

Director

Mental Health Act Review

Department of Health

PO Box 2368

FORTITUDE VALLEY QLD 4006

By email: MHA.Review@health.qld.gov.au

1st August 2014

Dear Colleague,

Re: Discussion Paper - Review of the Mental Health Act 2000

We welcome and appreciate the opportunity to make a submission in relation to the discussion paper on the Review of the Mental Health Act 2000 (“MHA”), released May 2014.

PRELIMINARY CONSIDERATION: OUR BACKGROUND TO COMMENT

The Aboriginal and Torres Strait Islander Legal Service (QLD) Ltd (“ATSILS”) provides legal services to Aboriginal and Torres Strait Islander peoples throughout mainland Queensland. Our primary role is to provide criminal, civil and family law representation. We are also funded by the Commonwealth to perform a State-wide role in the key areas of: Law and Social Justice Reform; Community Legal Education and Monitoring Indigenous Australian Deaths in Custody. As an organisation which, for over four decades, has practiced at the coalface of the justice arena, we believe we are well placed to provide meaningful comment. Not from a theoretical or purely academic perspective, but rather from a platform based upon actual experiences. We trust that our submission is of assistance.

GENERAL COMMENT

We commend the vast bulk of the initiatives aimed at overhauling the MHA. Our view is that many of the recommendations will be of great assistance to Queenslanders – both Indigenous and non-Indigenous alike.

RECOMMENDATION 1 - INVOLUNTARY EXAMINATIONS AND ASSESSMENT

A major issue that we see in Queensland is people with mental illness or intellectual/cognitive disabilities who are managed by the police by being placed in custody, instead of being referred for treatment to a mental health facility. This is an example of where a health and welfare issue is being passed to the criminal law system to deal with. There are several ways in which this occurs:

1. There are insufficient treatment facilities in Queensland to properly support those with a mental illness or intellectual/cognitive disability, leading to many being taken into custody and dealt with in the criminal justice system, rather than the health system. Such has been a systemic failure for decades.
2. Many people who suffer from a mental illness or intellectual/cognitive disability have not been formally diagnosed. This means that in many situations, police officers are placed in the invidious situation of either making lay-person decisions about a person's mental state or indeed, proceeding upon a basis of being totally unaware that such issues are in play (especially is masked by superimposed considerations such as drug use or intoxication).
3. The lack of diversionary options (to either the police or the court) means that those who suffer from a mental illness or intellectual/cognitive disabilities are often:
 - a. Not receiving treatment for their illness, which will invariably lead to the continuity of criminal or anti-social behaviour; and
 - b. Being placed on bail without adequate support in terms of explaining the obligations and ramifications of such – especially where additional bail conditions apply – thus setting people up for a breach and further incarceration.
4. Recommendation 1.10 relates to potential Applications for Domestic Violence Orders (“DVO”). Whilst we recognise the need for and support the use of DVOs to assist the victims and potential victims of domestic violence – it is important that such

applications are not used exclusively to address a situation where a Respondent to an Application is suffering from a mental illness or intellectual/cognitive disabilities. Rather, such should only be used as an adjunct to medical treatment (or at least as a general rule, only to be diverged from in exceptional circumstances).

It is clear that the lack of resources for diagnosing and treating those with a mental illness or intellectual/cognitive disability is a huge barrier and creates significant frustrations – and clearly places unfair demands upon the police service (and indeed, the criminal justice system generally). Lack of referral resources at the disposal of the Police Service, means that often those with mental illnesses or intellectual/cognitive disabilities are being ‘processed’ by the criminal justice system rather than ‘treated’ by the mental health system in an appropriate facility.

RECOMMENDATION 3 – ASSESSMENT OF INDIVIDUALS CHARGED WITH AN OFFENCE

We note that Recommendation 3 suggests discontinuing the mandatory requirement for psychiatrist reports for those already on forensic orders or involuntary treatment orders (for summary offences or indictable offences that can be heard summarily). Such seems like an eminently sensible suggestion.

