

Office of the Public Advocate Systems Advocacy

Submission to the Queensland Department of Health

For the Review of the *Mental Health Act*
2000

Stage 1: Terms of Reference

August 2013

Interest of the Public Advocate

The Public Advocate was established by the *Guardianship and Administration Act 2000* to undertake systems advocacy on behalf of adults with impaired decision-making capacity in Queensland. The primary role of the Public Advocate is to promote and protect the rights, autonomy and participation of Queensland adults with impaired decision-making capacity (the adults) in all aspects of community life.

More specifically, the functions of the Public Advocate are:

- Promoting and protecting the rights of the adults with impaired capacity;
- Promoting the protection of the adults from neglect, exploitation or abuse;
- Encouraging the development of programs to help the adults reach their greatest practicable degree of autonomy;
- Promoting the provision of services and facilities for the adults; and
- Monitoring and reviewing the delivery of services and facilities to the adults.¹

People with mental illness constitute 54% of the population of adults with impaired decision-making capacity in Queensland and it is reasonable to suggest that many of these people may have had contact with, or will have contact with, the Queensland mental health system. In many cases, this is because they have committed a criminal offence, have been processed through the Mental Health Court and have been placed onto a forensic order. As a result of that order, they may be subject to ongoing and involuntary treatment and/or care.

The use of involuntary treatment and care raises many issues, both generally and in relation to compliance with human rights instruments. Of particular concern to me are those issues surrounding the use of involuntary treatment for, and the care and support provided to, persons with intellectual disability. I am of the opinion that these issues, which will be elaborated upon in this submission, are ones that should be explored by the Queensland government when reviewing the *Mental Health Act 2000* (the Act).

Position of the Public Advocate

I commend the Queensland government for its initiative in reviewing the *Mental Health Act 2000* and I will be pleased to support any reforms that promote and pursue the best possible outcomes for individuals who are made subject to an order or orders under the Act.

The review of this Act is something in which I have an ongoing interest and which my Office had been pursuing prior to the announcement of this review by the Queensland government. To that end, I would be pleased to offer my assistance and to work with the Government in undertaking this review.

Human Rights

Equal and proper recognition of human rights must be afforded to all persons with a disability, particularly those with impaired decision-making capacity. Involuntary treatment and care for a person with mental illness or intellectual disability necessarily impacts on and derogates from a person's human rights, and can therefore only be justified where it is necessary to protect the person or others from significant harm. Further the impact must be proportionate (to the harm likely to be inflicted) and subject to appropriate safeguards. This perspective underpins my submission.

In particular this submission is guided by the overarching obligation in the *Convention on the Rights of Persons with Disabilities* (the Convention) for state parties to recognise that people with disability are equal before the law and are entitled to equal benefit and protection of the law. It requires state parties to prohibit discrimination on the basis of disability and to provide people with disability with protection from discrimination.²

¹ *Guardianship and Administration Act 2000* (Qld), s 209.

² *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008) art 5 ('*Convention on the Rights of Persons with Disabilities*'); *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966 [1980] ATS 23 (entered into force 23 March 1976) art 26 ('*International Covenant on Civil and Political Rights*').

Structure of this Submission

This submission is divided into two parts. Part A identifies issues of general application to the *Mental Health Act 2000*, while Part B focuses on issues specific to people with intellectual disability (inclusive of those who may be better identified as having a cognitive impairment).

My Office recently commenced scoping a project involving a review of the systemic issues associated with the involuntary treatment of Queenslanders subject to forensic orders, with a particular focus on the involuntary treatment of people with intellectual disability subject to a forensic order (mental health court disability). Pending the issues determined for inclusion in the review of the *Mental Health Act 2000*, I will revise the scope for the project being undertaken by my Office to minimise any potential overlap.

In particular, should the issues identified in this submission in Part B in relation to the involuntary treatment of people with intellectual disability be included in the scope of the review, I will be pleased to provide further comment and suggestions for reform. Any issues that do not form part of the review of the Act will continue to be pursued by my Office and we will seek to work collaboratively with you in the course of doing so.

