, I would be aware—just for myself—of at least three matters where we identified that there would be merit to an appeal, but there were difficulties with standing to initiate that appeal. It certainly would not be in the two in 10-year scenario. We are one of a number of legal service providers working in that space. I am sorry, I would not be able to help more particularly with those statistics. In the annual reports, the numbers of appeals in the Mental Health Court are certainly low as compared with the number of matters that are heard by the Mental Health Review Tribunal.

Ms Williams: In terms of linking to the Guardianship and Administration Act—in my day job, I am with another community legal centre as well, with ADA Law, and both of our organisations are organisations that the tribunal reaches out to, to assist people in the predicament of the vulnerable people that you are thinking about here. Often what the tribunal may consider is the appointment of a separate representative under section 125 of the Guardianship and Administration Act—appointing someone to represent the views, wishes and interests of the person and look towards promoting their opportunities. That provision has recently been updated to be better in alignment with human rights considerations. However, those roles are often not widely understood, but both of our organisations from time to time provide that service to the tribunal and that allows us to work broadly with the person's support network and look at what are the current concerns and what are the legal rights and current opportunities before the person.

Dr Phillips: If I could add one further comment to that, I think in terms of the best-interests language, there is a view that that is not properly human rights compatible language. It did exist in the act before the introduction of the Human Rights Act 2019 in Queensland. There certainly has been authority from Victoria suggesting that that language is not properly human rights compatible, and we would support that.

As legal practitioners in considering the merit and whether we consider that an appeal would, having regard to all of the circumstances, be appropriate to initiate, we certainly are focusing on the least restrictive options for our clients in the context of a regime where people are subject to involuntary treatment for mental illness. It is quite an unusual and specific jurisdiction. Involuntary medical treatment is something that does sit at odds with other health jurisdictions. Just to contextualise it, that is the really quite specific space that we are operating in.

Mr MADDEN: As a former member of the Law Society, I am always interested in the Queensland Law Society's submissions. My question relates to something that you discussed in your opening submission, Dr Thompson, and that is to do with the audio reporting and the availability of transcripts. I note that you say that you understand, from correspondence with the tribunal, that its electronic recording project is not available to progress for implementation at that time. Assuming that that is the case, I note that you point out that the Recording of Evidence Act requires all proceedings before the courts to be recorded. Are there any other instances where proceedings before courts are not recorded and transcripts are not available—mentions, callovers perhaps?

Ms Williams: I am not aware.

Dr Phillips: I am not aware.

Mr MADDEN: Everything in QCAT is recorded, isn't it?

Ms Williams: That is correct.

Dr Phillips: It is.

Mr MADDEN: Dr Thompson, I will give you the opportunity to again point out the importance of recording proceedings and having transcripts available for further proceedings.

Dr Thompson: It would be our position that this is the requirement under the relevant legislation that all courts and tribunals have a recording system in place. The Mental Health Review Tribunal should come under the same legislation as every other court and tribunal in Queensland does. I believe that the New South Wales Mental Health Review Tribunal has a system of recording and transcription in place, so we do not see why there would not be that same system in place in Queensland where it is required under the legislation.

It is, for us, an issue of access to justice, people being able to have access to the transcription so that they can initiate an appeal if they want to. We also know that you may go to one tribunal hearing and then you may go to another tribunal hearing and you will not have the same tribunal members sit on your second tribunal hearing, so to have that recording would be, we think, of benefit to the person as well as the tribunal in having a record of what has gone on before. Karen might be able to add to that as well.

Ms Williams: Yes, it certainly would promote consistency. You can imagine that it is quite stressful for a person to attend a hearing about something as private and personal as their mental illness, so they may not be able to remember and recall everything that was said. Sometimes there are quite helpful suggestions that come across. Often as human beings, we do not remember the whole lot. To have that, I think, would enable the tribunal to fully agitate the therapeutic jurisprudence. It is a space in which they occupy. It allows for fairness, justice, openness, transparency and engagement, and the ability to build on, instead of going around in circles which sometimes happens because of that lack of consistency which can be very frustrating for some clients attending tribunal hearings and wanting to demonstrate, 'I have moved on. That was an issue last time. I have done this,' building that narrative or that story about their recovery journey. It can be an impediment not having the recording.