The background paper also considers a number (4) of separate options for the more serious offences that must be dealt with on indictment (and possibly a newly created category of certain specified offences that can be dealt with summarily albeit at the higher end of the scale of seriousness).

Our preference would be for options 1 or 2 as identified in the background paper. Option 2 presents challenges for those who exhibit mental health considerations but who are not already on an ITO or a forensic order – in the sense that it has long been a challenge (especially for our client base) to obtain funding with which to obtain a private psychiatric report. Option 1 on the other hand places greater strain on Legal Aid Queensland in terms of the funding of reports across the board. In our view, either LAQ must be adequately funded (i.e. additionally funded) and/or recourse should remain available to public sector psychiatrists.

Ultimately, what is important is that for those identified as having (or appear likely to have) mental health issues – and who lack the financial resources to fund their own reports –

recourse must be available to psychiatric assistance (whether a private report funded by a properly resourced LAQ or via a government sector psychiatrist). Proper resourcing might also go a long way towards addressing the quite deplorable situation which often arises in terms of totally unacceptable delays in the provision of reports. We would like to see any change to the legislation specifically address and mandate time lines in this regard. Exceptions could apply – for example, where a patient does not turn up for an appointment etc – but in the numerous cases where the individual has been remanded in custody – there should be zero tolerance of non-compliance with time lines (with similar obligations placed upon the police service in terms of the timely provision of materials).

A further positive by-product of stringent mandatory time lines would be that of cost reductions. Undoubtedly, in many instances, more timely reports will mean reduced incarcerations periods – leading to less strain on the public purse – with associated cost savings being able to transfer across into the health sector.

RECOMMENDATION 4 – ORDERS AND OTHER ACTIONS FOLLOWING COURT FINDINGS

This section poses the question: *“will the recommendations improve the system for dealing with individuals found to be unsound mind or unfit for trial?”* Our view is that for the most part, the answer is “yes”. However, we strongly feel that Recommendation 4.13 needs to be revisited. We would certainly support the MHC having the discretion to impose a non-revocation period in relation to an Order made in circumstances which seemingly warranted such. However, we are of the view that there is no justification (given that ultimately we are dealing with a health issue) to differentiate between classes of offences in terms of the maximum duration of any non-revocation period. Further, given the vagaries of mental health illnesses and the variety of patient responses to treatment etc – we are of the view that the maximum non-revocation period should be two rather than three years. In the alternative, any period beyond such, should have a review mechanism built in to the system.

It should be remembered that if two years were adopted – then upon the expiration of the non-revocation period the patient would still be subject to a continuation of the Order after a review by the MHRT (see Recommendation 4.14). As a consequence, more than adequate safeguards would remain in place, ensuring that someone was not prematurely released.

As to Recommendation 4.25: we can see some benefits to the public purse in considering a codicil to this recommendation – in effect excluding purely summary offences from the provision.

RECOMMENDATION 5 – TREATMENT AND CARE OF INVOLUNTARY PATIENTS

We note that Recommendation 5.4 provides that ‘an authorised doctor must decide and review a patient’s treatment and care in consultation with the patient and, as far as practicable, family, carers and other support persons’.

We note that the current MHA does not define ‘family’ and the definition of ‘carer’ does not provide for the unique dynamics of Aboriginal and Torres Strait Islander culture. In line with the proposed principles outlined in Recommendation 17, we submit that ‘family’ and ‘carer’ be clarified or defined to take into consideration the unique family dynamics of Aboriginal and Torres Strait Islander people. These definitions should not only apply to Recommendation 5.4, but to all areas where the family or carers of a patient are relevant. We note that this approach has been adopted in other Australian jurisdictions such as in the **Northern Territory**, where the *Mental Health and Related Services Act* states at 7A:

(1) A primary carer for a person is:

- (a) someone providing care and support to the person because of his or her sense of responsibility as a relative of, or someone close to, the person; or*
- (b) if the person does not have anyone providing care and support as mentioned in paragraph (a) – someone most closely involved in the treatment or care of, or support to, the person.*

(2) For this section, a relative of the person includes anyone related to the person through a relationship that arises through common ancestry, adoption, marriage, de facto relationship or any customary law or tradition (including Aboriginal customary law or tradition).

