Aboriginal & Torres Strait Islander
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22 August 2013
Mental Health Act Review
Department of Health
PO Box 2368
Fortitude Valley BC Qld 4006

BY EMAIL: MHA_Review@health.qld.gov.au

Dear Colleagues,

RE: *MENTAL HEALTH ACT 2000* REVIEW

We refer to the above and thank you for the opportunity to provide submissions.

Background – preliminary consideration

The Aboriginal and Torres Strait Islander Legal Service (QLD) Ltd ("ATSILS") provides legal services to Aboriginal and Torres Strait Islander peoples throughout 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 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 will identify some areas in the *Mental Health Act* 2000 (MHA) desperately requiring reform. We welcome the review but acknowledge that many issues exist beyond the provisions of the MHA which require addressing. We are also somewhat cautious in regard

to any future amendments given recent amendments being inconsistent with therapeutic treatment models, breaching individual's rights and liberties and not being evidence based.

We trust that our submission is of assistance.

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

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 enquiries;
- evidence of the higher incidence of mental illness and intellectual disability amongst Aboriginal & Torres Strait Islander detained in facilities[1i] 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.*

[1] 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.

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.

It is unclear as to whether the Psychiatrists writing the reports, or making the initial diagnoses, have received training to work with Aboriginal and/or Torres Strait Islander peoples. This is particularly important so that thought processes relating to cultural and spiritual matters can be distinguished from mental health matters and correct diagnosis and interpretations made.[2] Unless the service is provided by an Aboriginal and Torres Strait Islander organisation, training in cultural competency is required for staff working with or writing reports on Aboriginal and/or Torres Strait Islander peoples.

While reports often mention a person's descent, they often fail to detail the importance and relevance of cultural factors for the person and their healing process. Aboriginal and/or Torres Strait Islander peoples with mental illness and families and communities espouse the importance of culture, family, community and country as an essential part of healing. Also, other factors which are more likely to affect Aboriginal and Torres Strait Islander peoples including dispossession of land and children, trauma, government intervention, etc. need to be understood and considered as part of the context of a person's mental health.

Delays

The purpose of the *Mental Health Act 2000* (MHA) is stated as safeguarding the rights and freedoms of people with mental health issues while balancing their rights and freedoms with the rights and freedoms of others. Unfortunately this is not the experience of many of our clients. Instead, people captured by the MHA can feel, and are often penalised on account of being mentally unwell. The consequences of being found to be of unsound mind at the time of an offence can be that the person is placed on a forensic order and placed in a Psychiatric institution for a longer period of time than if they were convicted and sentenced

[2] Westerman, T.G., Psychological Interventions with Aboriginal People. Connect, Health Department of Western Australia, 2002, p. 2. http://www.gtp.com.au/ips/inewsfiles/P2.pdf

in the criminal justice system. There is also a large amount of uncertainty for a person captured by this process in terms of the timing of their release.

Also, it is not uncommon for people to be disadvantaged under the MHA due to the lateness[3] and quality[4] of s 238 MHA reports when remanded in custody or returned to custody for breaching their bail or parole conditions. At times people spend in excess of 12 months in custody awaiting a s 238 MHA report. Similarly those clients in the community can wait long periods for s 238 reports, suffering stress awaiting an outcome.

We have never been provided reasons for the tardiness in writing and providing s 238 MHA reports, therefore we are unable to discuss the issues surrounding this. At one stage, one of our offices received a Mental Health feedback form from Mental Health for the court seeking a 3 month adjournment, despite the legislated timeframes for s 238 MHA reports. We have in the past tried to address the issue of delayed s 238 MHA reports, to be informed that although at that point there were plenty of Psychiatrists in the region, they were overawed by the reports (being told that they only needed to be brief), issues with English, that Psychiatrists tend to put off doing the reports and that it was at times difficult to locate people in the community. We suggest that without investigating thoroughly why s 238 MHA reports are delayed it should not be assumed that it is a resource issue.

Even if the process is changed, high level Psychiatric reports should remain for more serious violent offences before the Mental Health Court (MHC). Many of the above mentioned issues and possibly others (we are aware that some, if not many, Psychiatrists feel conflicted when required to write s 238 MHA reports when they are also the treating Psychiatrist) will remain. One way to address this issue is to have a pool of Psychiatrists who are trained and willing to write the reports.

Rather than the process espoused by the MHA of removing mentally unwell people from the criminal justice system our observation is that it can result in them being entrapped and punished more harshly. As mentioned above, people can spend time in custody awaiting s

[3] There is no set timeframe ("as soon as practicable") for the Director of Public Prosecutions to provide copies of documents relating to the offence to the administrator (s 237A). However, we are unaware that this is the main cause of the delays.

