HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Ms L Linard MP (Chair)
Mr MF McArdle MP (via teleconference)
Mr SE Cramp MP (via teleconference)
Ms LE Donaldson MP (via teleconference)
Mr AD Harper MP (via teleconference)
Mr DC Janetzki MP (via teleconference)

Staff present:

Mr K Holden (Research Director)
Mr J Gilchrist (Principal Research Officer)

PUBLIC HEARING—MENTAL HEALTH AMENDMENT BILL

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 24 JANUARY 2017

Brisbane

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Committee met at 8.56 am

CHAIR: Good morning, ladies and gentlemen. Before we start, can I request that mobile phones be turned off or switched to silent? I now declare open this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into the Mental Health Amendment Bill 2016. I would like to acknowledge the traditional owners of the land on which we meet and pay my respect to elders past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members of the committee present via teleconference today are Mr Mark McArdle, deputy chair and member for Caloundra; Mr Aaron Harper, member for Thuringowa; Mr Sid Cramp, member for Gaven; Ms Leanne Donaldson, member for Bundaberg; and Mr David Janetzki, member for Toowoomba South.

Today's hearing is part of the committee's examination of the Mental Health Amendment Bill 2016. The bill was referred on 30 November 2016 and the committee is required to report on the bill by 21 February 2017. The committee is a statutory committee of the Queensland parliament and, as such, represents the parliament. It is an all-party committee which takes a nonpartisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence. Witnesses have been provided with a copy of the instructions for witnesses, so we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript. This hearing will also be broadcast.

I remind those attending today that these proceedings are similar to parliament in that the public cannot participate. Members of the public may be admitted to or excluded from the hearing at the discretion of the committee. We will invite each witness to make a brief opening statement of up to five minutes and members will then ask questions. I ask witnesses to please identify themselves before speaking for the first time and to speak clearly into the microphone when addressing the committee. I also ask members on the line to please identify yourself for the benefit of Hansard.

SCHOFIELD, Mr Mark, Assistant Director, Legal Aid Queensland

CHAIR: Welcome. Thank you for your submission on behalf of Legal Aid and thank you for coming today. I invite you to make an opening statement of up to five minutes.

Mr Schofield: Good morning. Firstly, thank you for providing Legal Aid with the opportunity to comment on the Mental Health Amendment Bill 2016. As set out in the submission letter from Mr Reilly, our CEO, Legal Aid Queensland supports the new mental health legislation and the amendments contained in the bill. It is hoped that the new legislation will lead to more timely and efficient access to justice for vulnerable and disadvantaged Queenslanders. We welcome the proposed amendments to the act in this bill which attempt to safeguard the rights of mentally ill persons charged with criminal offences and encourage the proper engagement in the process, thus enhancing the prospects of a positive and just outcome for them and the community.

To clarify, at paragraph 3 of our submission letter we make reference to an inconsistency between section 180 and section 180A with respect to the admissibility of the report at sentence hearings. That inconsistency was identified in the draft amendment that was provided to our office during stakeholder consultation. That inconsistency is not present in the current bill, and there is no longer an issue with respect to that inconsistency. It has been rectified, so we thank you for that.

The amendment bill pursuant to section 180 and 180A makes inadmissible statements made by defendants and examination reports. While it is important that safeguards are in place to protect the rights of the mentally ill against self-incrimination—and that is something that our office strongly supports—there will be occasions when it is in the best interests of a defendant that information contained in an examination report or a statement made by a defendant be admitted into evidence. As an example, if a complaint is not dismissed under section 172, the person may decide to proceed to trial and run a section 27 Criminal Code defence of insanity. It may be in the defendant's interests for information contained in an examination report or statements made during a section 172

application to be made admissible at the trial. Similarly, where a complaint is not dismissed under section 172, a person may decide to plead guilty. In these circumstances, a report detailing a mental health condition may be able to properly inform the court of the relationship between the mental health condition and the offending, and therefore could be of great assistance in mitigating penalty.

As we understand the amendment bill, the statements made by a defendant and an examination report would arguably not be admissible in those circumstances. In those circumstances, where there is a known mental health condition a defendant may have to look to other ways of putting the evidence before the court—for example, obtaining a report from a psychiatrist or psychologist, and these reports are likely to have to be funded by Legal Aid or the state. The position of Legal Aid is that statements made by the defendant or examination reports should be prima facie inadmissible. However, they should be admissible at the behest of the statement maker or the subject of the report if they desire that.

The other matter raised in our submission is with respect to section 16 offences. We note that proposed section 180A(3) (b) provides that proposed section 180A(1) would not apply to offences relating to the administration of justice under chapter 16 of the Criminal Code. As set out in the submission, we submit that proposed section 180A(1) should apply to many of the offences in chapter 16. The offences that the safeguard should not apply to should be limited to those as set out in the submission. The other offences in chapter 16 are offences that could well be committed by persons who would be the subject of an application under section 172—for example, an offence of retaliation against a witness or something of that nature.

Our office set out a proposed section 180 in our submission. On reflection, one potential change to that proposal is to amend section 180(3) (d) to 'in circumstances where the statement maker or subject of the examination report consents to the admission of the statement or report' rather than using the terms I think we used in the submission of 'defendant' or 'respondent', because that would resolve the issue if the statement maker or the subject of the report is, for example, the applicant in civil proceedings or the like. Unless there is anything further in particular, that is our opening statement.

CHAIR: Thank you, Mr Schofield. Thank you for your clarifying comments in regard to paragraph (3). I had a question for you on that, so you have headed off my question in that regard. Member for Caloundra, do you have any questions?

Mr McARDLE: I do, Madam Chair. Mr Schofield, thank you for your opening statement. I did not quite catch the paragraph (3) point, but I assume that paragraph is no longer an issue in relation to the inconsistency you highlight; is that right?

Mr Schofield: That is correct.

Mr McARDLE: We had an amendment to this bill coming through that you have seen?

Mr Schofield: Yes.