In **South Australia**, the *Mental Health Act 2009* defined relative as:

a person is a relative of another if—

- (a) the person is related to the other by blood or marriage; or*
- (b) the person is a domestic partner of the other; or*

- (c) *the person is of Aboriginal or Torres Strait Islander descent and related to the other according to Aboriginal kinship rules, or Torres Strait Islander kinship rules, as the case may require;*

RECOMMENDATION 6 – TREATMENT IN THE COMMUNITY

With respect to Recommendation 6.5, where a client is an Aboriginal and/or Torres Strait Islander person, the Court or Tribunal should also have an awareness of, and regard to, the importance of culture, spiritual beliefs, lore and practices to the healing process. It is often the case that, because of a lack of resources in Aboriginal communities, an Aboriginal or Torres Strait Islander person will have to sacrifice connection to family and community support (lore and culture, and country), to receive treatment in the city. Whilst it is accepted that certain considerations, such as “safety” will have paramountcy, such does not mean that core cultural considerations do not play a key part in the treatment/support of Aboriginal and Torres Strait Islander patients. We recommend a provision similar to that in the **Northern Territory Mental Health and Related Services Act** section 8 (Interpretation of Act):

This Act is to be interpreted and a power or function conferred or imposed by this Act is to be exercised or performed so that:

- (g) *the assessment, care, treatment and protection of an Aboriginal person or a person from a non-English speaking background who has a mental illness is appropriate to, and consistent with, the person's cultural beliefs, practices and mores.*

With respect to Point 6.13 of the Discussion Paper:

Of course if a patient was considered a serious risk of re-offending etc, then presumably they would not be released at all – rather this recommendation is centred upon those who are considered a significant risk of not returning (or have been previously non-compliant when released).

Whilst we support the option of “monitoring conditions” generally, we would oppose any monitoring condition which would require a patient to wear a GPS monitoring device

irrespective of the underlying nature of their offending (or alleged offending) behaviour. We are also mindful that:

1. The Department's test review of patients monitoring conditions revealed that of the 57 patients reviewed, 55 were determined to have sufficient support from treating psychiatrists to address any risk.
2. We note that GPS tracking systems have been used overseas for those who suffer from dementia. There are positives and negatives to this system - however it is important to recognise that a person who suffers from dementia and might become lost or disorientated, is quite different to a person who suffers from a mental illness or intellectual/cognitive disability and may be suicidal or at risk of self-harm. In the case of the latter, it is difficult to see how a GPS would prevent the suicide or self-harm from occurring.
3. We note that GPS tracking was trialled as a local initiative by South London and Maudsley Hospital following the death of David Kemp at the hands of convicted rapist Terrance O'Keefe¹. What is pertinent to note, is that Terrance O'Keefe *escaped* the custody of a mental health facility - he was not on a sanctioned release into the community at the time that he committed the murder².
4. It is prejudicial to those who are not a danger to others, to place them in the same categories as dangerous offenders and sex offenders. This increases the stigma attached to those who suffer a mental disability, and creates further difficulties for people with a mental illness who are trying to reintegrate back into society.

We acknowledge that there might well be circumstances where a GPS tracking device is a fair and necessary option – and indeed, but for such – a release back into the community might not be considered realistic. However, the category of patients to which such could apply should be restricted (e.g. in terms of underlying offending behaviour – sexual offenders and stalkers being obvious categories).