[4] This is extremely disappointing given that often a large amount of time has passed before a report is provided and it is extremely expensive and arguably it should be unnecessary to obtain an "independent" Psychiatric Report.

238 MHA reports and this time can and at times does extend beyond the time that the person would serve if sentenced. It is arguable that if there was greater compliance with timeframes this would not occur. However, there is presently no way of enforcing timeframes and there is a lackadaisical culture relating to completion and quality of s 238 MHA reports. This seems to have resulted in s 238 MHA reports being reduced to proforma tick a box reports lacking reasons for decisions.

While the MHA allows for bail and does not prohibit parole applications, the process of gaining documentation of the client's mental state at that point in time is extremely difficult and often does not occur. Both the court and parole board often want evidence of a client's current mental health in order to assess risk to community safety. We have made several requests for this type of information for bail and parole applications with no response or with a response failing to provide any information of use to the court or parole board, despite specific questions posed in the requests. We are also aware of a case where the parole board wrote directly to Mental Health for information on a client's mental health and failed to receive any response after months of waiting. We are also aware that bail is sometimes refused simply due to the lack of mental health services in a community.[5]

Similar to the above, we are concerned that reports for review hearings before the Mental Health Review Tribunal (MHRT) are often provided to the patient's solicitor or advocate and possibly the MHRT on the day of the review. Clearly this is a serious issue and adjournments should not be relied upon to work around this. Often adjournments are not sought because the patient wants the hearing to continue and the timeframe for an adjournment can be weeks.

Gaps in the system

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

[5] Queensland Alliance, (31 March 2005) *Criminalising Illness? Strategies to Reduce the Over-Representation of People with Mental Illness in the Criminal Justice System – Submission to the Review of Corrective Services Act 2000*, p. 2. www.**qldalliance**.org.au/resources/items/**2005**/04/06768-upload-00001.pdf

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.[6]

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.

There has been debate in regard to the continuing requirement of a s 238 report when an order has been revoked. This often occurs once the 21 day time frame for the report has lapsed. It is our view that the report should have been completed within the legislated timeframe and in the spirit of the MHA, it is still required to assess the person's state of mind at the time of the offence and their fitness to plead.

Unfortunately this debate has the result of delaying a person's matter, which can place them in a position where they are pressured to enter a plea in order for their charges and sentencing to be concluded. We refer you to s 236 MHA in regard to this issue.

In relation to the issues mentioned above we view the MHA as not capturing many young people suffering mental health issues. Unfortunately, contact with the criminal justice system may present the first opportunity for a young person to be assessed and diagnosed in regard to mental illness or disability. Again, due to the deficiencies in the above processes depending on whether the young person is in custody or the community and the level of their mental illness it is often not in a young person's short term interest to be processed under Chapter 7 Part II MHA. We view that reform is required so that adults and young people are not further punished due to their mental illness, but are supported in gaining the support and treatment they require.

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

We provide the following case study to illustrate practical issues regarding requests for current information on a person's mental health for a bail application and delayed s 238 MHA report. N was charged with common assault and serious assault in March. At the time of the alleged assaults N was on an Involuntary Treatment Order. N was remanded in custody.

These matters were in the Magistrates Court in late July and were further adjourned to early-August for a bail application and due to awaiting a s 238 MHA report. In late July a solicitor requested information from Mental Health in regard to N's present mental health and treatment. No information was provided and a bail application was made in early-August, however it was unsuccessful. Another request for information was made to Mental Health. Mental Health discussed information with the solicitor on two occasions, agreeing to provide information for the next date for a bail application in mid-August, but failed to do so. On this occasion the Magistrate made a Direction for Mental Health to provide the requested information by the next Court date (late August). The information was provided by Mental Health and the bail application was successful.

The material provided by Mental Health was a brief letter from a Consultant Psychiatrist with some information in regard to N's present treatment, a prediction that issues may occur regarding compliance with treatment after release, with no detailed information on treatment or case management upon release.

Forensic Patients who have a dual diagnosis of both a mental illness and an intellectual disability

There is strong statistical evidence and medical opinion that many patients who suffer from a mental disorder have a co-morbid intellectual disability, and vice- versa. The incidence of dual diagnosis in relation to matters referred to the Mental Health Court is approximately 35-40%.

Since the inception of the *Forensic Disability Act 2011* (Qld) which came into operation on 1 July 2011, and the consequent amendments to s 288 MHA, a regular and recurring difficulty has arisen in relation to the provisions of s.288 and specifically the interpretation of s 288(5) MHA. A person placed on a Forensic Order (Mental Health Court) is detained for

"treatment" (as defined - as opposed to "care") and can only be detained to an authorised mental health service. On the other hand, a person made subject to a Forensic Order (Mental Health Court – Disability) is detained for care only, preventing an authorised psychiatrist from imposing involuntary treatment, even though the patient may require medication.