PART A: THE MENTAL HEALTH ACT 2000 AND PEOPLE WITH MENTAL ILLNESS

ISSUE 1: Convention on the Rights of Persons with Disabilities

The review of the *Mental Health Act 2000* is timely given that since the last review conducted by Brendan Butler AM SC in 2006, the United Nations General Assembly adopted the *Convention on the Rights of Persons with Disabilities* in December 2006 and Australia ratified the Convention in 2008.

While it is acknowledged that the principles in sections 8 and 9 of the Act were amended in 2011 with the commencement of the *Forensic Disability Act 2011*, it is now timely to conduct a review of the purpose, objects and principles of the Act to assess consistency with the Convention and other key human rights instruments.

As Public Advocate, I am committed to ensuring that state parties uphold the overarching obligation to protect people with disability from discrimination and to ensure they are provided with equal benefit and protection of the law. In particular, the Convention provides that persons with disability have the right to equal recognition before the law,³ meaning that they must enjoy legal capacity on an equal basis and be provided with support to exercise their legal capacity where required.

For example where a person has impaired decision-making capacity, it is recognised that sometimes support must be provided to a person to enable them to exercise their legal capacity. Article 12 of the Convention provides that there must be safeguards related to the exercise of their legal capacity that are respectful, proportionate, of the shortest possible length and subject to regular review. Persons with disability also have the right to effective and equal access to justice, including procedural and age-appropriate accommodations, to facilitate their role as participants in legal proceedings.⁴

There are also obligations to ensure that persons with disability are not deprived of their liberty unlawfully or arbitrarily;⁵ are free from torture or cruel, inhuman or degrading treatment or punishment;⁶ are protected from exploitation, violence and abuse;⁷ have their equal right to live in the community recognised, with choices equal to others;⁸ have access to information in accessible formats;⁹ and have the right to habilitation and rehabilitation, with services and programs, particularly ones related to health, employment, education and social services, offered at the earliest possible stage and supportive of participation and inclusion in the community and society.¹⁰

Ultimately, the restriction on a person's liberty to the degree authorised by an involuntary treatment order or forensic order must, in the exercise of the order, ultimately aim to result in an improvement in a person's functioning and their overall quality of life.

³ *Convention on the Rights of Persons with Disabilities* art 12.

⁴ *ibid* art 13.

⁵ *ibid* art 14.

⁶ *ibid* art 15.

⁷ *ibid* art 16.

⁸ *ibid* art 17.

⁹ *ibid* art 21.

¹⁰ *ibid* art 26.

ISSUE 2: Definition of ‘Mental Illness’

The definition of mental illness in the Act is extremely broad. The *Mental Health Act 2000* defines the term ‘mental illness’ as “a condition characterised by a clinically significant disturbance of thought, mood, perception or memory”¹¹ and it is a requirement that “on an assessment, a decision that a person has a mental illness must be made in accordance with internationally accepted medical standards.”¹² This broad definition carries with it numerous issues.

First ‘clinically significant’ is not defined. It is therefore incumbent upon the psychiatrist who carries out the assessment for that person to make this subjective determination. As a result, the subjectivity of what may be deemed clinically significant may lead to conflicting diagnoses or opinions between psychiatrists and thus bring about difficulties should the decision of a psychiatrist need to be reviewed by another professional.

The Diagnostic and Statistical Manual, edition 5 (the DSM-5) is generally relied upon by psychiatrists in Australia when diagnosing mental illness and it is commonly said that a person has a mental illness if they have a condition that falls within axis 1 of the DSM-5. However, the DSM-5 is not the only internationally accepted medical standard for psychiatric diagnosis and in some countries is not considered to reflect an accepted standard.