¹ Harriette Halepis Mental Health Patients Get Tagged Rocky Mountain Tracking 6 July 2009 (online): <http://www.rmtracking.com/blog/2009/07/06/mental-health-patients-get-tagged/>

² Harriette Halepis Mental Health Patients Get Tagged Rocky Mountain Tracking 6 July 2009 (online): <http://www.rmtracking.com/blog/2009/07/06/mental-health-patients-get-tagged/>

RECOMMENDATION 7 – SUPPORT FOR INVOLUNTARY PATIENTS

Recommendation 7 is another instance where the definitions of ‘family’ and ‘carers’ should be clarified to include the unique dynamics of Aboriginal and Torres Strait Islander families (please see earlier references in this regard).

With respect to Recommendation 7.6 in the Report, we highly commend the objective behind the creation of an Independent Patient Companion (“IPC”). However it is crucial that adequate resourcing is provided so as to ensure the capacity of this newly created role to encompass all remote and outer regional areas.

RECOMMENDATION 14 - REGULATED TREATMENTS

In relation to Recommendation 14.4 – we assume the ability for a patient to waive the two-day timeframe will be restricted to those patients that have “capacity”.

RECOMMENDATION 17 – INDIGENOUS AND MULTICULTURAL ISSUES

As a general comment, we commend the Department on the objective of Recommendation 17. However, we would raise two considerations in regard to the way Recommendation 17.1 currently reads:

1. Whilst the objective of the “principle” being enshrined in legislation is of itself to be commended – such might have little impact in reality unless the “practices” allied to this principle are similarly enshrined and mandated in the legislation.
2. Placing Aboriginal and Torres Strait Islander peoples under the same umbrella as those from culturally and linguistically diverse backgrounds could be interpreted as overlooking the unique context of Aboriginal and Torres Strait Islander peoples as First Nation peoples.

Point 2 is certainly not intended to suggest that there should not be recognition and accommodation of those from culturally and linguistically diverse backgrounds (i.e. other than Indigenous Australians) – far from it. However, in our view, in order to properly acknowledge the unique position of Aboriginal and Torres Strait Islander people in the mental health system, they cannot in effect be regarded in the same category as those from culturally and linguistically diverse backgrounds.

We refer to our previous submission to the Department dated 22 August 2013 (“*MENTAL HEALTH ACT 2000 REVIEW*”), we stated:

It is our view that when addressing mental illness, the unique position of Aboriginal and Torres Strait Islander peoples as Australia’s first people and the trauma inflicted on Aboriginal and Torres Strait Islander peoples since British settlement cannot be ignored. One of the results of this trauma is mental illness, the other is disproportionate contact with the criminal justice system. Aboriginal and Torres Strait Islander peoples continue to be strong in culture and lore. This and the following require consideration within the provisions of the MHA:

- evidence of the disproportionate percentage and over-representation of Aboriginal & Torres Strait Islander clients in the criminal justice system in general and specifically in the prison system;
- the findings and recommendations from enquiries such as *The Royal Commission into Aboriginal Deaths in Custody*, *the Stolen Generation*, *Little Children are Sacred*, *the Forde* and the Carmody inquiries;
- evidence of the higher incidence of mental illness and intellectual disability amongst Aboriginal & Torres Strait Islander detained in facilities³ⁱ and prisons; and
- the compounding effect of the constellation of the above factors.

We suggest consideration be given to amending the MHA to specifically include - in s 8, “General principles for administration of Act” – a provision to this effect:

Acknowledgment of needs and considerations in relation to Aboriginal and Torres Strait Islander peoples.

To the greatest extent practicable, the particular cultural, language, communication and other special needs of Aboriginal and Torres Strait Islander persons must be recognised and taken into account

E.g. – Connection to the land, extended family, spiritual beliefs, customs, etc.

Research has identified colonisation as one of the primary contributing causes to mental distress and mental illness among Aboriginal and Torres Strait Islander people⁴. Associated

³ 50% of the clients detained at the newly established Forensic Disability Service at Wacol are Aboriginal or Torres Strait Islander, including some from remote indigenous communities such as Mornington Island.

with colonisation is sociocultural dislocation, isolation and related effects, which was contributed to by dislocation from lands, kinship groups and family⁵.