Mr McARDLE: This amendment in relation to self-incrimination has taken everybody by surprise. I know that the department in its documentation makes the point that this was never raised by anybody when the bill initially was put together. What prompted the necessity now from Legal Aid's perspective to change what had been established law?

Mr Schofield: The proposed new system under the legislation, as we understand it, is to make the system more efficient and more timely. Currently the system involves a lengthy process for matters referred to as section 238 reports. It can be a very lengthy process. The idea of these changes, as we understand it, is to make the process more efficient. The only way it is going to be more efficient is if defendants are inclined to participate in the process, because the reality is that it is an opt-in system. Defendants will be reluctant to participate, in our view, unless there are safeguards in place. With safeguards in place, it is our view that people will be more inclined to engage properly. That will lead, we think, to a better outcome and a more just outcome for them and the community. It is always of concern for our organisation that people's rights against self-incrimination are safeguarded, so our office is keen to protect those rights always.

Mr McARDLE: Legal Aid appears in many jurisdictions across the system. On how many occasions on a yearly basis—and you may need to take this on notice—has Legal Aid been involved in a matter where such reports are required and/or tendered to the court?

Mr Schofield: Reports where Legal Aid would attempt to obtain some sort of psychiatric evidence for a client?

Mr McARDLE: Correct.

Mr Schofield: I would have to take that on notice. I could not give you accurate numbers, other than to say it is something that is not infrequent.

Mr McARDLE: I am trying to gauge the expertise of Legal Aid for the committee in relation to matters of this nature where reports are obtained that gives credence to the background of the statement. The other point I want to raise is: in your amendment you still pursue the issue of the person having the right to consent to the admission of the statement?

Mr Schofield: Yes.

Mr McARDLE: To me, it seems that it is all one-sided. We have an amendment here that protects from self-incrimination but then gives the defendant—I will use the word 'defendant' if you do not mind in this case—the right to waive that but no right exists in relation to the Crown and/or the court. You are saying, 'I want the protection but I alone have the right to waive that protection.'

Mr Schofield: Yes.

Mr McARDLE: Can you rationalise that for me, as to why one person should have that right?

Mr Schofield: As I indicated earlier, it is an opt-in system. A defendant agrees to participate in the process and the process, as I understand it, is designed to make the system more timely, more efficient and save cost. If a defendant is not afforded these protections, we think that a likely result is there is not going to be an uptake by defendants. They will not want to participate in something when they are advised that anything they say to a psychiatrist could potentially be used against them, so I think the safeguards are important. Likewise, if something that can assist the defendant's case comes out of these evaluations, we are of the view that that is something a defendant has the right to use if it assists them. If they are not able to, the reality we think is that they will be forced to go away and obtain that information elsewhere, and the concern is that obtaining that information elsewhere will involve expense to the community or the defendant.

Mr HARPER: I was hoping I would get a bit of clarification from the lawyers on the non-government side. To carry on from what the member for Caloundra was discussing in terms of the opt-in system—that evidence should be admissible if the accused person consents to its admission—you said in your verbal submission that statements made by the defendant should be admissible but only at the behest of the state.

Mr Schofield: Sorry, if I said that I meant at the behest of the defendant.

Mr HARPER: I may have written that down wrong.

Mr Schofield: I may have said it wrong.

Mr HARPER: Are there issues around the cost of reports by psychologists and psychiatrists? Were you alluding to that?

Mr Schofield: What I was alluding to is that it may be that allowing a defendant to use information obtained through an examination report has the potential to save cost because, rather than going away and obtaining independent evidence that there is someone who suffers from a mental health condition and it is relevant to either their trial or their sentence, the defendant can just use the information that the state has already paid for by way of an examination report or feedback to the magistrate from a mental health nurse or the like. They can use that information to assist them, rather than having to go away and obtain that same information by way of a different process.

Mr HARPER: Thank you very much for that.

Mr JANETZKI: I want to ask a question on the amendments to section 180. In Legal Aid's experience representing people who have undergone a mental health assessment or examination, how often would Legal Aid see statements or findings that have been uncovered during a mental health assessment or examination used against them in a subsequent criminal proceeding? How often that does that happen in practice?

Mr Schofield: The system we are discussing now has not commenced. The ordinary case is that if you have a client that you believe requires assessment the lawyer engages a psychiatrist or psychologist—whichever is appropriate—to assess the person for a forensic psychiatric report. In terms of any statements made to the psychiatrist or medical professional in those circumstances, legal privilege attaches to those discussions. Nothing said to a psychiatrist or medical professional in those circumstances can be used against them, because the medical professional has been engaged as part of the preparation of their legal defence.

Mr JANETZKI: Another submitter to the committee has discussed and raised how these bill's amendments would draw us into line with other jurisdictions in Australia. Do you have any comment on the law in other jurisdictions, in your experience of it?

Mr Schofield: I am sorry, I could not comment, unfortunately, on the other jurisdictions. I would have to take that on notice.

CHAIR: Given that members have no further questions, I thank you very much, Mr Schofield, for appearing today, answering our questions and assisting with our inquiry.

Mr Schofield: Not a problem. Thank you.

THOMAS, Mr Barry, President, Mental Health Review Tribunal

TROY, Mr Robert, Executive Officer, Mental Health Review Tribunal

CHAIR: Thank you for coming before the committee today and assisting us with our inquiry. Would you like to make an opening statement of up to five minutes? Then we will open for members to ask questions.

Mr Thomas: Thank you, Madam Chair. The submissions from the tribunal are based on the tribunal's obligation to discharge its duties in a timely and economical way. They are mainly directed to attempting to see that patients are not disadvantaged by administrative barriers. If they are clinically well enough to be discharged from a hospital, they should not be detained awaiting a tribunal hearing for a change of category or something like that.