Given the breadth of the definition of ‘mental illness’ as referenced in the Act, there is therefore scope for a person to be diagnosed with a clinically significant disturbance without being diagnosed with an axis 1 condition. This may in turn expose those people to being made subject to various mental health orders and, by association, to involuntary treatment should they also meet the threshold for involuntary treatment.¹³

Finally there is also a lack of clarity in relation to whether disorders such as Borderline Personality Disorder (BPD) or conditions such as Dementia are, or should be, included in the definition of mental illness.

BPD is associated with severe and persistent impairment of psychosocial function, high risk for self-harm and suicide, a poor prognosis for co-existing mental health illness and heavy use of healthcare resources, with estimated suicide rates among people with BPD ranging from 3% to 10%.¹⁴ However people with BPD often fall within the gaps between existing service systems and as a result miss out on appropriate care and support.

I am also aware that there is some debate and discussion about whether persons with dementia could be classified as having either a mental illness or cognitive impairment. Given that this could be determinative with respect to whether they could be subject to an involuntary treatment or a forensic order of some type, this should also be clarified.

Considering these matters, I would respectfully recommend that the definition of ‘mental illness’ in the *Mental Health Act 2000* be reviewed.

ISSUE 3: A discriminatory approach to the treatment of criminal offenders

Potential exists for the current system for involuntary treatment in Queensland to result in inequitable treatment for people with mental illness or intellectual disability who come into contact with the criminal justice system, as opposed to those who do not present with these conditions.

The Convention recognises, and I acknowledge, that equal treatment does not always result in the best outcomes. In recognition of this, I do not necessarily advocate for mental health and criminal justice systems that operate in the same way. However, I am of the view that there are some aspects of the involuntary treatment of people with mental illness who have committed an offence that are discriminatory including:

- the indefinite nature of forensic orders;
- the compulsory involvement in treatment programs;
- the indiscriminate use of involuntary treatment; and
- the potential for further infringement of rights once a person is made subject to an order.

¹¹ *Mental Health Act 2000* (Qld) s 12(1).

¹² *Mental Health Act 2000* (Qld) s 12(4).

¹³ *Mental Health Act 2000* s14.

¹⁴ National Health and Medical Research Council, *Clinical Practice Guideline for the Management of Borderline Personality Disorder* (Australian Government 2012) 20.

Issue 3.1: The indefinite nature of forensic orders

If a person commits a criminal offence they are usually sentenced to a determinate sentence. This is not the case for people with impaired capacity who commit a criminal offence, are the subject of a reference to the Mental Health Court and for whom a forensic order is made. Under the *Mental Health Act 2000* there is the potential for a person to be detained indefinitely.

The review should consider whether finite time periods should apply to orders for involuntary treatment and forensic orders when a person is placed on such an order following them having been charged with an offence and, if so, what factors should be taken into account in determining appropriate terms for the duration and/or continuation of forensic orders.

One option could be to provide for an upper limit, after which more stringent assessments and reviews are incorporated to further safeguard the person's rights and to avoid people becoming 'lost' in the system.

Issue 3.2: The authorisation of involuntary treatment as part of a forensic order (mental health court)

Normally, a person may only be made subject to an involuntary treatment order if an assessment determines that the 'treatment criteria' are applicable to that person. The treatment criteria are:

- the person has a mental illness that requires immediate treatment that is available at an authorised mental health service;
- because of the person's illness, there is an imminent risk that the person may cause harm to himself or herself or another person, or is likely to suffer serious mental or physical deterioration;
- there is no less restrictive way to ensure the person receives appropriate treatment; and
- the person lacks capacity to consent to be treated for the illness or has unreasonably refused proposed treatment for the illness.

However, when a person is made subject to a forensic order, it seems no consideration is given to whether the treatment criteria apply and involuntary treatment is authorised as an automatic component of the forensic order. Again this means that important rights are removed from a person subject to a forensic order without due consideration of whether the person could consent to treatment or whether a substitute decision maker, in order of the priority outlined in section 66 of the *Guardianship and Administration Act 2000*, could make that decision.