We note that other jurisdictions in Australia have recognised the individual and unique context that Aboriginal and Torres Strait Islander culture. For example, In **South Australia**, the *Mental Health Act 2009* states at section 7 (Guiding Principles):

(1) *The Minister, the Board, the Chief Psychiatrist, health professionals and other persons and bodies involved in the administration of this Act are to be guided by the following principles in the performance of their functions:*

(c) the services should—

- (i) be governed by comprehensive treatment and care plans that are developed in a multi-disciplinary framework in consultation with the patients (including children) and their family or other carers or supporters; and*
- (iv) in the case of patients of Aboriginal or Torres Strait Islander descent, take into account the patients' traditional beliefs and practices and, when practicable and appropriate, involve collaboration with health workers and traditional healers from their communities...*

The Government of **Western Australia** is currently in the process of overhauling their mental health legislation. The *Mental Health Bill (2013)* was introduced to the Legislative Assembly on 23 October 2013 and has not yet (to our knowledge) been passed by Parliament. The Bill introduces a new 'Schedule 1 — Charter of Mental Health Care Principles' with Principle 7 being:

A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.

⁴ Australian Government Department Of Health "Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy" last updated February 1995.

⁵ Australian Government Department Of Health "Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy" last updated February 1995.

Culturally appropriate services

Consist with and pursuant to the objective of Recommendation 17, we submit that the review should include provision for culturally appropriate services. Other jurisdictions in Australia have legislated culturally appropriate services. In **Western Australia**, the *Mental Health Bill (2013)* gives considerable weight to the role of an Aboriginal or Torres Strait Islander mental health worker at:

Clause 80 (Information to which examiner may have regard):

(1) The psychiatrist or practitioner may have regard to any information about the person being examined that is obtained by the psychiatrist or practitioner from one or more of the following —

.....

(b) if the person is of Aboriginal or Torres Strait Islander descent —

- (i) an Aboriginal or Torres Strait Islander mental health worker; or*
- (ii) a significant member of the person's community, including an elder or traditional healer;*

Clause 50 (Assessment of person of Aboriginal or Torres Strait Islander descent):

To the extent that it is practicable and appropriate to do so, the assessment of a person who is of Aboriginal or Torres Strait Islander descent must be conducted in collaboration with —

- (a) Aboriginal or Torres Strait Islander mental health workers; and*
- (b) significant members of the person's community, including elders and traditional healers.*

Clause 81 (Examination of person of Aboriginal or Torres Strait Islander descent):

To the extent that it is practicable and appropriate to do so, the examination of a person who is of Aboriginal or Torres Strait Islander descent must be conducted in collaboration with —

- (a) Aboriginal or Torres Strait Islander mental health workers; and*
- (b) significant members of the person's community, including elders and traditional healers.*

At Division 4 (Provision of treatment to patients of Aboriginal or Torres Strait Islander descent) clause 189 (Provision of treatment to patient of Aboriginal or Torres Strait Islander descent):

To the extent that it is practicable and appropriate to do so, treatment provided to a patient who is of Aboriginal or Torres Strait Islander descent must be provided in collaboration with —

(a) Aboriginal or Torres Strait Islander mental health workers; and

(b) significant members of the patient’s community, including elders and traditional healers.

In the **Northern Territory**, the *Mental Health and Related Services Act* provides that the involuntary treatment and care of an Aboriginal and Torres Strait Islander person is to be, where possible, provided in collaboration with an Aboriginal and Torres Strait Islander health practitioner (section 11). An Aboriginal and Torres Strait Islander health practitioner is defined as:

“a person registered under the Health Practitioner Regulation National Law to practise in the Aboriginal and Torres Strait Islander health practice profession (other than as a student).”

We would urge the consideration of further measures to encourage culturally appropriate services in line with similar Australian jurisdictions. Such is also consistent with the first of our two points above (re the need to enshrine “practices” not just “principles”).