Mr MADDEN: I must say I agree with you. I completely understand the importance of recording for all court proceedings. Thank you again for coming in today. Those are my questions.

Mr HART: Carrying on with the recording of proceedings side of things, can you tell us where does the Mental Health Review Tribunal hold its investigations? Is there a dedicated facility?

Dr Phillips: By 'investigations', do you mean hold the hearings?

Mr HART: Yes.

Dr Phillips: It is a travelling tribunal. The tribunal actually constitutes for each hearing. Ordinarily it will spend a lot of time sitting in hospitals or community health services with videoconferencing always available for those hearings where they do not have members that can sit personally. Since COVID we have certainly seen a move to almost solely videoconferencing hearings.

Mr HART: It would not be very hard to record a videoconference, though. I am just trying to get a sense of why there are no recordings. There would be no possibility of using a courtroom for something like this, with the facilities already in it?

Ms Williams: It is a lot more imposing and I think the Mental Health Review Tribunal have steered away from that. They have a lot of hearings in hospitals, as do QCAT—they have hospital hearings as well. There is transportable audio equipment that has been used by QCAT in the past, and they also rely on the Queensland Health audiovisual system which has been underway for some considerable period of time. It is quite a good system.

Mr HART: What about the Mental Health Court? Is it in the same boat?

Ms Williams: No, it would not be.

Dr Phillips: The Mental Health Court sits as part of the Supreme Court as a dedicated court within that framework. It is a different part of government, as I understand it, whereas the Mental Health Review Tribunal is part of Health.

Mr HART: Going back to QCAT—I think you said there was a seven-month delay. If it will take seven months in QCAT, do you have any other alternatives to proceed?

Ms Williams: It might be an all-up process of around seven months. I think that is the difficulty in that a lot of matters where people are suspected to have a decision-making disability or cognitive disability all track back to QCAT. That is the difficulty—just the sheer volume. I cannot quote the figures, but I am sure the Law Society could look at the annual reports of QCAT to show that annual increase in the number of applications. As people become more and more aware of the breadth of the guardianship jurisdiction, more matters go, from people with a disability, younger people and older people with an age-related cognitive condition. With the ageing population as well, naturally there are increased applications.

Mr HART: If there is a backlog in QCAT—and I understand there might be different QCAT tribunals that do different things—is there a better alternative than QCAT? This committee may be able to suggest-

CHAIR: On that, member for Burleigh, when we are talking originally about this, this was the appointment of a solicitor under the guardianship act 2000 for that one there. I do not know how common occurrence that is in these MHRT proceedings.

Dr Phillips: I would like to comment that the appointment of a guardian is an appointment of—even where it is not the decision-maker of the OPG, the Public Guardian that is appointed, the appointment of a guardian is a really significant imposition on the liberties and the rights of a person. Obviously that needs to be balanced up and considered against the value of the appointment. I would hold some concerns about a guardianship appointment made for the sole reason of initiating an appeal because even if it was limited to that extent, it still does represent a really significant infringement on someone's rights and liberties. Often a person who does lack capacity to instruct can, with some informal support, still be absolutely capable, particularly where the capacity guidelines are followed, and the care is taken to ascertain what their views and wishes are about their own treatment and about the legal options open to them.

In my view, there are less restrictive options, just keeping in line with trying to support people ultimately, to have the treatment and care that they are wanting. I think a better option would be a less restrictive one. We do have in place a piece of legislation—the Mental Health Act 2016—that is already broader in terms of its appreciation because it is a very unique jurisdiction of the circumstances in which matters can be progressed—the lack of need for formal rules of evidence. There is some departure from more conventional legal systems in that legislation, so I would certainly be supportive of a less restrictive option. It is on that basis that we have offered the suggestion that where a lawyer is appointed to act in a best-interests capacity, allowing that lawyer without the need for further formal appointments to be able to initiate that appeal would be a preferable option.