Issue 3.3: Further rights infringements – monitoring; the ability of the Director to suspend LCT; and the use of restraint and seclusion.

The amendments to the *Mental Health Act 2000* by the *Queensland Mental Health Commission Act 2012* provided for monitoring (which could include GPS monitoring) to be imposed on some patients as part of conditions authorised by the Director Mental Health on their limited community treatment order. Further, the Director Mental Health was given the power to suspend limited community treatment for a 'class' of patients. By providing these powers to an executive officer, an inherent conflict arises with respect to the principles contained in human rights instruments to which Australia is a signatory. The powers can also, arguably, be identified as potentially discriminatory. I respectfully submit that these powers should now be reviewed.

The Director Mental Health has an important statutory role in relation to protecting the rights of involuntary patients. The *Queensland Mental Health Commission Act 2013* also amended the *Mental Health Act 2000* to allow the Minister a new power of direction over this role. This power potentially undermines the independence of the role and may lead to a serious conflict of interest for the Director Mental Health in the execution of his or her role. The review should consider these provisions again.

When a person is subject to an order under the *Mental Health Act 2000*, there is also potential for that person to be made subject to further orders that authorise the use of restraint, seclusion or behaviour control medication. I am concerned that, in some circumstances, these practices may contravene the provision against "torture or cruel, inhuman or degrading treatment or punishment."¹⁵

The use of these practices should be scrutinised by the review with regard to matters such as their authorisation, purpose, frequency, duration and means of execution.

¹⁵ *Convention on the Rights of Persons with Disabilities* art 15; *International Covenant on Civil and Political Rights* art 7.

ISSUE 4: Access to mental health services with a focus on habilitation, rehabilitation and benefit

Currently when a person is subject to an involuntary treatment order or a forensic order they must have a treatment plan prepared for them. ‘Treatment’ is defined as follows: “treatment, of a person who has a mental illness, means anything done, or to be done, with the intention of having a therapeutic effect on the person’s illness”.¹⁶ The treatment plan must include: an outline of proposed treatment to be provided, details of the services to be provided (including who will provide services), where and how often it will be provided, the duration for which it will be provided, and intervals for the patient’s regular review by an authorised psychiatrist.

Elsewhere in the Act, Authorised Mental Health Services are defined.

Together these definitions appear to form the limit regarding the extent to which the provision of mental health services in Queensland is described in the *Mental Health Act 2000*.

I believe the review of the Act should consider the extent of and how the provision of mental health services to all Queenslanders, including those subject to involuntary treatment, should be described. Given that Queensland now has the Queensland Mental Health Commission, whose role is to “drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system”,¹⁷ the scope of the *Mental Health Act 2000* should be reviewed to reflect the system-wide delivery of mental health services.

In light of the *Convention on the Right of Persons with Disabilities* there also needs to be a review of whether the Act in its description of mental health services, and in particular ‘treatment’, focuses sufficiently on habilitation and rehabilitation of people with mental illness and reflects a recovery orientated perspective.

ISSUE 5: Patient participation and advance decision-making

The review should also focus on how to increase patient participation in decision-making, including utilising advance directives in relation to people with mental illness.

There is currently much discussion, debate and momentum in Australia regarding less intrusive mechanisms to support people with impaired decision-making capacity to exercise their legal capacity and make decisions.

Issue 5.1: Patient participation in treatment decisions

The *Convention on the Rights of Persons With Disabilities* recognises the equality of people with disability before the law and places an obligation on State parties to assist people with disabilities to exercise their legal capacity.

There needs to be a much greater focus throughout the *Mental Health Act 2000* on people with mental illness receiving information, advocacy and support to enable them to participate in their treatment decisions. The review should consider mechanisms to support this.

Issue 5.2: Involvement in treatment programs

In the mainstream corrections system people have the right to consent to participation in treatment programs (even though this ‘choice’ may be a precondition for parole). This is not the case for a person who is made subject to a forensic order.