It has been the experience of legal practitioners in the Mental Health Court (confirmed in the decisions and statements made by the Judges and Assisting Psychiatrists of the Mental Health Court) that the 2011 amendments are somewhat awkward and have created some unsatisfactory outcomes.

The difficulty arises when a person has, as their primary or predominant diagnosis, an intellectual disability (which includes a cognitive impairment) but also has a co-existing subsidiary mental illness, that may or may not require treatment in the form of psychotropic medication.

Under the MHA, if a person has as their primary or predominant diagnosis, an intellectual disability (which includes a cognitive impairment), but also has a co-existing subsidiary mental illness (that may or may not require treatment), the current interpretation of s 288(5) MHA leads to the often absurd and unsatisfactory[7] outcome where, the Mental Health Court is left with no choice, but to order that the person be detained on a Forensic Order. This is despite the people requiring specific care for their intellectual disability. The requisite care for intellectual disability cannot always be offered in an authorised mental health service. It is therefore proposed that consideration be given to amending s 288(5) MHA to read "*is **substantially** a consequence of an intellectual disability."*

We also wish to draw to your attention that the statutory intent of s 288(7), (8) and (9) is frustrated by insufficient resource facilities for patients with an intellectual disability. As detention to "the" (as opposed to "a") forensic disability service (there is one single 10 bed facility in this State which has been at full capacity since 24/9/12) is subject to a Certificate of forensic disability service availability, 90% of people detained on a Forensic Order (Mental

[7] We refer you to the numerous references to this in various decisions of Lyons J, President of the Mental Health Court.

Health Court – Disability) are detained, by default in an authorised mental health service, which is often totally inappropriate.

References to the Mental Health Court (MHC)

We wish to raise an issue in regard to withdrawals of references made to the MHC. Due to the time taken for a matter to be referred, serious issues can be caused by a withdrawal of a reference. We are aware of a scenario where the Director of Mental Health referred a matter to the Mental Health Court based on the s 238 MHA report. On being caught for allegedly committing an indictable offence the person was taken into custody for breach of parole. The s 238 MHA report was written approximately 8 months later finding the person to be of unsound mid at the time of the offence. The Director of Mental Health later referred the matter to the MHC. We were then informed by a Psychiatrist that the referral had been withdrawn on the basis of the Psychiatrist's recommendation to the Director that the person would spend a lengthy period in custody before the matter was heard by the MHC. The reasons provided to the MHC for the withdrawal was disputed facts, however this was not understood to be the case by the person or the legal representative.

The above action was clearly well intended on the basis of a number of complex issues. These include:- the time frame for MHC hearings; delays in producing s 238 MHA reports; and people being incarcerated for less serious indictable offences due to breaches of bail or parole or being remanded in custody. This is despite it not being appropriate for the person to be dealt with in the criminal justice system.

The effect of the above was that to again refer the person back to the MHC was going to take more time and require the person to spend more time in custody when it was extremely unlikely that the person would be sentenced to a custodial sentence for the offence. We also note that the court granted bail with conditions; however the parole board did not feel they could release the person with the information before them, until he was sentenced. Although this is a reasonably extreme example, the delay in matters being heard by the MHC and the practical consequences for some people (those in custody) obviates the need for a different process. Those less serious indictable offences could be processed in a mainstream court in a specialised list. However, it is suggested that supporting documentation such as an experts report are still required for an alternative

process if a decision makers is to be confident in their role. We are concerned that if this were not the case people will continue to be processed through the criminal justice system without consideration of their mental health. Although not directly related to the MHA Review, if a process such as this was to be pursued, training and support should be provided to Magistrates, Judges and other court staff to effectively perform their roles.

Despite the focus of the MHA on treatment and support for mentally ill people, we are aware of the general practise of the Director of Public Prosecutions to continue proceedings despite the content of s 238 MHA reports and the facts surrounding charges. While we raise this as an issue and as not being in the spirit of the MHA, we wish for the provisions to remain and suggest that a case conferencing or similar process could be included to enable matters to be settled in a timely manner. We understand that the Director of Public Prosecutions may wish to proceed to the MHC in order for a forensic order to be made, however in less serious cases there may be opportunities for resolution through case conferencing or a similar process.