Further, if a hearing has already been organised and planned, it should perhaps proceed rather than be cancelled at the last minute because a person has been discharged from a hospital or gone missing. Australia Post is slow. Not all patients have access to email. Notices may not get through to various people. They will still perhaps attend at the hearings. Interestingly, even patients who have gone absent will sometimes attend their hearings because they wish to argue that they should not be on the order. When a person goes absent, there is of course a need to look at the risk that has been posed as they have dropped out of treatment, and it may be appropriate to change their category or to take away some limited community treatment that they have. Having the matter automatically adjourned takes away those protective steps that might be taken. Thank you.

CHAIR: Thank you very much. It appears to me that many of your suggested amendments or comments do not directly relate to the amendment bill before the committee, which is very focused, in regard to some of the issues and where those issues have arisen. Could you give me the benefit of understanding the context of some of these amendments? Were these amendments that you raised during the initial consultation on the broader review of the act?

Mr Thomas: A number of them were. Certainly the one about the notice in relation to children is something that came out of a recent situation. There have been ongoing discussions about how the system will interrelate. As we work down into the day-to-day planning for hearings that will be starting soon, there are obvious situations where there might be barriers to the less restrictive option coming out for the patient. We are drawing attention to them in the hope of achieving the best outcome for patients.

CHAIR: You are referring to 2.7 in your submission around the provision to allow notification of child safety risks to the department of child safety?

Mr Thomas: Yes.

CHAIR: I was interested in that. Could you speak to that—what arose and why it is suggested?

Mr Thomas: One of the factors in the tribunal reviewing any order is an element of risk. Sometimes the risk as assessed by the tribunal members is different to that as presented by the clinicians. In this particular case, a patient was indicating that they were going interstate to have custody of their children during the school holidays. The treating team did not appear to have connected into that, that perhaps the patient was not as well as they could be, and had not engaged with children's services. That was then taken up with the team and the point was made, but there is always that chance that where you have a mobile patient cohort there may be situations where really urgent information has to get through and perhaps the members of the treating team either are not connected to that or are new to the process. Having that second layer of members being able to bring it to the president's attention to contact the department, either here or interstate, might be a process of providing another level of child protection. It is not envisaged that that would be used often.

CHAIR: The submission suggests that if a patient is absent without authorisation the hearing should still take place. From a layperson's point of view, is that a common occurrence? Also, does that perhaps not provide the patient with an appropriate chance or opportunity to be present at something which is very important to them? Could you speak to that?

Mr Thomas: Yes. Our proposal is that if the patient has gone absent within 28 days of the scheduled hearing then the hearing should go ahead. As I said before, the issues that have to be looked at are matters of risk. If that patient was on either a treatment support or order or a forensic order, that would have come out of some previous criminal charge that the Mental Health Court had dealt with, so there are demonstrated risk issues when this person becomes unwell. If they have gone absent then they have dropped out of treatment. Those risk issues come into sharp focus. To stop or adjourn the hearing means that their category cannot be changed, their limited community treatment

cannot be changed and it might be more appropriate for them to then be changed to the category of inpatient or to have certain limited community treatment restricted so that when they are in contact with a clinical service, either here or interstate, that is the decision that service will operate on, rather than 'this person has been approved to be in the community', so they are then brought back to treatment where they can properly be assessed about the risks, having dropped out of treatment for who knows how long.

CHAIR: What safeguards do you envisage could be placed around that if somebody is absent? How we define 'absent' is obviously a question. What steps are taken to ensure they are found, identified or located, just to ensure the rights of the patient are also protected in these situations, because obviously they are quite vulnerable as well?

Mr Thomas: Yes. The patient is already on an authority or an order that requires them to attend and take treatment. Therefore, they have chosen to not comply or have been so unwell that they have not complied with those orders. Included in that is of course the element of community protection. Notices are sent to the patient's last known address. If the patient, knowing they are on an order, then chooses not to engage in the process, they have willingly withdrawn from the process. Where they are located after an absent without approval notice and brought back to the service, the hearing has to get on within 21 days, so they can immediately do it. As I said, we have had patients who are absent attend their hearings because they get their notice and they want to argue that they should not remain under the order.

Mr McARDLE: Gentlemen, thank you very kindly for your oral submission today and for the written document. Taking up the point raised by the chair in relation to your submission, I want to go back to the initial review of the Mental Health Act. There were two bills before the House. Looking at the web, I do not see the tribunal making a submission to either of those bills when they came before the House and/or the committee. Am I wrong in that?

Mr Troy: We made submissions to both bills. The most recent submission, to the 2016 bill, was taken down off our website once the bill was introduced to parliament.

Mr McARDLE: I am just looking at the website for the committee. Did you make a submission to the committee or to the government?

Mr Thomas: To the government.

Mr McARDLE: You did not make one to the committee?

Mr Thomas: No. We have only made a submission to the committee on the amendments that are currently here.

Mr McARDLE: Given the relevance of the tribunal and the importance of the two bills, is there any reason you did not make a submission on either of those bills except to the government but not to the committee?

Mr Thomas: We had put in a comprehensive submission. There had been, as you said, two bills discussed so there were those submissions available. Apart from that, no, there was no particular reason that we did not then come to the committee.

Mr McARDLE: Were the points you raise in your current submission to the amendment bill contained in the submission you put to the initial two bills or one of the bills?

Mr Thomas: A significant number of them were. I would have to perhaps take it on notice to indicate every one of them, but there were ongoing discussions about the practical effect. Certainly, having criteria for the step-down process between a forensic order and a treatment support order was raised. Some of the perhaps more mechanical processes may not have been as clearly spelt out as they have been in our recent submission.

Mr McARDLE: I note that the memorandum that accompanied the amendment bill refers to the Court Liaison Service Steering Committee. A number of bodies are on that committee but the tribunal is not. Do you feel that there is a role for you on that committee?

Mr Thomas: We do not have any direct contact with the Magistrates Court process. Whilst I have had discussions with the Chief Magistrate, I do not know that there is a lot of role for us to be in that area of jurisdiction. We receive material from courts rather than precipitate things going to courts.

Mr McARDLE: You do not think the tribunal would have a role to assist other jurisdictions in relation to the bill being implemented?

