

**Submission**

**to**

**Department of Health**

**Review of the *Mental Health Act 2000* –  
Discussion Paper**

**by the**

**Anti-Discrimination Commission Queensland**

**July 2014**

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## Introduction

1. The Anti-Discrimination Commission Queensland (Commission) is an independent statutory authority established under the Queensland *Anti-Discrimination Act 1991*.
2. The functions of the Commission include promoting an understanding, acceptance and public discussion of human rights in Queensland. 'Human rights' is defined by reference to seven core international human rights instruments, which include the *Convention on the Rights of Persons with Disabilities*, the *Declaration on the Rights of Disabled Persons*, and the *Declaration on the Rights of Mentally Retarded Persons*.
3. The Commission also deals with complaints alleging contraventions of the *Anti-Discrimination Act 1991* and of whistle-blower reprisal. Complaints that are not resolved through conciliation can be referred to the Queensland Civil and Administrative Tribunal for hearing and determination.
4. This submission focuses on the broad human rights aspects associated with some of the issues identified and recommendations in the Discussion Paper.<sup>1</sup>
5. The feedback and comments in the submission refer to the review recommendations in the Discussion Paper by item numbers, and where applicable, the headings from the item numbers in the Discussion Paper.

## Commission recommendations

6. The Commission makes the following recommendations for re-writing the *Mental Health Act* to achieve the stated objectives:
  - I. The proposed objects and purposes provisions be expanded to adopt the principles in the *Convention* and *the MI Principles*, and that the *Convention* and *MI Principles* be incorporated in schedules to the new Act.

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<sup>1</sup> *Review of the Mental Health Act 2000: Discussion Paper* (May 2014).

- II. The detail in the proposed new arrangements for involuntary examinations and assessments ensure:
  - (a) there is an appropriate level of and adequate training of the specially authorised justices of the peace;
  - (b) there is continual monitoring of power given to justices of the peace to ensure it is not inappropriately used;
  - (c) persons who believe they have been inappropriately subjected to involuntary examination or assessment have an avenue of review of the order, including whether it should have been made in the circumstances;
  - (d) further training of the relevant magistrates or justices of the peace occurs if it appears that inappropriate exercise of the powers may have occurred.
  
- III. Non-medical models of treatment that are in place should not be automatically ceased when a person is admitted into custody. Wherever possible any existing ‘recovery model’ treatments should continue.
  
- IV. The determination of a prima facie case should occur as a matter of course rather than at the election of the accused person, and should occur before the making of a forensic or involuntary treatment order because of unfitness for trial.
  
- V. The processes for the making of involuntary treatment orders in the Magistrates Court have a similar level of rigour as suggested for the special hearing process, and that the person has adequate legal representation during the process.
  
- VI. Court liaison service officers as well as duty and other lawyers appearing before the Magistrates Courts are properly trained and resourced so that they can appropriately identify people who may have a mental illness or intellectual disability that impacts on their fitness for trial or their soundness of mind.

- VII. Before a Magistrate makes an involuntary treatment order, the Magistrate must be satisfied that there is:
  - (a) significant risk of harm to people; or
  - (b) significant damage to property; or
  - (c) a significant risk of re-offending in a manner that has a serious impact upon a person or the community.
  
- VIII. The conflict in the role of the Independent Patient Companion be further considered and clarified.
  
- IX. Ensure the role of the Independent Patient Companion of assisting the patient at Tribunal hearings is not a substitute for independent legal advice for matters where it is in the patient's best interest to have the benefit of legal advice/representation.
  
- X. There be a greater access to free legal representation, in particular for:
  - (a) forensic order reviews;
  - (b) matters concerning a patient who at the time of the hearing is held in seclusion;
  - (c) people with increased vulnerabilities such as people under personal guardianship, people with intellectual disabilities, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds; and
  - (d) patients who have been in in-patient care for over 12 months.
  
- XI. There be independent, centralised data collection and reporting on the use of restrictive practices, to allow external monitoring and public scrutiny.
  
- XII. Provisions regulating the use of physical and chemical restraints be prescribed in the *Mental Health Act*.

XIII. The levels of protection, scrutiny and reporting afforded to patients in relation to the use of restrictive practice such as mechanical restraint, seclusion, and physical and chemical restraint under the *Mental Health Act* have a similar level of rigor as those afforded to persons subjected to restricted practices under the *Guardianship and Administration Act 2000* (Qld).

In particular, any long term use of restrictive practice (for example, more than a day) be implemented only in accordance with a treatment plan, which:

- (a) provides strategies aimed at reducing and eliminating restrictive practices and in the long term will improve the adult's quality of life;
- (b) must be formulated in consultation with the patient, their family and other relevant supports (for example, allied services); and
- (c) is subject to review by the Tribunal.