Treatment Plans

Practising Psychiatrist, Dr Ernest Hunter provides a scenario set in a remote area where a young Aboriginal man who had a serious psychotic disorder, was charged with assault after spitting at a police officer. The problem that Dr Hunter and the young Aboriginal man faced was that resources were not available to sustain the recommendation that Hunter wanted to make in respect to the young man. Hunter pointed out that if the young man lived elsewhere, such as a city or town, there would be no issues with access to the requisite services.[8] The practical result of this is that a Psychiatrist is required to adapt their recommendations based on the services available to the person, not what would be the best and most appropriate treatment and support for the person in an ideal world, or even a city.

The above is an issue that can arise when treatment plans are drafted. An ideal treatment plan will often act as a practical inhibitor for an Aboriginal and/or Torres Strait Islander

[8] Hunter, E., Disadvantage and discontent: A review of issues relevant to the material health of rural and remote Indigenous Australians, Ernest Hunter (The Centre for Rural and Remote Mental Health, Cairns, Queensland, Australia) *Australian Journal of Rural Health* (2007) 15, p. 88.

person to live in their community if it is remote or rural. As mentioned elsewhere, part of the healing process for Aboriginal and Torres Strait Islander peoples is residing on country, practising culture and being with family and community. The MHA presently fails to include the essential requirement pertaining to consideration of cultural matters. This must also be done from the perspective of the person's cultural background and documented evidence of the inclusion of consideration of cultural matters in treatment plans, s 238 MHA reports and other documents requiring opinion or decisions.

Mental Health Review Tribunal (MHRT)

There are sparse resources for people to be represented before the MHRT. The process is also often compromised by reports being provided on the day of hearings and at hearings. This fails to provide the patient and their representative time to absorb, understand and discuss the report, seek clarification or correction on certain aspects of the report. It also diminishes the value of having a legal representative, given that they will not be able to do their job to the extent they otherwise could.

We are also aware that dates for hearings are rigid being made without input from the legal representative. Hearing dates may therefore be made for a date when a solicitor is not available due to other commitments. Given that usually either community legal organisations or Legal Aid are likely to be the representative, due to resourcing issues, it is unlikely that another staff member would be able to attend. We suggest that consultation occurs with legal representative in relation to hearing dates. We understand that a number of matters are heard on the same day; therefore an alternative may be to set dates well in advance to avoid clashes.

Recommendations:

- Amendment to s 8 MHA to incorporate an acknowledgment of the needs and considerations relating to Aboriginal and Torres Strait Islander peoples.
- Detailed practise directions for s 238 MHA reports. Guidance may be obtained from other jurisdictions where practise directions exist for expert witness reports (e.g., Federal Court of Australia Practice Note CM 7).

- A court of summary jurisdiction be established to decide issues of unsoundness of mind and fitness for trial for summary or simple offences. However a detailed psychiatric report would be required to determine this, unless there is an existing report on the person's general level of functioning which indicates that they are either not capable of being, or were unlikely to be criminally culpable.

  At a general level solicitors are often able to assess a person's fitness to provide instructions and to plead, however a process is still required so that supporting documentation can be provided to the court. Where clients have been diagnosed with intellectual impairment or Acquired Brain Injury this information may be relatively easy to obtain.

  However, one of the issues we view with the above process is that unless a dedicated court list is created, such as is the case with the mental health call over list, Magistrates will not have the time to dedicate to these cases.

- Although, this goes without saying, compliance must be required for reports to be provided to patients, their legal representatives and advocates in the MHRT hearings within seven days of a hearing.

- Clarification on the requirement for a s 238 MHA report where a person's order has been revoked either during the time a s 238 MHA report is required and after that period.

- The provision of information on an alleged offence by the police to the administrator as per s 237A should include a timeframe, such as within 14 days from the date of the request.

- Inclusion of a provision in the MHA requiring cultural matters to be included in diagnosis, assessments, all reports and treatment plans.

- Those working with Aboriginal and/or Torres Strait Islander peoples and Psychiatrists writing reports, or making an initial diagnoses, be required to receive cultural

competence training to work with Aboriginal and/or Torres Strait Islander peoples and/or be aided by Aboriginal and Torres Strait Islander mental health workers.

- A pool of trained Psychiatrists formed to write s 238 MHA reports.

- Amending s 288(5) MHA to read "*is **substantially** a consequence of an intellectual disability.*"

- A case management conference to enable an opportunity to settle matters following a referral to the MHC.

- Consultation with the patient and legal representative when setting dates for MHRT hearings. Ideally this should occur well in advance of the proposed hearing date.

We wish you well in your deliberations and trust that our submission is of assistance. Again, we thank you for providing us with the opportunity to provide comment.

Yours faithfully,

Shane Duffy

Chief Executive Officer