Mr Thomas: As I said, I have had discussions with the Chief Magistrate at meetings but not on committees.

Mr McARDLE: You would be reluctant to comment about proposed section 180 in relation to self-incrimination issues?

Mr Thomas: Yes. It is, I suppose, best left to those who need to make the decisions as a policy issue.

Mr McARDLE: Looking at the content of your submission to this bill, and accepting that all amendments have an important role in relation to the effective operation of any act, are there particular areas that are of enormous concern to the tribunal when I read your submission?

Mr Thomas: The criteria for step-down I think is a significant step. Essentially, the same test is applied to a forensic order as to a treatment support order. If you satisfy one, why do you not satisfy the other? Even a few criteria that focused on the unacceptable risk of an event—like the index offence has been addressed. There are other concerns of a lasting nature such as ongoing substance or alcohol use, lack of compliance with medication—just a definition of those sorts of things. Many a person on a forensic order, by the time they have been in treatment for many years, would not satisfy the criteria of a treatment authority, so the step-down allows exactly what it says: a person not to have as strict oversight but a recognition that their understanding and behaviour are not at a level that the community would be comfortable for them not to have some oversight by the mental health service.

Mr McARDLE: Gentlemen, are you prepared to table a copy of your submission to the government on the first two bills?

Mr Thomas: Of course.

Mr McARDLE: Madam Chair, I seek leave for the report to be tabled.

Mr Thomas: I do not have both copies with me.

Mr McARDLE: No, in due course. You can do it within seven days, or whatever the case may be.

Mr Thomas: Certainly.

CHAIR: Thank you, member for Caloundra. I take it that was your last question?

Mr McARDLE: I seek leave for the submission by the tribunal to the first two bills to be tabled.

CHAIR: Member for Caloundra, Mr Thomas says he does not have it with him, so we will essentially leave it with him as a matter taken on notice.

Mr McARDLE: That is okay?

Mr Thomas: Yes, certainly. I will have it.

Mr McARDLE: Thank you very much.

Mr HARPER: Thank you, gentlemen, for your submission. In regard to patients with untreatable medical conditions such as dementia and those with an intellectual disability whose conditions have resulted in offences for which they have been found to be permanently unfit for trial, your submission suggests that they should not be placed in an authorised mental health service unless that mental health service can provide treatment for them. Are such patients currently being placed in these facilities?

Mr Thomas: Quite a number are.

Mr HARPER: What impact is this having on those patients?

Mr Thomas: I regard it as distressing. It is quite negative for a patient who may have an intellectual disability, or be in a state of dementia, to be held in a ward with some very mentally unwell people. It is bad for the inpatients with mental illness where they might have somebody who is physically well but has an intellectual disability and perhaps an undeveloped sense of control over their sexual urges so that they could become a danger to other patients. People with dementia are extremely vulnerable. They are also in a situation where there may be high expressed emotion around them. The staff, whilst being very caring, may not be skilled in the area of intellectual disability in particular and so they get quite frustrated at the process of having someone in their bed who they cannot treat in any way that they are trained. I believe that there is a crying need for other forms of accommodation for people who really do not have a treatable mental illness and that the end of the line should not be a mental health ward.

Mr CRAMP: Thank you, gentlemen, for your submission and for being here today. I have a question about 2.8 of your submission in regard to patients waiving their right to legal representation.

Mr Thomas: Yes.

Mr CRAMP: You suggest that patients should have the right to orally waive their right on the day of the hearing, subject to their capacity. Before I go further, do you want to put anything further to that? If we are already assessing a patient, including their possible mental illness or other mental incapacities, should we be relying on an oral statement on the day of the hearing when there is already pressure, or where there would be perceived pressure, on them, being the subject person, to not want to even be there? I am just wondering about the clarity of their thoughts on the day to be able to say, 'No, I don't want legal representation.'

Mr Thomas: There is an enormous range of people. Legal representation has to be provided under the act to people receiving electroconvulsive therapy. You will have people who are almost non-communicative and very clearly lacking capacity. You will have people who are manic and, again, fairly obviously in a state where they could not make that decision. You will also have situations where a treating psychiatrist might believe that the person possibly has capacity but they are referring them to the tribunal to ensure probity in the decision-making so that they are not just taking it for granted that the person has capacity. The tribunal will do the assessment and might well refuse the application on the basis that this person has the capacity to make the decision and therefore they should be the decision-maker, not the tribunal. Someone like that would have capacity to then talk with their lawyer and say, 'I don't want you here,' or, 'I don't need you here.'

In other situations it would be a forensic patient, where the Attorney-General is choosing to appear. They may be, again, in that whole range of mental illnesses—from extremely unwell to very stable and having been stable for years in most circumstances—and, again, could form a view whether they had capacity. One of the tests in the forensic area is not whether the person has capacity; it is about unacceptable risk from their mental illness on those occasions that they may either naturally get unwell or be noncompliant or take substances, or the whole range of things that could contribute to their becoming unwell and perhaps potentially very dangerous but, in the good times, they are right.

Mr CRAMP: I am more concerned about the fact that I would assume—and please correct me if you think differently—a person who would seek to waive their right to legal representation regardless of their capacity would be more, I believe—and this is where I would like your input into this—inclined to make a reasonable and sound decision prior to the day of the hearing. The fact that they have to put it in writing means they have the time to seek advice and to have a think about it, whereas on the day of the hearing, when emotions are heightened—they are probably receiving advice already, or they are speaking to people—they may make a decision that will impact on their right to justice by the fact that they suddenly feel under pressure and make a rash decision and waive their right to legal representation. What is your feedback on that? You do not think their capacity will be any less reasonable on the day of the hearing, when their emotions are already heightened?