RECOMMENDATION 20 – OTHER LEGAL ISSUES

We, like many others, are naturally concerned about the large number of Aboriginal and Torres Strait Islander people who suffer a mental illness or intellectual/cognitive disability who are caught up in the criminal justice system because of inadequate resources in the mental health system. 73 per cent of male and 86 per cent of female Aboriginal and Torres Strait Islander people in Queensland’s high security prisons suffer a mental disorder⁶. The current lack of services for those with a mental illness or intellectual/cognitive disabilities is leading to a ‘criminalisation of care’, whereby the police and the justice system are passed the burden of dealing with the problem of inadequate health services (not to mention system poverty issues).

⁶ Heffernan, E.B, Andersen, K.C., Dev, A., and Kinner, S., *Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland Prisons*, Medical Journal Australia 2012; 197(10) 37-41

This problem is no less a consideration in the courts overseeing summary offences. We refer to our earlier submission of 22 August 2013 in relation to this issue:

There is a failure to protect the large number of people who are charged with summary offences and not on an order or those on an order who have only committed summary offences. These people cannot be referred to the Mental Health Court and are not afforded the same protections under the Mental Health Act 2000. Rather, they need to rely on the limited provisions in the Criminal Code 1899. Therefore, at present, many people are being processed through the criminal justice system, entering pleas and being sentenced in the same manner as others despite issues of fitness to plead or soundness of mind at the time of the offence. Clearly this situation is unacceptable and compromises the person's rights and their need for legislative protection. On this matter we refer you to the case of R v AAM; ex parte Attorney-General of Queensland [2010] QCA 305. In that case McMurdo P provided strong comment on the inappropriateness of the above and the need for law reform on this area.⁷

In order to provide a fair process to and to protect the human rights of all people with mental illness captured by the criminal justice system the current regime requires amendment to create a court of summary jurisdiction to decide issues of unsoundness of mind and fitness for trial for summary or simple offences.

It is further submitted that the Mental Health Act should be consistent with the United Nation's Declaration on the Rights of Indigenous People (2007). For example:

Article 24

- 1.Indigenous individuals also have the right to access, without any discrimination, to all social and health services.*
- 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.*

COMMUNITY EDUCATION

It is unfortunately the case that there is a stigma attached to mental illness, and a general sense of fear of people who are mentally unwell. This stigma is destructive to the treatment

⁷ *R v AAM; ex parte Attorney-General of Queensland [2010] QCA 305 at para 9.*

of all people with mental illness, including Aboriginal and Torres Strait Islander people, who already face discrimination from large sectors of the community. This stigma and discriminatory views are counterproductive to the efforts of patients who are trying to better themselves, as well as the efforts of the health care and justice system.

Our view is that wider public education is required to address the stigma attached to people with a mental illness or intellectual/cognitive disability. Public education needs to address widely-held perceptions of public safety, the health care and criminal justice system's treatment of those with a mental illness or intellectual/cognitive disability, and steps that the community can take to help those who are suffering from a mental illness or intellectual/cognitive disability. A lack of education also leads to discriminatory and unfair views about those with a mental illness or intellectual/cognitive disability seemingly "getting off easy" by being placed on ITO's rather than being incarcerated – this view is supported by a lack of understanding for the fact that treatment not only benefits the patient, but the community as well.

In light of the foregoing, we would urge the consideration of an extensive advertising campaign to accompany the revisions of the MHA, and therefore address some of the changes that need to be made to the mental health system, which cannot be done through legislation. Namely, community attitudes and perceptions.

I close by once again thanking the Department for this opportunity to have input into this very important area. I also take this opportunity to acknowledge and thank Ms Julia Anderson, our Law and Justice Advocacy Development Officer for her assistance with the original draft of this submission. If required, we would be only too pleased to provide additional information to the Department.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Shane Duffy". The signature is fluid and cursive, with the first name "Shane" being larger and more prominent than the last name "Duffy".

Shane Duffy
Chief Executive Officer