XIV. There be careful supervision and monitoring of the extended time for obtaining a second opinion to confirm or revoke an involuntary treatment order in designated regional, rural and remote areas, information about the timeframes be reported, and this measure be reviewed after six months.

XV. The power to designate areas where the period of detention for assessment can be extended from 72 hours by a further 72 hours be subject to the Director of Mental Health being satisfied that there has been, or is reasonably likely to be, transportation issues that render impracticable an assessment at a suitable place within 72 hours.

XVI. There be strict monitoring of, and reporting on when the discretion to extend the period of detention for assessment is exercised, the period of the extension, and details of the transportation and timeframes for transportation and assessment. This measure to be reviewed after 12 months.

## Objectives – item 21

7. The purpose of the *Mental Health Act 2000* is to provide for the involuntary assessment, treatment and protection of persons who have mental illnesses, while also supporting their rights and freedoms and balancing their rights and freedoms with the rights and freedoms of other persons.<sup>2</sup>
8. The review of the Act is part of a range of reforms intended to deliver the best possible mental health care for Queenslanders, with the second round of consultation represented by the release of the Discussion Paper in May 2014.
9. The Discussion Paper makes over 200 recommendations, including the repeal and replacement of the Act, in order to implement the changes. According to the Discussion Paper, the proposed changes to the legislation aim to:
  - safeguard the rights of people with mental illness;
  - promote an individual's recovery and ability to live in the community without the need for involuntary treatment and care;
  - strengthen the importance of family, carers and other support people to a patient's treatment and recovery;
  - only impinge on rights and liabilities if there is no less restrictive way to protect the health and safety of the person and others; and
  - provide for simpler and fairer processes under the Act.
10. Improvement of the objectives of the Act has been identified as an issue, and recommendation 21.1 in the Discussion Paper is that:

The main objective of the Act be as follows:

  - to improve and maintain the health and well-being of the people with a mental illness who do not have the capacity to consent to treatment;

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<sup>2</sup> *Mental Health Act 2000*, section 4



- to enable people to be diverted from the criminal justice system where found to have been of unsound mind at the time of an unlawful act or unfit for trial; and
- to protect the community where people diverted from the criminal justice system may be at risk of harming others.

These objectives to be achieved in a way that:

- safeguards the rights of individuals;
- affects a person's rights and liberties in an adverse way only if there is no less restrictive way to protect the health and safety of the person or others; and
- promotes the person's recovery, and ability to live in the community, without the need for involuntary treatment and care.

11. The Discussion Paper asks at 21 'Will these recommendations address other relevant issues?'

12. The Commission suggests that other relevant issues include:

- obligations under international human rights instruments to which Australia is a party; and
- statutory interpretation.

### **International human rights instruments**

13. Australia has agreed to be bound by a number of international human instruments, including the *Convention on the Elimination of All Forms of Racial Discrimination*<sup>3</sup>, the *International Covenant on Economic, Social and Cultural Rights*<sup>4</sup>, *International Covenant on Civil and Political Rights*<sup>5</sup>, the *Convention on the Rights of the Child*<sup>6</sup>, and the *Convention on the Rights of Persons with Disabilities*<sup>7</sup>.

14. The *Convention on the Rights of Persons with Disabilities* (*Convention*) brings together the principles and obligations under all international human rights instruments so far as they relate to people with disabilities. The Convention reaffirms the entitlement

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<sup>3</sup> Entry into force in Australia on 30 October 1975

<sup>4</sup> Entry into force in Australia on 10 March 1976

<sup>5</sup> Entry into force in Australia on 13 November 1980

<sup>6</sup> Entry into force in Australia on 16 January 1991

<sup>7</sup> Entry into force in Australia on 16 August 2008

of all people with all types of disability to equal rights and freedoms, including:

- inherent dignity and individual autonomy, including the freedom to make one's own choices (Article 3);
  - equality (Article 5);
  - effective access to justice (Article 12);
  - enjoyment of personal liberty and security (Article 14);
  - freedom from torture, cruel, inhuman or degrading treatment or punishment (Article 15);
  - to live independently and to be included in the community (Article 19);
  - freedom of expression and opinion and access to information (Article 21);
  - privacy (Article 22);
  - health (Article 25);
  - work (Article 27); and
  - an adequate standard of living (Article 28).
15. To provide guidance on how people with mental illness can be expected to be treated in the health-care system and the community, the United Nations adopted *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991 (MI Principles)*. These *MI Principles* influence the interpretation of Australia's human rights obligations.
16. The *MI Principles* require the 'least restrictive alternative' in terms of treatment, as well as individualised plans for treatment.<sup>8</sup> The

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<sup>8</sup> United Nations, *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, 75<sup>th</sup> plenary meeting, UN DocA/Res/46/119 (17 December 1991) Principle 9 Treatment:

1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

concept of involuntary treatment as a last resort was also recognised by Australia in the following declaration made at the time of ratification of the *Convention* in July 2008:

Australia recognises that every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others. Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary as a last resort and subject to safeguards.