Mr Thomas: I do not know that you can have a one-size-fits-all approach. What we are suggesting is that the lawyers who are engaged in the process have to go through their usual ethical decision-making about, 'Does this person have capacity to give me instructions or are they being overborne by the pressure of the situation?' Remember, we do hearings in 70-odd venues around the state and we will not necessarily have the lawyer there in person as much as we would like to. There will be telephone conversations to take instructions and people appearing by videoconference at hearings and through various other forms of communications. On the day, you will then have a situation perhaps where a patient who has capacity, who says 'I don't need anyone to talk for me', is appearing and then their lawyer, who has been refused instructions, is also appearing for them, which sets up a dynamic—and perhaps a stressful dynamic—in the hearing as well.

Mr CRAMP: I have previous experience in representing people in a whole different setting, in industrial relations. I know that people think a lot more clearly in setting out instructions prior to a matter being heard as opposed to on the day. I just find it difficult to believe that a person of a sound, unquestioned mental capacity, would not find it difficult to think clearly on the day, let alone a person with potential mental issues and illness.

Mr Thomas: Yes.

Mr CRAMP: That is okay.

Mr Thomas: Thank you.

Mr JANETZKI: I want to go to clause 2.7. Child safety is a topical issue in Queensland at the best of times.

Mr Thomas: Yes.

Mr JANETZKI: Could you expand a little on the amendment you propose? Also, could you expand on the lines of communication between the tribunal and the department of child safety under the current legislative framework?

Mr Thomas: There are none under the current legislative framework. Our communications about child safety usually come in the form of in the hearing. An issue will come up. Obviously, treating teams are looking at that, but often what they are looking at is whether the person has the care of a child or, if there are forensic matters that have sexual offending against children, whether they have noncontact with children. They also recognise that, for many parents with mental illness, the care of their child is an enormous benefit to them and it is certainly nothing that people want to take away.

What we are envisaging is that, in situations where the tribunal sees evidence that it believes indicates that a child may be at risk and that the treating team does not seem to be taking that on, normally if they report that to me I would phone the clinical director of that service and say, 'You have X patient. There are concerns about the situation of child safety. Could I ask you to take a look at it?' That may be enough, but in the situation that we saw the patient was going interstate on holidays. There is not really any process under the legislation to look at breaching confidentiality in those ways to pass on information that 'there is a concern here that this person who is less well than they might be, but still in the community, is going to go interstate and may have unregulated custody of a child'.

Mr JANETZKI: Outside of this submission, have you raised those concerns with the department?

Mr Thomas: With the department of children's services—Child Safety?

Mr JANETZKI: Yes.

Mr Thomas: No. We have acted consistent—

Mr JANETZKI: That is all, Madam Chair.

CHAIR: Thank you very much. There being no further questions, can I thank you both again for attending today, for your submission and for assisting us with the inquiry.

Mr Thomas: Thank you.

ALLAN, Associate Professor John, Acting Executive Director, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

SHEEHY, Mr Paul, Mental Health Act Implementation, Queensland Health

CHAIR: Thank you both for coming. The timing of your coming before the committee serves a number of purposes. We have not yet had an opportunity to be initially briefed by the department on the bill before the committee. Of course, as you are coming at the end of our public hearing, that also assists to clarify matters and submissions. I also appreciate that you will be giving a written briefing, but thank you for coming today. I offer you the opportunity to give the committee an opening statement in regard to the briefing and then we will open for questions.

Prof. Allan: Thank you. I am the Acting Executive Director of the Mental Health, Alcohol and Other Drugs Branch. My substantive position is the Chief Psychiatrist. Chair and members of the committee, thank you for the opportunity to brief you on the Mental Health Amendment Bill 2016. As you are aware, if it is passed this bill will amend the Mental Health Act 2016, the Public Health Act 2005 and, consequentially, the Coroners Act 2003.

I will briefly outline the specific amendments before I answer any questions that you might have. I will concentrate on the admissibility of statements made during an assessment or an examination. The significant amendments to the bill relate to the framework established under the Mental Health Act 2000 that provides for persons with a mental illness to be diverted to appropriate treatment and care if required. Under the Mental Health Act, if a person is charged with a simple offence and the Magistrates Court is reasonably satisfied that the person was of unsound mind at the time of the offence or was unfit to stand trial, the magistrate may dismiss the charge or adjourn the hearing of the charge.

In deciding these matters the Magistrates Court will be supported by the Queensland Health Court Liaison Service. This service consists of senior mental health practitioners and psychiatrists who will assess the person's mental state and provide an assessment report to the Magistrates Court. These amendments make clear that oral and written submissions made by a person during these assessments will not be admissible in evidence against the person in any criminal or civil proceeding.

If a Magistrates Court dismisses the charge due to a finding of unsoundness of mind or unfitness for trial, or adjourns a hearing because a person is temporarily unfit for the trial, the magistrate may make an examination order in relation to the person. Alternatively, the magistrate may make an examination order on the basis it would benefit the person even without dismissing or adjourning the charge.

In making the examination order the magistrate must be reasonably satisfied the person has a mental illness or must be unable to decide whether the person has a mental illness or other mental condition. An examination order requires a person to be examined by an authorised doctor, an authorised mental health service or public sector health service facility. The purpose of this examination is to determine whether the person has mental health treatment needs.

The amendments make clear that oral or written statements made by a person during an examination conducted pursuant to a magistrate's examination order are not admissible in evidence against the person in any criminal or civil proceeding. The amendments further clarify that examination order reports may only be used to assist the Magistrates Court to decide whether to make another examination order or to refer the person to the Mental Health Court. The amendments do not change the ability of health practitioners in clinical settings to disclose examination reports to other health practitioners so that appropriate treatment and care can be provided to the person.

Just to clarify the technical amendments, you will note that they only contain very straightforward and minor amendments intended to improve the operation of the new Mental Health Act. I may be very broad in my statements about these amendments and I am happy to answer any questions on any specific amendments. As you are aware, the Mental Health Act is a significant act. It is not unreasonable or unexpected that opportunities for minor improvements were identified by the department and stakeholders involved in the planning for the implementation of the act.