While a person who comes before the Mental Health Court may be found unsound of mind or permanently or temporarily unfit for trial, such a finding should not lead to an assumption that they lack capacity in all areas of their life, nor that with support or assistance they could not make or participate in other types of decisions.

A person who is subject to a forensic order should be given the opportunity to consent to involvement in treatment programs, and generally to make decisions about and be involved in planning their treatment.

If a person was deemed to lack the capacity to make a decision about whether they participate in treatment programs, consideration could be given to whether a guardian or other independent person could consent to treatment on a person’s behalf and to monitor the effectiveness of the treatment for that person over time.

¹⁶ *Mental Health Act 2000* (Qld) Dictionary.

¹⁷ *Queensland Mental Health Commission Act 2013* (Qld) s4.

Issue 5.3: Advance decision-making

The concept of supported decision-making is central to many of the current discussions regarding the reform of guardianship legislation.¹⁸ The term is often used to describe a variety of decision-making models that have, as a common factor, less intrusive forms of assisting a person to exercise their legal capacity, including making decisions with the support or assistance of others. Many of the jurisdictions in Canada have been at the forefront of advocating and implementing supported decision-making where the model grew out of the same movement that advocated for community living for people with intellectual disability.¹⁹

Specifically in relation to people with mental illness, there has been much discussion in relation to the use of advance directives and advance decision-making.

These models have been implemented in some jurisdictions with the *Mental Health (Care and Treatment) (Scotland) Act 2003* for example providing for patients to make an advance statement regarding how they wish to be treated or not treated for their mental disorder.²⁰

The ability to make an advance statement about their treatment may be one mechanism that the review should consider to allow people with mental illness maximum autonomy in relation to treatment and treatment decisions. Advance statements could particularly focus on aspects of their mental health treatment such as which treatment they prefer, and which treatment they do not prefer, which facilities they would prefer to be treated in, who they would like as their allied person, and any other relevant aspect of their treatment plan.

Issue 5.4: Allied Persons

Currently there are provisions within the Act for an Allied Person to be involved in a supportive role for the person. The Allied Person may be a friend, relative or a guardian of the person and may be either chosen by the person or appointed by an administrator. In undertaking this role, Allied Persons can also attend hearings of the tribunal and support the person to put forward their views and wishes.

While this is an important role, it can also have limitations, shared by similar roles in other jurisdictions. In many cases the Allied Person may not be well informed about the mental health system, including the patient's rights under the system, which may severely limit their ability to advocate for the person. It is acknowledged that in some cases the Allied Person may not necessarily act in the best interests of the patient, for example where a conflict of interest exists between the patient's interests and the Allied Person's interests.

The role of the Allied Person should be reviewed. Consideration could be given to what type of further support and training a person may require to carry out the Allied Person role, or whether the concept of the Allied Person should be changed to provide for the involvement of some type of independent support person, similar to a community visitor, who is specifically trained to carry out the advocacy role. Such a revised role should not detract from the rights of family members to support and participate in the person's treatment.

Issue 5.5: Right to second opinion

The right to a second medical opinion is something that as citizens we can all demand. Given the significant impact on a person's autonomy imposed by involuntary treatment, the review could also consider whether a person who is subject to an involuntary treatment order should be able to access a second opinion about whether less restrictive means of treatment could be implemented in their treatment plan and for whether the proposed treatment is the most clinically efficacious given their individual circumstances.

The right to a second opinion is incorporated into both the United Kingdom and New Zealand Mental Health Acts. For example the New Zealand *Mental Health (Compulsory Assessment and Treatment) Act 1992* provides a right to independent psychiatric advice so that "every patient is entitled to seek a consultation with a psychiatrist of his or her own choice in order to get a second opinion, and, if the psychiatrist agrees to the consultation, he or she shall be permitted access to the patient upon request".²¹

¹⁸ Victorian Law Reform Committee, *Guardianship: Final Report* (2012).