Ms Williams: If I could underscore that the current act allows for that supported decision-making approach in that under section 14, 'Meaning of *capacity* to consent to be treated', subsection 3—

A person may be supported by another person in understanding the matters mentioned …—

which is what is required to have capacity to consent—

and making a decision about the treatment.

It is that same framework of using your natural supports to assist people in coming to a view, but in a harsh technical legal sense sometimes that may not be sufficient to initiate an appeal.

Dr Phillips: That is consistent with, for example, the proposed reform as part of this bill around ECT. Lawyers do invariably take on, to the greatest extent, the views, wishes and preferences of clients in making submissions to the Mental Health Review Tribunal about what the order for a particular client should look like. We have certainly been supportive of the requirement that those views, wishes and preferences are taken into account, which is a way of further supporting the decision-making by the person who is ultimately living subject to the order. We think that would sit really well together.

CHAIR: Further questions, member for Burleigh?

Mr HART: No, that explains it well, thank you.

Mr SMITH: I have a few questions that are not necessarily related to your particular submission, but I am wondering if you could put some legal knowledge to some questions around the Mental Health Court and the process there. The first question is: how does somebody get to the Mental Health Court? There is an alleged crime. They may be charged. Is it the acting solicitor, guardians of the alleged person, or is it a claim by the alleged person? How do we get to the point where there is a charge and then we come before the Mental Health Court to make a determination as to whether or not they are fit to stand trial?

Ms Williams: I apologise in advance for probably being quite generalised. Part of the reforms of the act were enabled to allow the local Magistrates Court to have the mental health liaison services at court so that magistrates were supported by mental health clinicians to help identify at those early stages when someone was charged and first coming before the courts as to whether their particularly unique and individual circumstances may be a situation that gets referred to the Mental Health Court. That is generally what I would say. The magistrates also have power to dismiss minor charges as well. There is a lot of work done behind the scenes by mental health services in report writing, too, and there are a lot of psychiatrists who are highly skilled in differentiating person's motivations, behaviours and the like, but I really do not want to talk on behalf of that skill set. There is a lot of assistance provided to the Mental Health Court. They are supported by two psychiatrists to assist the judge in interpreting the evidence before them and the reports. It is very broad-brush, but I hope it helps in some way.

Mr SMITH: By way of confirmation, the alleged person who will be standing in the Mental Health Court to determine whether or not they are unfit for trial, they do not have to make an agreement that they do not dispute the alleged crime in terms of there is no process where they are told, 'The Mental Health Court will see whether you are fit to stand trial or not, to see whether you were of sound mind at the time of this alleged crime'; there is no suggestion that the person who is being alleged has to say that they do not dispute that they most likely committed the crime?

Ms Williams: It is usually on referral, but we have a criminal law committee within the Law Society. We are not representative of them, so maybe we could take that as a question on notice and clarify that process. I do not practise in that area and can only talk on generalist terms. It is usually a referral. There are various parties set out in the act who have the authority to make that referral or make that recommendation for referral. Sorry I cannot take that much further, but we are happy to provide that in writing.

Mr SMITH: I absolutely respect the differences there. It was more in response to the submission by the Human Rights Commission, so it is probably a question for them. Maybe, Chair, it might be something that the committee could look into. Maybe we could look to be briefed by the criminal part of the Queensland Law Society?

CHAIR: Member for Bundaberg, we can take that as a question on notice. If you would like to liaise directly with the secretariat and then we will send that out as a question on notice.

Ms Williams: I appreciate that you are wanting more detailed information than we can probably provide here this morning, so we are happy to do that.

CHAIR: That will be a question on notice. Do you have any further questions, member for Bundaberg?

Mr SMITH: They are along the same lines, so I will put some questions on notice. That might be the best way to proceed.

Mr HART: Does the Law Society have a view on the opt-in rather than opt-out model in relation to medical records that was put forward by the Information Commissioner?