### **Statutory interpretation**

17. The words of a statute must be read in the context of the statute as a whole. The process of statutory construction begins with examining the context of the provision that is being construed.<sup>9</sup> There is also a presumption that the legislature has not intended to interfere with basic rights, freedoms and immunities, unless there is unmistakable and unambiguous language to the contrary.<sup>10</sup> Further, the Queensland *Acts Interpretation Act 1954* requires that the interpretation of a provision that will best achieve the purpose of the Act is to be preferred to any other interpretation.<sup>11</sup>
18. These principles demonstrate the need for clear and fulsome objects and purposes clauses in the new Act. Guiding principles would also benefit the implementation and application of the legislation.
19. Whilst the objectives expressed in recommendation 21.1 are sound, the Commission considers they should go further and provide greater assistance to those who will be using the legislation.

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2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.

...  
<sup>9</sup> *Project Blue Sky v Australian Broadcasting Authority* (1998) 194 CLR 355

<sup>10</sup> *Coco v The Queen* (1994) 179 CLR 427

<sup>11</sup> *Acts Interpretation Act 1954*, section 14A

### **Commission recommendation 1**

The Commission recommends that the proposed objects and purposes provisions be expanded to adopt the principles in the *Convention* and the *MI Principles*, and that the *Convention* and *MI Principles* be incorporated in schedules to the new Act.

## **Involuntary examinations and assessments – item 1**

20. The Commission supports the recommendations that increase the level of security before a person can be subjected to an involuntary examination or assessment.

### **Commission recommendation 2**

The detail of the implementation arrangements is critical. There should be:

- (a) an appropriate level of and adequate training of the specially authorised justices of the peace;
- (b) continual monitoring of power given to justices of the peace to ensure it is not inappropriately used;
- (c) an avenue of review of an order, including whether it should have been made in the circumstances, for people who believe they have been inappropriately subjected to involuntary examination or assessment.
- (d) further training of relevant Magistrates or justices of the peace if it appears there may have been an inappropriate exercise of powers.

## **Individuals held in custody – item 2**

### **Continuity of recovery model**

21. Recommendation 2.7 of the Discussion Paper states:

On admission [into custody] of a patient who is already on an involuntary order or forensic order:

- a community category of an involuntary treatment order or forensic order for the patient is to automatically change to an in-patient category;

- any limited community treatment approved by an authorised doctor for the patient is revoked; and
  - an authorised doctor must review the patient's treatment needs, document the changed treatment, and talk to the patient about the treatment.
22. The Commission is concerned that there should be continuity of existing community treatment orders wherever feasible, even though the person is being held in custody.

### **Commission recommendation 3**

Non-medical models of treatment that are in place should not be automatically ceased when a person is admitted into custody. Wherever possible any existing 'recovery model' treatments should continue.

## **Orders and other actions following court findings – item 4**

### **Special hearings following findings of unfitness for trial – items 4.21 to 4.23**

23. The Commission supports the introduction of a 'special hearing' for a court to test the evidence against an accused:
- following a finding of permanent unfitness for trial; or
  - where a finding of temporary unfitness extends over 12 months.
24. Queensland and Western Australia are the only Australian jurisdictions without special hearings of this kind. A gross breach of human rights occurred in the Western Australian case of Marlon Noble. Mr Noble was detained for ten years for offences which the complainants have reportedly said did not happen. He is now released but on strict conditions. Mr Noble's case illustrates the risk of not having special hearings, and their importance in ensuring a person's human rights are protected.
25. The proposal is that the person can elect to have a special hearing after the Mental Health Court makes a forensic order or involuntary treatment order following a finding of unfitness for trial, whether permanent or

temporary. From a human rights perspective, no forensic or involuntary treatment order should be made for an accused person unless the court is satisfied that the person committed the offence as charged. At the very least, the level of satisfaction should be that the accused person would have a prima facie case to answer if the person was of sound mind and fit for trial.

#### **Commission recommendation 4**

The Commission considers the determination of a prima facie case should occur as a matter of course rather than at the election of the accused person, and should occur before the making of a forensic or involuntary treatment order because of unfitness for trial.