¹⁹ Robert M Gordon 'The Emergence of Assisted (Supported) Decision-Making in the Canadian Law of Adult Guardianship and Substitute Decision-Making', *International Journal of Law and Psychiatry*, 23(1) 61-77, 63.

²⁰ *Mental Health (Care and Treatment) (Scotland) Act 2003* s275.

²¹ *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ),s69.

ISSUE 6: Interactions with the Guardianship System

Currently the mental health and guardianship systems predominately operate separately in Queensland and the interaction and application of the two systems in relation to people with mental illness and intellectual disability subject to the *Mental Health Act 2000* would be worth exploring in the review.

The role of the guardianship system and its interaction with mental health systems both in Australia and internationally is being discussed, debated and questioned. For example, some commentators have drawn attention to the potentially discriminatory nature of a legal system that allows people with mental illness to be treated differently to people without mental illness.²² As noted earlier in this submission, this may be particularly relevant in respect of upholding the right of a person to consent to treatment and/or habilitation or rehabilitation options that may be available.

Commentators also argue for careful consideration to be given to legislative schemes specifically for those with mental illness. They argue that consideration should be given to whether such schemes have the potential to remove a person's right to other forms of less restrictive and intrusive ways of receiving health care, including through consents provided by guardians or other substitute decision makers.²³

This is not to suggest that a person shouldn't be detained to an Authorised Mental Health Service and/or placed on a limited community treatment order where the nature of their offence and their condition suggests significant risk to the person and/or community. Instead this reflects the view that the way in which legislative schemes for people with mental illness are administered should allow for people to be involved in deciding the 'treatment' and/or habilitation or rehabilitation options that may be available to them where they are deemed to have the capacity to appropriately do so.

In accordance with this, there may be some specific tensions between the current mental health system and the guardianship system in Queensland that could be explored as part of the review. These are discussed below and in relation to people with intellectual disability, more specifically addressed in Part B.

The issues involved are complex and rightly point to the risk for conflict of interest in providing guardians with potential powers to consent to involuntary treatment for mental illness, and the need for independent and reviewable decisions about decisions that interfere so greatly with a person's autonomy.

Issue 6.1: Treatment during the assessment period

The review should consider whether legislation should be amended to give greater recognition to a guardian or attorney when medication is proposed to be administered during the assessment phase and/or under urgent circumstances. For example, it could be explored whether guardians and attorneys could be given a reasonable opportunity to provide informed consent.

Issue 6.2: Exploring the potential role of a Guardian or Attorney where a person is subject to involuntary treatment

The potential role for guardians, as well as the involvement of other family members and people in the person's support network, in decisions regarding a person's treatment, the development of a treatment plan, decisions regarding any complementary support programs that should be offered to the person, and the use of restraint or seclusion should also be considered.

In particular the review should explore whether in practice people are provided with adequate opportunity to consent to treatment. If it is determined that the person does not have the capacity to consent and the circumstances do not require urgent treatment, it may be appropriate for a person's guardian or attorney to be consulted and provided with the opportunity to consent on the person's behalf.

Consideration could be given to strengthening the obligations on medical staff in the *Mental Health Act 2000* and the *Forensic Disability Act 2011* to consult with and involve guardians and attorneys in decisions made about treatment, where a person does not have the capacity to make their own decision.

²² T Campbell, *Mental Illness: Prejudice, Discrimination and the Law*, (Dartmouth, Aldershot, 1991); S Rosenman 'Mental health law: an idea whose time has passed' (1994) 29 *Australia and New Zealand Journal of Psychiatry* 560.; M Allen 'Why specific legislation for the mentally ill?' (2005) 30(3) *Alternative Law Journal* 103; Neil Rees 'Learning from the past, looking to the future: Is Victorian mental health law ripe for reform?' (Mental Health Review Board of Victoria's 20th Anniversary Conference, Melbourne, 2007).

²³ M Allen 'Why specific legislation for the mentally ill?' (2005) 30(3) *Alternative Law Journal* 103.