Dr Thompson: We would need to confer with our privacy law committee on that question. We have definitely restricted our response on this bill to the provisions of the Mental Health Act. We are happy to take that question on notice as well.

CHAIR: Member for Burleigh, could you liaise with the secretariat for the specific form of that question on the privacy model for patient records?

Mr HART: Sure.

Mr McDONALD: My question is following up on an offer from Ms Karen Williams with regard to the response to the member for Burleigh's question. I think you said the Law Society could have a look at the annual reports of QCAT and disclose the numbers of those matters that relate to mental health issues. I think they would be worthwhile figures to get. Could you take that on notice as well?

CHAIR: Would that be something that we could do ourselves?

Mr McDONALD: It is public knowledge, yes.

Ms Williams: It would be worthwhile in terms of the line of questioning that you are relevantly interested in to have a look at year on year the growth of applications. It is a very busy tribunal.

Mr McDONALD: I do not mind how we get it. I just thought the offer was made.

CHAIR: Yes. We can talk directly to Justice and Attorney-General. We all know that QCAT is always flat out. It would be interesting to get those figures. Could you liaise with the secretariat on the specific form of that question?

On the issue of adjournments, in your submission—and we have talked about this previously—you say that the person in question would need to attend the hearing in order for the MHRT to consider that adjournment. Queensland Health said in response to this that the Mental Health Review Tribunal can consider an adjournment of a hearing 'on the papers' under section 746 of the Mental Health Act. As a non-lawyer, what specifically does that mean—that they can decide that 'on the papers'?

Ms Williams: We have referred to that process as an administrative adjournment that can be done in advance of the tribunal being constituted.

CHAIR: So only an administrative adjournment.

Ms Williams: 'On the papers' means that there is not an actual hearing, so it can be done internally with the tribunal's processes. It is something we have raised, I think as we have said in the material, with the tribunal. They consider that they have to be properly constituted as a tribunal which means that they need to sit to be able to consider the adjournment.

Dr Phillips: More broadly, adjournments are a significant issue of concern for us. Would it be helpful to briefly paint a picture of what we are looking at just so you can understand our concerns?

CHAIR: Yes.

Dr Phillips: Of the Mental Health Review Tribunal hearings that QAI does, we estimate that about a quarter of them—20 to 25 per cent—would be adjournments. I think that is consistent with statistics that we located in the MHRT annual report. Ultimately there are a number of reasons. Again, in the most recent annual report they do set out the reasons why adjournments are requested and granted. There are always going to be inevitable adjournments where the tribunal is constituted and then it becomes clear that it cannot proceed. We are not taking issue with those.

Many of the adjournments are for reasons which are known about before the tribunal actually sits. Doing that, particularly in non-COVID times, will involve the tribunal members, usually the person subject to the order—they do not always attend the hearing but they are certainly encouraged to do so—members of their treating team and their lawyer if they have an appointed lawyer all travelling to the hearing. The area that we service goes right up the Sunshine Coast, down to the Gold Coast, out west towards Toowoomba. That means people are sometimes travelling for a couple of hours by car to get to a hearing. For many of our clients who might be very disadvantaged or—and they might be if they are living in a community and the hearing is at a health service—that means travelling by bus. If you are facing a significant hearing, I think we would all be having some trepidation and apprehension about what is going to happen at that hearing.

We can expect and almost certainly guess that sometimes those hearings will be adjourned. For example, the clinical report has not been provided in accordance with the time frame prescribed by the act. That is a good example of a type of hearing where the tribunal will be constituted, everyone appears and then they will make a decision to adjourn at that time. Purely as an administrative exercise it is really messy. We have very busy lawyers trying to meet as much of the unmet demand in this area as they can. Obviously time can be freed up when hearings are not going to proceed. There is stress for the person and family members and the cost for the government of having these hearings actually begin and then only 10 minutes later to be adjourned.

Sometimes decisions, for example, about the attendance of the consultant psychiatrist will be made once the tribunal is constituted. That will result in an immediate adjournment to allow for that psychiatrist to attend. These are some of the reasons we feel quite strongly about this issue.