#### **Magistrates Court powers on finding of unsoundness of mind or unfitness for trial – items 4.24 to 4.29**

26. Magistrates Courts have only one option following a finding of unsoundness of mind at the time of an offence, and that is to discharge the defendant. Also, there is no clear process for dealing with unfitness for trial in the Magistrates Court.
27. The Commission supports reform in this area, particularly in light of the decision of the Court of Appeal in *R v AAM; ex part A-G (Qld)*, where the Court said at [9]:

It seems unsatisfactory that the laws of this State make no provision for the determination of the question of fitness to plead to summary offences. It is well documented that mental illness is a common and growing problem amongst those charged with criminal offences. The Magistrates Court has attempted to meet this problem through its Special Circumstances Court Diversion Program which apparently presently operates only in the Brisbane area. This program assists categories of vulnerable people including those with impaired decision-making capacity because of mental illness, intellectual disability, cognitive impairment, or brain and neurological disorders. This commendable initiative, which allows for suitable compassionate supervisory and supportive bail and sentencing orders to be made in appropriate cases, may well be effective in assisting those vulnerable people. But it does not and cannot provide a satisfactory legal solution where people charged with summary offences under the criminal justice system are unfit to plead to those charges. The legislature may wish to

consider whether law reform is needed to correct this hiatus in the existing criminal justice system.<sup>12</sup>

28. The Commission agrees with the proposal to give magistrates an express power to discharge a person unconditionally if satisfied, on the available information, the person is likely to have been of unsound mind at the time of the offence or unfit for trial (4.24, first dot point). This proposed power in relation to fitness to plead should ensure that the *AAM* scenario<sup>13</sup> does not recur.
29. However, as highlighted in Background Paper 4, ‘dismissing a charge on the basis of unsoundness or unfitness will not address the underlying issues that led to the charge, and will not meet the needs of the accused person, the victim (if relevant), or the broader community. Further options are therefore also proposed.’<sup>14</sup>
30. Background Paper 4 goes on to state:

Where unsoundness or unfitness results wholly or partially from a mental illness and there appears to be a risk to other persons or their property, a power to make a non-revokable [involuntary treatment order] is also proposed. This order would have a maximum period of six months for a summary offence and one year for an indictable offence.

Where the unfitness is temporary, the order would be mandatory, matching the [Mental Health Court] arrangements.

The threshold for making an order should be that the community cannot be adequately protected by voluntary treatment or a ‘standard’ [involuntary treatment order] from harm, property damage or repeat offending of the type the person was charged with. **In making an order on the basis of permanent unfitness, the magistrate should also consider the strength of the evidence against the accused before making an order.**<sup>15</sup>  
(emphasis added)

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<sup>12</sup> *R v AAM; ex parte A-G (Qld)* [2010] QCA 305 at [9], per McMurdo P with whom White JA and Cullinane J agreed. The Special Circumstances Court Diversion program has since been closed.

<sup>13</sup> A person who pleaded guilty to 15 simple offences over a 2 year period was subsequently found, by the Mental Health Court, to be unfit for trial by reason of intellectual disability, which existed at the time of the guilty pleas. The Court of found there had been a miscarriage of justice and the convictions were set aside with verdicts of acquittal entered. The matter came before the Court of Appeal by way of referral from the Attorney-General following a petition to the Governor of Queensland for a pardon.

<sup>14</sup> *Review of the Mental Health Act 2000: Background Paper, 4. Orders and Other Actions Following Court Findings* (May 2014) 11.

<sup>15</sup> *Ibid* 11-12.

31. In some other Australian jurisdictions the ‘special hearing’ procedure in the Magistrates’ Courts requires the court to determine; whether the accused person is not guilty of the offence,<sup>16</sup> whether the accused person engaged in the conduct required for the offence charged,<sup>17</sup> or proceeds to committal for an indictable offence as if the person pleaded not guilty.<sup>18</sup>
32. The proposed new powers for magistrates include the discretion to make an involuntary treatment order with a non-revoke period of up to six months for summary offences and up to 12 months for indictable offences, where the magistrate is satisfied the person is likely to be, or appears to be, unfit for trial or of unsound mind due to mental illness. In the case of a person charged with an indictable offence, where the magistrate is satisfied the person is unfit for trial or of unsound mind due to mental illness or intellectual disability, the magistrate would have a discretion to refer the matter to the Director of Mental Health or the Director of Forensic Disability to assess whether the matter should be referred to the Mental Health Court. Where the accused person is unfit for trial or of unsound mind due to intellectual disability, the magistrate would have to discharge the person unconditionally and would have a discretion to refer the person to the Department of Communities, Child Safety and Disability Services to consider whether appropriate care can be provided to the person.

### **Commission recommendation 5**

The Commission suggests the processes for the for the making of involuntary treatment orders have a similar level of rigour as suggested above for the special hearing process, to prevent injustices such as a person being subjected to an involuntary treatment order when the evidence against them has not been adequately tested. It is also essential that the person has adequate legal representation during the process.