Issue 6.3: Clarity regarding the role of a Guardian or Attorney where a person is not subject to involuntary treatment

It seems that the role of a guardian or an attorney is currently unclear when the person for whom they are a guardian or attorney:

- is not subject to any mental health orders and has a mental condition that requires treatment, but does not meet the involuntary treatment criteria; or
- is only subject to a forensic order (mental health court disability) and has a mental condition that requires treatment, but does not meet the involuntary treatment criteria; or
- is subject to involuntary treatment but requires treatment for a condition, either in relation to a mental health issue or otherwise, that does not come within the definitions of ‘mental illness’ and ‘treatment’ and therefore could not be provided on an involuntary basis.

The review should consider this issue.

ISSUE 7: Operation of the Mental Health Review Tribunal

The Mental Health Review Tribunal (MHRT) has a fundamentally important role. As the entity principally responsible for the review of involuntary treatment and forensic orders (as well as numerous other review functions), the Tribunal provides independent oversight of the involuntary treatment and detention of people with mental illness and intellectual disability in Queensland.

I have two concerns that I believe should be considered in the review of the *Mental Health Act 2000* in relation to the functioning of the MHRT.

First, while a patient may be represented by a lawyer before the tribunal there is no absolute right to legal representation or advocacy for people who appear before the MHRT. The consultation paper could explore the advisability or feasibility of this.

Second, there should be a review of the administrative placement of the MHRT. It should be considered whether the MHRT is appropriately placed under the administrative oversight of the same agency (that is the Department of Health) that is responsible for the involuntary treatment of people with mental illness. While I can understand that some administrative efficiency must flow from this arrangement, it carries with it a question about sufficient separation and independence and for that reason would benefit from examination.

ISSUE 8: Diversion for people with impaired decision-making capacity who commit a simple offence or an indictable offence that can be dealt with summarily

At present, the Queensland Magistrates Court does not offer a diversionary option equivalent to the Mental Health Court for people who have committed a summary offence and deemed to be of unsound mind or unfit for trial. In *re AAM*,²⁴ the Queensland Court of Appeal noted that this is particularly problematic, stating:

“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 these 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.”²⁵

²⁴ *R v AAM; Ex parte A-G* (Qld) [2010] QCA 305 (5 November 2010) [9] (McMurdo P).

²⁵ *Ibid.*

The Special Circumstances Court no longer exists, having been discontinued in 2012. Thus, the Magistrates Court has no equivalent to the Mental Health Court and no ability to divert persons with disability and/or impaired decision-making capacity who have committed summary offences away from the criminal justice system.

The Commonwealth and New South Wales (NSW) legislation do not allow a Magistrate to determine a person's fitness to plead, but does give Magistrates a discretionary power when a person charged with a summary offence appears before the court and it appears to the Magistrate that they are intellectually or developmentally disabled.²⁶ In NSW, a Magistrate has the power to adjourn or dismiss matters, grant a person bail or make another appropriate order if a person has a developmental disability, mental illness or treatable mental condition.²⁷ The Magistrate may dismiss a charge or charges and discharge the defendant unconditionally, discharge the defendant into a responsible person's care or discharge the defendant on the condition that the person attends for assessment, treatment or both. In order to discharge the matter in this way, the Magistrate must be of the opinion that this is the most appropriate course of action.²⁸ The Commonwealth provides Magistrates hearing federal offences of a summary nature with the same powers in relation to a person with intellectual disability or mental illness.²⁹

The benefit of these provisions is that they do not require an assessment to be carried out (although the Magistrate may make this a condition of discharge). Assessments can be both time consuming, resource intensive and costly and perhaps sometimes unnecessary, depending on the circumstances.