Ms Williams: Section 746 states—

'The tribunal may, if appropriate, conduct all or a part of a proceeding …',

so the tribunal is not in existence until it is sitting on the day. It is not clear that there is any current provision that they can sit prior or that allows for a member in a non-sitting capacity to review the matter on the papers. While it looks like there is power to do an adjournment on the papers, it is not clear that that is the case. The QCAT act—and do not ask me to quote it—has that clearly unfettered discretion to do interim orders and other matters on the papers. The tribunal has to be in existence first which means it has to sit and then all the things flow from that, as my colleague Emma has just outlined.

Mr MADDEN: I am seeking clarification. We are talking about adjourning the matter on the papers without appearances. Is it the case that what you are seeking is that it is dealt with through the registry via emails and letters that the parties agree to an adjournment? Is that what we are talking about?

Ms Williams: Yes. There are many uncontentious adjournments, but there is not a clear authority for the tribunal to have that power to do it in advance. There are practise directions about the parties communicating with each other. There is a specialist report that is still outstanding or the ordinary medical report is still outstanding.

Mr MADDEN: Just assume that there is a hearing and it has to be adjourned because a witness is not available, what you are proposing quite simply is that it be dealt with through the registry through some form of correspondence whether that is by email—

Ms Williams: Yes and then a tribunal member can oversight, 'Yes, everything is in order.'

Mr MADDEN: If there is a problem, the tribunal member can then contact the parties and say, 'I am a bit concerned about this.'

Ms Williams: Yes. 'This doesn't seem to stack up.'

Mr MADDEN: 'I think I want it to proceed on this date. I want to ask questions.' That is really what you are saying—that, to avoid the two-hour drive to a hearing, it be dealt with on the papers. By 'papers' we are saying it be dealt with on file and via some form of communication. That is technically what is meant. That is what Chris wanted to know when he asked what 'on the papers' meant. I think that is what we are talking about, isn't it—that it be adjourned without the parties needing to do a two-hour trip? They do not even talk. It is dealt with through emails where the parties are notified there is some problem and therefore it cannot proceed.

Ms Williams: Yes.

Mr MADDEN: Then of course the tribunal officer would have to okay it. In the event that they did not okay it, it would proceed.

Dr Phillips: In relation to the QCAT model, while we do have some significant concerns about some of the decisions that can be made by interim orders, the adjournment process is something we would support the adoption of—

Mr MADDEN: Of QCAT.

Dr Phillips: Yes, of QCAT. I appreciate it is simpler because ordinarily for guardianship you have one tribunal member. You have a case manager assigned. That is the point of contact. It gets signed off by the tribunal member. It can be done very simply or quickly through email correspondence, as you say.

Mr MADDEN: We are only talking about adjournments.

Dr Phillips: Yes.

CHAIR: Do we have any further questions? No. There being no further questions, the time allocated for this part of the public hearing has expired. We will communicate the questions on notice from the member for Bundaberg and member for Burleigh specifically to the Queensland Law Society. If we could have the answers by Friday, 4 February 2022, that would be appreciated. Thank you for attending today.

HOLMES, Ms Neroli, Deputy Commissioner, Human Rights Commission (via teleconference)

LEONG, Ms Rebekah, Principal Lawyer, Human Rights Commission (via teleconference)

CHAIR: I welcome via teleconference from the Human Rights Commission Neroli Holmes, Deputy Commissioner, and Rebekah Leong, Principal Lawyer. Good morning and thank you both for appearing before the committee today. I invite you to make an opening statement and then we will go to questions afterwards.

Ms Holmes: I first acknowledge the traditional owners of the land on which we meet today and pay our respects to elders past, present and emerging. I thank the committee very much for the opportunity to be heard today, particularly by telephone. We appreciate it.

I want to quickly outline the role of the QHRC and the Human Rights Act just to give you our background because we have not appeared before the committee overly frequently. As you know, the QHRC was initially established as the ADCQ, the Anti-Discrimination Commission, in 1991. In 2019 when the Human Rights Act was coming into play, the ADCQ became the QHRC. We have the functions under both the Anti-Discrimination Act and the Human Rights Act of receiving and conciliating complaints under those acts.