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<sup>16</sup> Tasmania, *Criminal Justice (Mental Impairment) Act 1999*, section 15.

<sup>17</sup> Australian Capital Territory, *Crimes Act 1900*, section 315C.

<sup>18</sup> Western Australia, *Criminal Law (Mentally Impaired Accused) Act 1996*, section 17.



## **Items 4.24 and 4.28**

33. A further matter for consideration is the level of expertise available to magistrates to determine whether the unsoundness or unfitness of the accused is due, wholly or partially, to mental illness or to intellectual disability. Many of the defendants appearing before magistrates each year may be unsound or unfit, but the issue is not raised by the defendant or identified by the defence lawyer.
34. In the discussion of the proposed model that differentiates between offences that can be heard summarily and offences that must be heard on indictment in Background Paper 3, it is stated, in relation to offences that can be heard summarily:

Identifying persons appearing before a Magistrates Court who have mental health issues would be undertaken by lawyers and watch-house officers, as occurs for the majority of matters currently, supported where appropriate by the Court Liaison Service in South-East Queensland and [authorised mental health service] staff elsewhere in the State. Court liaison officers will play an important role in the revised arrangements. The 'gap' left by the discontinuation of mandatory psychiatric reports for many offences is likely to result in an increased demand for court liaison services. As part of the consultation process for the Review, an assessment will be made of the best way that court liaison officers can support the revised arrangements.<sup>19</sup>

### **Commission recommendation 6**

It is imperative that the court liaison service officers as well as duty and other lawyers appearing before the Magistrates Courts are properly trained and resourced so that they can appropriately identify people who may have a mental illness or intellectual disability that impacts on their fitness for trial or their soundness of mind.

### **Item 4.26**

35. Given the possible human rights implications for a person who is the subject of an involuntary treatment order, the Commission questions whether the test of the Magistrate being 'satisfied the community cannot

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<sup>19</sup> *Review of the Mental Health Act 2000: Background Paper, 3. Assessment of Individuals Charged with an Offence* (May 2014) 9.

be adequately protected ... from harm, property damage or repeat offending' is a sufficiently high enough standard. The Commission is concerned that this test is not sufficiently clear and could be highly subjective, particularly when there are low levels of risk to the community or where an alleged offender is a repeat offender for offences such as urinating in public, begging, simple trespass or using indecent language.

36. In the ACT and Western Australia the options available to the Magistrate depend on whether the offence is a 'serious offence'. A 'serious offence' in the ACT is an offence involving actual or threatened violence punishable by imprisonment for longer than 12 months, or committing an act endangering life under section 27 of the *Crimes Act 1900* (ACT).<sup>20</sup>

#### **Commission recommendation 7**

The Commission suggests that before making an involuntary treatment order, the Magistrate must be satisfied that there is:

- (a) significant risk of harm to people; or
- (b) significant damage to property; or
- (c) a significant risk of re-offending in a manner that has a serious impact upon a person or the community.

37. The Commission agrees it is important for an independent evaluation of the revised arrangements for the Magistrates Court powers be undertaken after three years (item 4.30).

## **Support for involuntary patients – item 7**

### **Independent patient companion – item 7.6**

38. It is proposed that each authorised mental health service be required to employ or engage (e.g. from a non-government organisation) a person or persons as an 'Independent Patient Companion', to report directly to the administrator of the authorised mental health service and not be part

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<sup>20</sup> *Crimes Act 1900* (ACT), section 300.

of the treating team. The Commission supports the need for a system that ensures that an involuntary patient has someone available to explain his or her rights and obligations under the *Mental Health Act*, and considers that extra resources dedicated to this role are very worthwhile.

39. However the Commission has some concerns about the level of independence of the Patient Companion from both the treating team, and also from the mental health service. While it appears one of their major roles is to assist the patient and others to constructively engage with the treating team, another role is to further the patient's interests. If there are differing views about what the patient's interests are, the role may have in-built conflicts of interest between the view of the mental health service, and the views of the patient and their family.

#### **Commission recommendation 8**

The conflict in the role of the Independent Patient Companion needs further consideration and clarification.

40. The Commission is supportive of the role the proposed Independent Patient Companions will have of advising patients, family, carers and other support persons of pending Tribunal proceedings, the patient's rights at Tribunal proceedings, and the need or appropriateness of engaging an advocate or legal representative at a hearing. To support a patient in this regard, the Independent Patient Companion is to be advised of all pending hearings.
41. The Commission is also supportive of role of the Independent Patient Companion to discuss any upcoming Tribunal hearings with the patient, and any statement the patient would like to make.
42. The Commission also supports the role of Independent Patient Companion attending the Tribunal hearings, if the patient wished, to help the patient convey his or her views. However, this should not be a substitute for independent legal advice for matters where it is in the patient's best interest that they have the benefit of legal advice/representation.