If passed, the bill will make clarifying and technical amendments to the Mental Health Act and also the Public Health Act. These amendments can be categorised in the following ways: clarification of wording to ensure effective implementation; adjustments to ensure processes can operate effectively and efficiently; and technical amendments to strengthen the underlying purposes of the act. The department has provided the committee with a detailed summary of these amendments in

its written briefing to the committee and these amendments are straightforward and will ensure the success of the Mental Health Act when it commences. I would be very happy to answer any particular questions that you might have.

CHAIR: Thank you for that. Have you had the opportunity to read the submissions that the committee has received?

Prof. Allan: Yes.

CHAIR: There are a number that raise concern about time periods and whether those time periods will actually be able to be adhered to in regional and rural areas. Can you provide comment in regard to that?

Prof. Allan: There are two aspects to time periods. One is around the notification and passing of information from one place to another. As we have an electronic record system, CIMHA, one of the improvements in the act will be that many of the forms, much of the information, will be able to be entered directly into that information system by clinicians so there will not be passing forms back and forth. In fact, that communication is fairly rapid.

The other issue is around time frames for examination and so on. Firstly, we think those can be met. There is a good enough network through our telehealth system and through the network of clinicians that we can meet the time frames in terms of the days for reviews of hearings. You are probably referring to some of those things about the length of time a person can be held and examinations made, so the six-hour period and the extension to 12?

CHAIR: Yes.

Prof. Allan: We think that is reasonable given that we will have authorised mental health practitioners available for most of those. Where it is an authorised mental health service, there will be doctors and other mental health professionals who are authorised mental health practitioners. We anticipate under the act there will be about 1½ thousand authorised doctors. In the current act there are around 3,000 authorised mental health practitioners, so there are quite a number of people on the books who will be available to do that.

Secondly, where it is required to have a doctor, the telehealth facilities, with the assistance of the people on the ground, we think we can meet those time frames. We came to those really because people have a right to get seen. We need to resolve matters. However, with the six hours there may be complicated issues. It is probably not about getting the doctors or the nurses to the point; it is often about collecting enough information for that person to make a reasonable decision. If we have to contact a relative or a GP or get other information, we need that sort of time to do that as well. Essentially, we think the 12 hours is reasonable because that allows that particular working day to come to some kind of reasonable assessment.

CHAIR: Thank you. You would have heard representatives of Legal Aid Queensland speak earlier; I believe you were in the room for that. They raised the point that they felt evidence should be admissible if the accused person consents to its admission. What is the department's view on that?

Prof. Allan: I think I heard them also say that this system, in particular the Magistrates Court, has not happened yet. In general, our position is that those services that we provide—the Court Liaison Service—are about giving clinical information to the court about the person's fitness for trial and their state of mental health at the time of the offence, to give the magistrate some indication. They are also about whether the person has any immediate or pressing treatment needs so that we can divert the person away. We are not really looking to provide in-depth legal reports at that particular time; we are looking to assist the person and assist the court rather than construct quite lengthy reports about particular aspects of cases.

From our point of view, this is really clinical material. As such, we were not intending that we would brief them in particular ways about the sorts of privilege that come when a psychiatrist conducts a psychiatric report at the instruction of their lawyer. We see this as a more practical event. That can be diverted and that can be done in a different place, but I do not think it is its primary service.

CHAIR: I take your point that it is not its primary purpose but, given that information can be shared from one health professional to another, obviously the information is important and would be useful. Would there be any reason, if it was deemed useful, they would not be allowed to elect to use that information? I appreciate that the department is still providing its response to those submissions. I am just wondering if there would be any obvious reason to not.

Prof. Allan: Sometimes I think we want people to be fairly forthright in discussion of their mental state. That would probably mean things like their previous criminal record, how other offences have been affected by mental illness, for example, and particularly what they were doing and feeling at the time. My personal experience in this matter is that often people will tell the psychiatrist things

that they do not really want to be heard in court. Having that down on paper can be quite compromising. Wanting to do it first and having good advice to do it I think are separate. It all gets a bit confused. I think they are separate. I would like to have a bigger think about that from that submission.

Mr Sheehy: I make an additional observation, which we can include in our written response. Section 180A talks about this material not being used in evidence against the person. I am not quite clear under what circumstances an individual would wish to present information to a court that was against their interests. We will have a bit more of a look at that and respond to that in our written submission.

CHAIR: Thank you. I would appreciate that. Also with regard to the Mental Health Review Tribunal—you heard my comments earlier—there is a lot of additional commentary there or suggested amendments which to my view are outside the terms of what the department has brought forward, which seems to be some of these more minor matters that have come up during implementation. Does the department have a view on these matters? Have they been previously considered? I appreciate you are probably going to provide us with a more fulsome response in writing but I am interested in your comments in regard to that.

Mr Sheehy: I can make a few observations. There were some matters that were raised in the review of the act. All of those views were taken into account at the time. The tribunal has been fully involved in and consulted on this amendment bill. Some of the provisions in the bill were done at the request of the tribunal and the tribunal was satisfied and supported the amendment bill in its final form. We have seen, I guess, a mixture of issues. As I say, some are historical issues that were raised previously. There were a couple of issues that were raised and discussed in the context of this amendment bill and then there were other issues which to my knowledge have not been raised previously.

CHAIR: The committee did a significant review into the two mental health bills. It was a large process and exercise and I appreciate that it was similarly for the department, so my questions are more around how broadly we are revisiting that act and, not being a practitioner in this area, how vital these particular amendments are and what sorts of issues they can create in the system. Of course, we depend on the advice of the department in that regard.

The deputy chair asked the president of the tribunal which of these matters were the most important to them or which were the key issues and he mentioned this step-down process. Does the department have any comments to make in regard to that, just to assist the committee to understand?

Prof. Allan: The step down from a forensic order to a treatment support order is meant to be part of a process of helping people to get off the forensic orders, to be less restrictive and then to allow usually community based treatment rather than inpatient treatment. There is less review. We have set up a forensic patient policy, which includes the treatment support orders talking about the types of review and expectation of services that would happen. That is a set of Chief Psychiatrist policies under the act.