Under the Human Rights Act, the commission also has the function to promote an understanding, acceptance and public discussion of human rights in Queensland and to make information and education about human rights available, with the goal of building gradually towards a human rights culture. As you are aware, parliament has responsibilities to ensure that legislation that is passed is compatible with human rights. Compatibility is an assessment of whether any limitations of human rights proposed by a bill are demonstrably justified. What we see as our role is about key considerations raised by the bill and statement of compatibility; we do not see our role in this process as providing the committee with definitive advice as to whether or not the bill as a whole is or is not compatible with the Human Rights Act. In this particular bill, as we have said in our written submission, we acknowledge that many of the amendments particularly in relation to the Mental Health Act seek to strengthen human rights protections. We think they are very positive amendments.

Two of the three issues that we have raised in our submission are not directly raised for amendment in the bill. The first is in relation to concerns regarding equality and access to justice for people found unfit to stand for trial which was particularly drawn to the commission's attention back in 2016 by the Western Australian case of Mr Marlon Noble. In that case Mr Noble, who has an intellectual disability as a result of childhood meningitis, was found unfit to plead to charges and was held in prison for more than 10 years when ultimately there were limited prospects of success in securing a conviction. While it is not likely that this scenario could occur in Queensland under the Mental Health Act, it does demonstrate the possible inequalities faced by people with disability who are found unfit for trial as compared to people without disability in the criminal justice system.

The second issue we raised in our submission relates to provisions of the Mental Health Act which prohibits the publication of statements of reasons of the Mental Health Review Tribunal, appeals of those decisions to the Mental Health Court and any information that identifies a party to those proceedings unless permission has been given by the court or tribunal. While the QHRC respects the need for confidentiality of court records and certainly the right to privacy for both the patient and any victims, this must be balanced against the right to a fair hearing which includes the right for all judgements or decisions made by a court or tribunal in a proceeding to be made publicly available. This is an important component of open justice and allows for public scrutiny and awareness raising of the court process.

The third issue which we speak to in our submission is in relation to the expanded access to the Viewer and the right to privacy. The commission acknowledges the important legitimate purpose of the amendment but wishes to highlight the importance of adequate safeguards being in place to ensure rights to privacy are protected. This does not necessarily need to be through legislative amendment but through regulation, policy, training and awareness raising. They are the main issues we would like to draw to the committee's attention.

CHAIR: Thank you very much for that. In your submission you describe a potential issue under this bill as this: if there is reasonable doubt as to whether a person being assessed by the MHRT committed the offence, they may still be on a forensic order or a treatment support order or an involuntary order and they would stay under that order for that length of time. You point out that that order cannot be revoked. It can be extended. The evidence cannot be tested as in other jurisdictions. Have I got that right?

Ms Leong: I can speak to that. It is just for temporary unfitness for trial. When the Mental Health Court makes a determination of unfitness for trial, if it is a permanent unfitness for trial, they will discontinue the proceedings and they have the discretion as to whether a forensic order is necessary or not to protect against risks of harm. That is an adjudication of the facts. However, if it is a temporary unfitness for trial, that requires a forensic order or a treatment support order to be made. They can be in the community. They do not necessarily have to be a detention order in a mental health facility or in a forensic disability service. It can still have significant implications for the person's freedoms and human rights, and they will have to stay on that order—that forensic order will have to continue—until the Mental Health Review Tribunal, who reviews decisions for fitness for trial at periodic intervals, decides that the person is now fit for trial and that charge can then be returned to the court process.

There is also the limitations in the act, so after three years or seven years depending on the type of charge in question the proceedings will be discontinued at that point and then the review of the forensic order or the treatment support order can take place. I think that there is opportunity for that to happen at an earlier time. It does not have to go for the full three years. I think if at an earlier stage there is evidence that this person is not going to regain fitness for trial within the time frames then the criminal proceeding should be discontinued.