### **Commission recommendation 9**

Ensure the role of the Independent Patient Companion of assisting the patient at Tribunal hearings is not a substitute for independent legal advice for matters where it is in the patient's best interest to have the benefit of legal advice/representation.

## **Mental Health Review Tribunal – item 9**

### **Legal Representation – item 9.2**

43. The right to legal representation is recognised as a fundamental freedom and basic right in *the MI Principles*. Principle 1(6) states:

Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a person representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.<sup>21</sup>

44. While patients have the right to be represented by a lawyer before the Mental Health Tribunal, there is a very low rate of legal representation at Queensland Mental Health Tribunal hearings. In 2012-13, only two per cent of patients were legally represented before the Tribunal. Queensland provides a very low level of legal support for people appearing before the Tribunal compared to other states. In NSW the Mental Health Advocacy Service provides free legal aid for many types of hearings before the NSW Mental Health Review Tribunal. Including

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<sup>21</sup> United Nation, *Principles for the Protection of Persons with Mental Illness...* above n 7, Principle 1-(6). 'Counsel' is defined in the *MI Principles* to mean a legal or other qualified representative.

mental health inquiries, representation was provided in 72% of all hearings in the Tribunal's civil jurisdiction, and 98% of all forensic hearings.<sup>22</sup> In Victoria, legal representation was provided in 12% of matters.<sup>23</sup>

45. In the Discussion Paper it is proposed to require legal representation at Tribunal hearings, at no cost to the patient, for:

- hearings involving minors
- fitness for trial reviews, and
- reviews where the State is legally represented by the Attorney-General.

The review proposes it would be the responsibility of the Tribunal to provide legal representation in these cases if the patient is unable to do so.

46. The Commission supports this increase in the level of legal representation, but is concerned that there is still insufficient access to legal representation to adequately protect the human rights of people appearing before the Tribunal. It is important to reiterate that the human rights standard is 'If the person whose capacity is at issue does not himself or herself secure such representation, **it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it.**'<sup>24</sup> (emphasis added).

47. The Commission recognises that in the current fiscally constrained economy it may not be feasible to provide legal support for each person in relation to every matter before the Tribunal. However, the Commission considers there should be a greater level of free legal representation provided.

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<sup>22</sup> NSW Mental Health Review Tribunal 2012-2013 Annual Report, p19.

<sup>23</sup> Victorian Mental Health Review Board 2012-2013 Annual Report, p10.

<sup>24</sup> United Nations *Principles for the Protection of Persons with Mental Illness* ... above n 7, Principle 1-(6).

### **Commission recommendation 10**

The Commission recommends there be a greater access to free legal representation, and in particular for:

- (a) forensic order reviews;
- (b) matters concerning a patient who is held in seclusion at the time of the hearing;
- (c) people with increased vulnerabilities, such as people under personal guardianship, people with intellectual disabilities, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds; and
- (d) patients who have been in in-patient care for over 12 months.

48. The Commission considers there is also merit in the suggestion by Queensland Advocacy Inc. to implement a duty lawyer system at, for example, The Park, along the lines of the experimental domestic violence service recently introduced at Holland Park Magistrates Court. This service could provide more intensive expert support and assistance to people than is normally delivered through the standard duty lawyer model.<sup>25</sup>

### **Restraint and seclusion – item 13**

49. Principle 11(11) of the United Nations *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* states:

Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular

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<sup>25</sup> Review of Mental Health Act 2000 submission by Queensland Advocacy Incorporated, August 2013 p14.

supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.<sup>26</sup>

50. In 2005 the Mental Health Working Group of the Australian Health Ministers' Advisory Council committed to reduce and wherever possible eliminate the use of restraint and seclusion<sup>27</sup> and in 2008, Queensland Health released a policy statement outlining several key principles targeted towards reducing and eliminating restraint and seclusion.<sup>28</sup>

51. In 2013 Mental Health Commissions across Australia issued a communiqué stating, inter alia:

We recognise that seclusion and restraint has been formed in part as a cultural practice across services and systems and is not based on evidence of effectiveness in caring for and supporting people with mental health difficulties and their families and supporters. We acknowledge the views of people with lived experience and recognise that seclusion and restraint can and does damage people, especially those who have experienced trauma. Seclusion and restraint practices can lead to further re-traumatisation and fear of accessing care, treatment and support.....