In terms of providing further guidance, this is a new provision. The decisions are actually made by the tribunal so, from our point of view, we have given the policy but it will sometimes depend upon the way the tribunal makes particular decisions as to how it does things. We are happy to provide further guidance, but I think this is a matter for policy rather than a matter for the bill.

CHAIR: Thank you very much.

Mr McARDLE: Thank you, gentlemen, for your submissions today and written documentation. I think it was Mr Sheehy who raised the issue of the word 'against' in relation to the report. You are quite right. The phrase 'against the person' in section 180A could give rise to some real debate as to what those words mean in the context of a full report and, more importantly, which particular provisions of a report fall under that term that could raise some very serious legal points that could go on appeal. I think you said you might look at that again because it does appear to be a little ambiguous as to the intent of the amendment to protect from self-incrimination, but then those words tend to allow a breach of that principle; is that what you are saying?

Mr Sheehy: As I say, we will have a look at that in our response. The words, to the best of my knowledge, would be standard words of this type in legislation and it would be a matter for the legal system to then apply them in practice on a case-by-case basis.

Mr McARDLE: I appreciate that, but you would also agree that the amendments are to prevent self-incrimination. The text and feeling of the memorandum that accompanied the bill into the House was to not allow these documents to be used at all, but the wording there raises a concern as to the extent of that principle enunciated in the bill being applied in practice. Would you agree with that?

Mr Sheehy: Because the issues have come up fairly recently, I would have to take some quick advice and get back to the committee in our written response.

Mr McARDLE: The Legal Aid office in its submission made it clear that there was an amendment to section 180. The amendment does not deal with that particular point that you raised earlier.

Mr Sheehy: It is my understanding, based on their evidence this morning, that the written submission from Legal Aid was referring to an earlier draft which made a reference to sentencing, which is not in this bill. It related to sentencing; it did not relate to this issue around admissibility against a person.

Mr McARDLE: Their letter does not relate to the bill we have before us now?

Mr Sheehy: From the information they gave this morning for that one issue around a reference to sentencing, I believe that is correct: it does not relate to the bill before the House.

Mr McARDLE: Okay, that is fine. In relation to the Court Liaison Service, the minister stated in his speech when introducing the bill 'to undertake mental health assessments for the purpose of assessing fitness for trial' et cetera. How does that body intend to work on the ground, in practice?

Prof. Allan: The short answer is that they will work in conjunction with the court officers to identify particular people from the list who they know are existing patients or the court has thought they might seek particular advice about. Those people will then be offered a screening and offered an opportunity to participate with a report. They will participate in that on a voluntary basis. Of course, a person may enter a court and the magistrate or the lawyers might decide that they would like to have that examination done, so they will then refer the person. There is a bit of anticipation in doing that. The initial examination will be done by a senior mental health practitioner, so that will be a senior nurse, a social worker or a psychologist. They will be under the supervision of a psychiatrist. Generally, the reports will be reviewed by the psychiatrist and submitted to the court. Where necessary, there is an opportunity for the psychiatrist to see that person. That may require a couple of hours or a one-day adjournment. We are hoping to resolve all matters either on the day or the next day, to provide those reports, but it depends on—

Mr McARDLE: If I had a client appearing before the court and I was concerned about their mental capacity or fitness for trial, I might ask the court for a referral to the CLS?

Prof. Allan: Yes.

Mr McARDLE: Do you think it would then take about a day to have that assessment undertaken? If that is the time line, just run through again the step-by-step process that a person who is referred goes through to get a report prepared and tabled back with the court.

Prof. Allan: In that process the person is referred, as I say, either from the list or from the court. During the normal court hours in the larger metropolitan courts and larger regional courts there will be somebody there and they will be then able to see that person in a short space of time. The examination will take half an hour to two hours, depending upon the particular nature of the event. We are really looking at under an hour, because it is not absolutely complete with everything. There is also an issue of checking other databases, checking with family, other collateral history and then preparing the report. There will be some sort of standardised formats for that as well, rather than just creating a large Word document. That will be checked by that system and, if referred in the morning, could be ready for the magistrate that afternoon.

Mr McARDLE: Let us look at a regional court. The chair raised this point. There is always going to be a question of bail applications as well. The bail expires when the accused appears before the court, or they may make application for bail on the day. If the report cannot be prepared and the application to the court is that this person may be of unsound mind, what happens with bail if you cannot get it done in the one day?

Prof. Allan: Those are the decisions for the magistrate to make.

Mr McARDLE: I accept that. Is there anything that the CLS would say to the court, such as, 'If you are considering bail, it will be take longer than one day and these are the matters that we recommend you take into account'?

Prof. Allan: We are not necessarily providing a specific report about bail. We are providing a report about unfitness and unsoundness and general mental health issues. The court could bail the person and the report could continue the next day. That would actually be something that might work for many people. We do not have a particular view about whether they should be in custody or not in custody.

Mr McARDLE: Neither do I, by the way.

Prof. Allan: I understand your point. If it is coming down to that point, I think the magistrate will have other material to help make a decision about bail. That will be around reference to the Mental Health Court and the particular charges. The workings of the court will proceed.

Mr McARDLE: Clause 3 refers to being detained under an examination authority. It details that you can be detained for up to one hour if it is not an authorised mental health service and from six hours to 12 hours if it is. When is the person deemed to be detained and when does that timeline commence?

Prof. Allan: In that instance, that one hour is about when the person is told that they are detained—when the officer makes the decision that that is what they should do. Then they arrange transport to an authorised mental health service.

Mr McARDLE: When you say the officer makes a determination, can you define who that person might be by way of qualifications or status within an organisation?

Prof. Allan: That would be an authorised psychiatrist, authorised doctor or authorised mental health practitioner.

Mr McARDLE: If it is a non-authorised mental health service they can be detained for only one hour, as I read the provisions lodged with the bill under clause 3?