CHAIR: We are saying that when someone is temporarily unfit for trial these orders can continue for years. Is that what you are saying? That has happened in Western Australia?

Ms Leong: In Queensland that is the case. It can extend for up to three years if that person has not regained fitness within that time.

CHAIR: That is quite a long time to be under those orders. You have suggested a solution to this particular issue. I think this is what you have suggested: to test the evidence or call a special hearing so that it is resolved in a timely fashion. Have I got that right?

Ms Leong: Yes, and that is taking the experience from other jurisdictions. One thing I want to highlight here is that the Mental Health Act in Queensland is really positive in the sense that a person who is found temporarily unfit to stand trial will not remain in prison. If they are under a forensic order, the option is to detain them in a mental health facility or to have them in the community, whereas I understand in other jurisdictions if an unfitness for trial determination is made that person will remain in prison or out on bail until that special hearing is had. I think that is certainly a very positive feature of the Queensland Mental Health Act—that we do not have people with a mental illness in prisons if there is an issue of unfitness.

CHAIR: Thank you for clarifying that.

Mr McDONALD: I would like to thank Ms Leong and Ms Holmes for appearing before us. I have no questions.

Mr MADDEN: I will continue with the issue you have raised in paragraphs 13 to about 18 of your submission. As I read it, are you proposing that Queensland adopt the model used in South Australia where, where it is deemed somebody is unfit to stand trial, there is a trial where the objective elements of the offence are determined and, should that trial conclude that the charges are not made out, then the role of the court with regard to that person as far as making any orders is concerned ends. Is that what you are proposing?

Ms Leong: I think so. If the person is not guilty of the offence, if they have not committed the offence, then they should not be subject to any restrictions that a person without a disability would not be subject to if they have been found not guilty for an offence. The community safety aspects is still protected in the sense that there are still options for doctors to place people under treatment authorities to ensure that they receive the mental health treatment that they might need—but, if there was reasonable doubt that a person did not commit a criminal offence such that they are not guilty of the offence, I cannot see how a fairly restrictive forensic order or treatment support order can be justified.

Mr MADDEN: Are you aware whether how that is dealt with in South Australia is called a trial or is it called something else? If they are only dealing with the objective elements of the offence, is it still called a trial?

Ms Leong: I apologise. I could not confirm that for you. I do accept that there are issues with having that special hearing and ensuring that their rights to a fair hearing, both for the person under trial and for any victims, are still respected through that process. There are difficulties, but I guess the commission's view is that this is something that warrants further consideration.

Mr MADDEN: Are you aware of how often this is used in South Australia? Is it a rare event? Is it regularly done? Which end of the scale is it? If you do not know the answer, that is fine.

Ms Leong: No, I do not.

Mr MADDEN: That is all right. I will leave it at that. Thank you.

Mr HART: Chair, I just wonder how that works in reverse actually. If the person is found to be guilty of the charge but not guilty because of mental illness, is it a worse outcome for them? I am not sure. I really do not get this one, I am afraid.

Ms Leong: Yes, and I acknowledge that issue and that is a really good point and that is why there is a fairly complex consideration that needs to take place before we come up with an actual solution. If a person is found of unsound mind, they will still be diverted from the criminal justice system, because if they were unsound of mind at the time of the offence then they certainly should not bear criminal responsibility for that charge. So we are talking about cases where, I guess, there is reasonable doubt that they committed the offence and that they were not of sound mind at the time of the offence.

Mr HART: Who decides that? Who decides whether there is reasonable doubt without having the trial that you have to have after you decide there is reasonable doubt? It is a minefield if we go down this way.

CHAIR: I do not know what response we can get to that, so we will take that as a general comment. If Ms Leong or Neroli want to comment on that, feel free to do so.