The use of involuntary practices and specifically seclusion and restraint is a complex area and together we will work to bring an end to the practices of seclusion and restraint across our mental health systems.<sup>29</sup>

52. The Chair of the National Mental Health Commission Prof. Allan Fels says: 'Seclusion and restraint of people with mental health problems is a human rights issue. It is not therapeutic, it's a sign of a system under stress, and in fact it adds to people's trauma.'<sup>30</sup>

53. The Commission agrees with the position that the practice of seclusion and restraint should be eliminated wherever possible. The practices should only ever be used as a last resort.

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<sup>26</sup> United Nations *Principles for the Protection of Persons with Mental Illness ...* above n 7.

<sup>27</sup> Australian Health Ministers' Advisory Council, *National safety priorities in mental health: a national plan for reducing harm* (2005).

<sup>28</sup> Queensland Health, 'Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health service' (2008).

<sup>29</sup> Meeting Communiqué, The Sydney Declaration: Meeting of State and National Mental Health and International Mental Health Leaders, 11 and 12 March 2013 Sydney, Australia.

<sup>30</sup> Media Release National Mental Health Commission 11 December 2013.

54. The Commission acknowledges that the legal authority to undertake restrictive practices derives from many Acts and the common law and is, by virtue of that fact, complex. The Discussion Paper outlines that the use of restrictive practices may lawfully be undertaken under the *Guardianship and Administration Act 2000*, the *Criminal Code*, workplace health and safety laws, and the common law. Whether restricted practices may be used, and how they are used, is dependent on the circumstances at the particular time.
55. The *Mental Health Act 2000* prescribes what can occur in an authorised mental health service in relation to seclusion and restraint. It states that a doctor may authorise the use of mechanical restraint if the doctor is satisfied it is the most clinically appropriate way of preventing injury to the patient or someone else. Seclusion may be authorised by a doctor or senior registered nurse if it is necessary to protect the patient or other persons from imminent physical harm and there is no less restrictive way of ensuring the safety of the patient or others.
56. Notably, the use of physical and chemical restraint is not regulated under the *Mental Health Act*.
57. The Review makes a number of recommendations for changes in relation to the restraint and seclusion provisions of the *Mental Health Act*.

### **Notification of mechanical restraint and seclusion – item 13.12**

58. While the Commission does not disagree with the proposed changes regarding the notification of mechanical restraint and seclusion, in light of the national emphasis on better understanding the incidence of restrictive practices, and the factors that lead to them occurring, the accountability systems under the *Mental Health Act* could be strengthened.



### **Commission recommendation 11**

The Commission recommends there be independent, centralised data collection and reporting on the use of restrictive practices, to allow external monitoring and public scrutiny.

### **Basis for authorising the use of a mechanical restraint and seclusion – item 13.18**

59. The Commission agrees with the recommendation that the authorisation for the use of mechanical restraint be on the same basis as the authorisation for seclusion (i.e. necessary to protect the patient or other people from imminent physical harm, and there is no less restrictive way of ensuring the safety of the patient or others).

### **Commission recommendation 12**

The Commission suggests that provisions regulating the use of physical and chemical restraints should also be similarly prescribed in the *Mental Health Act*.

### **Commission recommendation 13**

The Commission suggests the levels of protection, scrutiny and reporting afforded to patients in relation to the use of restrictive practice such as mechanical restraint, seclusion, and physical and chemical restraint under the *Mental Health Act* should have a similar level of rigor as those afforded to persons subjected to restricted practices under the *Guardianship and Administration Act 2000* (Qld).

In particular, any long term use of restrictive practice (for example, more than a day) should be implemented only in accordance with a treatment plan, which:

- (a) provides strategies aimed at reducing and eliminating restrictive practices and in the long term will improve the adult's quality of life;
- (b) must be formulated in consultation with the patient, their family and other relevant supports (for example, allied services); and
- (c) is subject to review by the Tribunal.

60. The Commission believes there is much more work to be done in the area of eliminating seclusion and restraint, and looks forward to the outcomes of the National Mental Health Commission's Seclusion and Restraint Project (the Project). The Project is looking at identifying best practice approaches to in reduce and eliminate the use of seclusion and restraint. Its scope extends beyond the health of the hospital system and facilities (such as inpatient units and emergency departments) to include the use of seclusion and restraint in community, custodial and ambulatory settings (such as remand facilities and patient transport services) and by first responders (such as police).
61. The Commission encourages all Queensland government departments that have staff working with persons who may have mental health issues, and who currently utilise restrictive practices, to use the outcomes of the project to reduce and eliminate the use of seclusion and restraint.