Mr Sheehy: That is correct. It could be circumstances where the doctor or authorised mental health practitioner is going to someone's home and in those circumstances the period of detention should be quite limited. If it appeared a more detailed examination was required, that is when the person could be transferred to an appropriate facility, an authorised mental health service or a public sector health service facility.

Mr McARDLE: What is the process whereby a person knows that they are detained? Is a document handed over? Is a verbal statement given? Does it occur after an examination is complete or when the examination commences?

Mr Sheehy: Under the act, there are a series of requirements. The doctor or authorised mental health practitioner must advise the person straightaway as to what is happening. That is spelt out in the act. If the person wishes to see a copy of the examination authority, they can request that as well.

Mr McARDLE: I was not involved with the committee at that stage. What section of the act are we talking about?

Mr Sheehy: It is section 35 of the act.

Mr HARPER: I was going to ask about emergency examination orders precluding those people who were detained for one hour or six hours. Can you speak to that first?

Mr Sheehy: Could you clarify the question?

Mr HARPER: Someone who has been placed on an emergency examination order in an emergency department before they are assessed can be held—I cannot remember the number of hours—before they are transferred to an authorised medical facility. Can you speak to that?

Mr Sheehy: Under the emergency examination authority provisions that are going into the Public Health Act, the time periods are the same—that is, six hours plus 12 hours. In that situation, a person is transferred to a public sector health service facility and the detention can only occur in that facility. As I say, the six-hour period and the 12-hour extension apply in the same way that they apply under the examination authority provisions as are outlined in the bill.

Mr HARPER: Thank you. If you were in the room with the tribunal you would have heard the discussion that we had. Just to clarify, in your opening statement you talked about clinical settings being appropriate to persons with mental illness. I recall the conversation that I had with the tribunal in their hearing time. They were talking about people with intellectual disability and people with dementia being placed in authorised mental health services and that they should not be placed unless that mental health service could provide treatment for them. I asked them if any such patients were being placed in those facilities. Can you speak to that?

Prof. Allan: I can speak to that as an operational issue. There are some people with disability who are on particular forensic orders who from time to time are admitted to mental health facilities. There are around—I give you an estimate of numbers, rather than actual numbers—40 or 50 people with a forensic order disability. The admission capacity for the Disability Forensic Service at Wacol is 10 beds. At any one time there are around 20 people who may be in mental health beds. Some of those people are there because of ongoing treatment needs. They may have a dual intellectual disability and mental illness and that mental illness is requiring treatment. Some people are there because of issues of inability to place them in other places. In general, the health services try to place people in an appropriate place, so community placement for a person with intellectual disability and

dementia units, for example, for people who have serious problems with dementia. However, there are times when those placements do not work out and people return to hospitals. Because of the act, we have an obligation to provide something for them. It is an issue that services raise fairly constantly. We work quite closely with the Department of Communities, Child Safety and Disabilities around the people with intellectual disability. We work quite closely with our colleagues in state and Commonwealth health around the placement of people with dementia. I think that is an ongoing clinical issue that I am not sure the act can particularly solve, but it is an ongoing clinical issue.

Mr HARPER: Thanks very much for that, gentlemen. I appreciate it.

Ms DONALDSON: You mentioned people being referred to dementia units or units that are more suitable for people with intellectual disabilities where possible. How available are units of those types? Does it present a problem? I am not aware of the numbers of people who are being referred, so it is just a general question.

Prof. Allan: In general, there is a range of community placements for people with intellectual disabilities—from independent living to living at home or living in supported accommodation with support packages. Some of those are support packages under the NDIS; some of those are support packages that are provided by the state government. As you are aware, there is a transition for many of those people from state government packages to NDIS, so it is a moveable feast at this time. There may be some changes in the landscape in that different providers under the NDIS will provide different—

Ms DONALDSON: I am aware of the changes. Say there is somebody who may need a mental health unit but that is not the most suitable. They have a disability which may be outside the realms of a community disability service provider to provide for, given that that is mostly share accommodation and given the complexity of disabilities or comorbidity with mental health issues. I am particularly thinking of dementia units, because I am aware that a person with dementia would not be suitable to go into a community disability unit.

Prof. Allan: Yes. They are two separate issues, really—the intellectual disability and dementia.

Ms DONALDSON: Yes.

Prof. Allan: On the intellectual disability, to start with, as you are aware, we do not have intellectual disability institutionalisation. We do not put people in large institutions. We look for community placements. As you rightly point out, some of those are share houses. Some of the particular people we are talking about here will often have an individual housing package and an individual support package tailored to their particular needs. However, not everybody has that in the sense that they have everything they would like about that, so there are always gaps and the need for services to be cooperative and find that.

In terms of the dementia process, people should be placed where it is appropriate for their particular condition. Assessments of risk are part of that assessment as well. Besides the ACAT assessment for going into a nursing home or a high-risk or dementia bed, there is also consideration of that person's risk. There are sometimes tensions around the forensic status and the risk that they pose in other places. That is just an ongoing clinical issue. That is the best that I can say it, really. It is hard to be specific without talking about particular cases.

Ms DONALDSON: I just made the point because I am aware of the long waiting list, particularly for aged care generally speaking, but in dementia wards or dementia units in aged-care settings that may be even more difficult. I am concerned about those people who may fall through the gaps of both services because one is not available and one is not appropriate.

Prof. Allan: If it is any comfort to you—

CHAIR: I just make the point that I know that this is picking up on a comment from the Mental Health Review Tribunal but it is not directly relevant to the bill.

Prof. Allan: Absolutely. I am happy to answer the question.

Ms DONALDSON: I am happy to leave it there.

CHAIR: There being no further questions, we will conclude this public hearing. If members require further information, we will contact you. There were a number of questions taken on notice. The secretariat will contact those individuals to clarify and confirm the questions. If we can make the time to return those answers by 4 pm this Friday, 27 January, that would be most appreciated by the committee. I thank everyone for attending today. Thank you, Mr Paul Sheehy and Associate Professor John Allan, for your assistance with the committee's examination of the bill. I declare the hearing closed.

Committee adjourned at 10.15 am