Ms Holmes: In terms of if you are not guilty of something, as in the case of WA and Mr Noble, it was quite clear at the end of the day that he was in jail for 10 years for something that he actually did not do and when the victims grew up—it was a sexual assault charge—they said, 'No, he never did this to us.' Somehow it was a terrible miscarriage of justice where someone who had an intellectual impairment was accused of a crime and was in jail for 10 years and then it was quite clear that he had not committed that crime. That is the principle that we are talking to. If you have not actually done the crime, you should certainly not be on a forensic order for it or in jail for it. It really is just that very basic principle of justice.

CHAIR: No worries. Any further questions, member for Burleigh?

Mr HART: No, I agree totally with that. It is a minefield. I have no further questions.

Mr SMITH: I have a few questions. I suppose I might start with a permanent. If someone is found to be permanently unfit to stand trial, they are put on an order. Can I maybe get some specifics around that order? If they are permanently unfit, do they have to remain within a form of hospitalisation or a mental health facility or are they allowed to see out that order under guardianship in a private residence?

Ms Leong: Just to give you a bit of background, when the Mental Health Court makes a forensic order it has the option to either make it an inpatient order or a community patient order. An inpatient order will mean that they will have to remain in a mental health facility or in the Forensic Disability Service, depending on whether they have a mental health issue or an intellectual disability. Potentially there is no leave from that facility—they cannot leave the service—but most of the time I imagine that they would get some form of limited community treatment, so leaving the service for two hours or four hours a day with or without supervision from the nursing staff or a responsible person. Those orders are reviewed every six months by the Mental Health Review Tribunal and it is a graduated process of leave, so gradually the leave will be extended depending on the rehabilitation of the individual and the risk to the community.

The overarching goal is to have that person living in the community and eventually having the forensic order revoked. There is no barrier to having the forensic order revoked at any stage if you are found permanently unfit for trial. The test is whether there is an unacceptable—I am sorry, but I cannot quite recall the term and I do not want to lead the committee astray, but it is about risk to the community. Also, the Mental Health Court can directly make a forensic order or treatment support order that starts in the community. It does not necessarily have to start in the hospital.

Mr SMITH: Thank you. So someone who is permanently unfit could see out the length of the order until the tribunal decides that the order is no longer in need, that the person is no longer a risk to the community, but they can still be considered permanently unfit for trial without an order once the tribunal has considered that the person is no longer a perceived threat to themselves or the community?

Ms Leong: That is right. Once a person is found permanently unfit for trial by the Mental Health Court, the charges are discontinued and the criminal charges no longer exist. All that remains is if one is made a forensic order then that forensic order is then subject to periodic reviews by the Mental Health Review Tribunal which at any stage can revoke that order, but there is no end date for that forensic order or treatment support order.

Mr SMITH: In a way though, someone who is found permanently unfit for trial could be forever on a forensic order that may require hospitalisation or a stay within a mental health facility and that could effectively be an order that is longer than what a maximum sentence of the alleged crime could actually be?

Ms Leong: Yes, absolutely.

Mr SMITH: In a sense, if someone has been accused of a crime and found unfit for trial, they would otherwise not be in a mental health facility if it was not for this charge brought against them, but because they are unfit they do not meet the requirement to prove their innocence. Is that where it comes in that we might need some other form of a trial such as SA so that there is at least some form of objective overview to say whether or not this person is likely to have committed the crime or not, otherwise we put an order on someone because of an alleged crime and they are now institutionalised for a longer period than what the maximum sentence of the crime could be?

Ms Leong: Yes. I think you have absolutely identified the issue that we are concerned about.

Mr SMITH: It raises a lot more questions, but I am happy to see if anyone else has any follow-up questions to that point.

CHAIR: I suggest that when we talk to Queensland Health and the Mental Health Court that might be something we can raise in the next session. As there are no further questions, I want to thank you, Neroli and Rebekah, for helping us out today. The time for this session has expired. I do not think we have any questions on notice. Thank you very much for contributing today. This is quite a fascinating bill we have before us, so I thank you for extending our knowledge on it. Thank you very much.

Ms Leong: Thank you for the opportunity.

CHAIR: The committee will now adjourn for a short break and will resume at 11.30 am with representatives from Queensland Health for the public briefing.

The committee adjourned at 11.07 am.