## **Regional, rural and remote issues – item 16**

### **Items 16.2, 16.3 and 16.4**

62. People in regional, rural and remote areas have the same human rights as people in other areas. Many people living in these areas are Aboriginal or Torres Strait Islander people, and until the gap is closed, a much higher percentage of this population experience mental health issues than the Australian population as a whole. Of these, some patients will be subjected to the provisions of the *Mental Health Act*.
63. The recommendations in the Discussion Paper include proposed greater flexibility in:
- allowing the same doctor to make a recommendation for assessment and an involuntary treatment order for a person (1.20);
  - the use of audio-visual facilities for assessments (16.2);

- the time within which a second examination (to confirm or revoke an involuntary treatment order) is to take place (16.3); and
- providing clinicians with the discretion to decide the appropriate place for community treatment (16.4).

64. These proposed changes appear to be consistent with the *Convention* obligation to provide reasonable accommodations to promote equality and eliminate discrimination, and recognise the importance of remaining in the community. There is however potential for people to be detained in a facility longer than necessary pending a second opinion. If implemented, this change should be carefully supervised and monitored, and reviewed after 12 months.

#### **Commission recommendation 14**

There should be careful supervision and monitoring of the extended time for obtaining a second opinion to confirm or revoke an involuntary treatment order in designated regional, rural and remote areas. Information about the timeframes should be reported and the measure reviewed after six months.

#### **Item 16.5**

65. An issue identified for rural and remote areas is that in some cases it is necessary to transport the person to a suitable place for an assessment. Transport availability and the time taken to transport sometimes make it difficult for the assessment to occur within the 72 hour time period required under the Act. The example in Background Paper 16 is where a person is required to be transported by the Royal Flying Doctor Service from a remote part of Queensland.<sup>31</sup>

66. It is proposed in the Discussion Paper (16.5) that the Director of Mental Health designate areas where the administrator of an authorised mental health service may extend the time in which a

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<sup>31</sup> *Review of the Mental Health Act 2000: Background Paper, 16. Regional, Rural and Remote Issues* (May 2014) 4.

person may be detained for assessment by a further period of 72 hours if it is necessary to enable transportation of the person to a suitable place for the assessment.

67. With this proposal there is again the potential for people to be unnecessarily detained for longer than appropriate. If this recommendation is implemented, the power to designate areas should be limited to where the Director of Mental Health is satisfied there has been or is reasonably likely to be transportation issues that render an assessment at a suitable place impracticable. There should be strict monitoring, and reporting on when the discretion to extend is exercised, the period of the extension, and details of the transportation and timeframes for transportation and assessment. This measure should also be reviewed after 12 months.

#### **Commission recommendations 15**

The power to designate areas where the period of detention for assessment can be extended from 72 hours by a further 72 hours be subject to the Director of Mental Health being satisfied that there has been, or is reasonably likely to be, transportation issues that render impracticable an assessment at a suitable place within 72 hours.

#### **Commission recommendations 16**

There should be strict monitoring of, and reporting on when the discretion to extend the period of detention for assessment is exercised, the period of the extension, and details of the transportation and timeframes for transportation and assessment. This measure should also be reviewed after 12 months.

## **Conclusion**

68. In Australia, one in five people are affected by a mental health disorder. The majority receive treatment and care for their illness voluntarily. However, some individuals are unable to give informed consent to

- treatment. Legislation is required to protect their rights and to ensure treatment and care is provided to support their recovery.
69. In a very limited number of cases, an individual may be of unsound mind at the time of an unlawful act, or be unfit for trial due to a mental illness or an intellectual disability. Legislation has the role of diverting those individuals from the criminal justice system into appropriate treatment and care.
70. Each and every person has human rights, including persons who have a mental illness or impaired capacity due to mental illness or an intellectual disability. Historically, individual and systemic breaches of the human rights of persons with mental illness and those with intellectual disability have been endemic in Australia and throughout the world. Unfortunately, major human rights breaches of these highly vulnerable people can still occur today.
71. The Anti-Discrimination Commission has been canvassing with Government the need for a **Disability Justice Plan** in Queensland. People with mental health and intellectual impairments are over-represented in the criminal justice system as defendants and victims of crime. They often experience difficulties accessing the criminal justice system, participating in the criminal justice process and securing an appropriate outcome. While the system does make some provisions to accommodate persons with mental health and intellectual impairments, more is required to be done. At all stages of the Queensland criminal justice system process - from prevention, through to interactions with police, the court process, and diversion and imprisonment - there are opportunities to make reasonable accommodations for people with disability, including a more holistic approach to addressing offending behaviours so as to prevent further crime and improve the experience of victims of crime.
72. It is essential that the legislation, processes and procedures associated with both the health and criminal justice systems, recognise and protect the human rights of persons interacting with those systems. The current

review of the *Mental Health Act* gives Queensland an opportunity to improve the human rights protections of this cohort of our community.

73. The Anti-Discrimination Commission thanks the review team for the opportunity to make this submission.