The approach taken by NSW and the Commonwealth may be preferable in that it allows for speedy resolution of a matter, particularly where it is very clear that a person has disability and/or impaired decision-making capacity. Alternatively, this process may also be of use in the case of those people who may be caught within the provisions of Chapter 7, Part 2, *Mental Health Act 2000*, and may already be subject to an involuntary treatment order or forensic order and subsequently commit another simple offence or an indictable offence that can be dealt with summarily. The Magistrates Court may also be given the discretion to take into account any previous findings of unfitness or unsoundness of mind, and whether the person is subject to an involuntary treatment order or a forensic order in determining whether to utilise the diversionary options.

This approach allows people to be discharged into a safe environment or, if an order for treatment is made, to be discharged with some support services that may assist in reducing the risk of further offending. The primary difficulty is that there may not be sufficient support services with sufficient resources and capacity to adequately meet the volume of orders and the specific needs of each person. Without the existence of adequate support services, the value of discharging a person with an order for treatment is greatly reduced.

Should such diversionary options be considered, the suggested provisions regarding processes by which to uphold people's rights by ensuring their involvement in decision-making regarding treatment options, etc as referenced earlier in this submission should also be included in respect of these arrangements.

PART B: PEOPLE WITH INTELLECTUAL DISABILITY

ISSUE 1: Need for an integrated system for people with intellectual disability

1.1 Background

In the previous review of the *Mental Health Act 2000* conducted by Brendan Butler AM SC in 2006, it was recognised that despite the purpose, principles and schema of the Act only applying to people with mental illness, people with intellectual disability were also being captured by the provisions of the Act. It was identified that this was primarily because of those provisions of the Act dealing with criminal charges and forensic orders. In addition to identifying the inappropriateness of detaining people with intellectual disability and no mental illness in authorised mental health services, Butler AM SC stated that:

“It would appear that the reason people with an intellectual disability who commit serious offences are dealt with under the *Mental Health Act 2000* is that there are no alternative legislative or service arrangements for people with an intellectual disability who require secure care. The *Disability Services Act 2006* (and its predecessor) does not contain analogous provisions

²⁶ Betheli O'Carroll, 'Intellectual Disabilities and the Determination of Fitness to Plead in the Magistrates' Courts' (2013) 37 *Criminal Law Journal* 51, 61.

²⁷ *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32; O'Carroll, above n 26, 61.

²⁸ *Ibid.*

²⁹ *Crimes Act 1914* (Cth) s 20BQ; O'Carroll, above n 26, 61.

to the civil or forensic provisions in the *Mental Health Act 2000* for the involuntary care and treatment of people with a mental illness.”³⁰

In his final report, *Promoting Balance in the Forensic Mental Health System: Final Report Review of the Queensland Mental Health Act 2000* (the Butler Report), Butler AM SC recommended that “a review of the provisions of the *Mental Health Act 2000* affecting people with intellectual disability be conducted as part of any reform to provide secure care for people with intellectual or cognitive disability who exhibit severely challenging behaviour”.³¹

In 2006, the Honourable William Carter QC commenced a review in relation to the “existing provisions for the care, support and accommodation of people with an intellectual/cognitive disability who represent a significant risk of harm to themselves or the community”.³² His final report *Challenging Behaviour and Disability: A Targeted Response* (the Carter Report) identified the inappropriateness of placing people with intellectual disability in Authorised Mental Health Services, as well as the fragmented response to people with intellectual disability who exhibit challenging behaviours generally, regardless of whether they are subject to a forensic order.³³

The Carter Report³⁴ recommended a legislative framework for restrictive practices inclusive of provisions for detention (where a person was not subject to a forensic order or another order of a court). However, this was only one of many recommendations aimed at “a fundamental process of reform, renewal and regeneration of the DSQ and disability sector’s response [to] provide an efficient, cost effective and financially sustainable outcome for the proper care and support of persons with intellectual disability and challenging behaviour across Queensland”.³⁵

The recommendations for reform included, amongst others:

- A comprehensive multi-disciplinary assessment process in respect of the particular person with a view to the development of an individualised positive behaviour support plan for that person;
- An ongoing effective interaction between the assessment process and the intervention process within the community which will require coordination and individualised plan management at the regional level so as to ensure the effective maintenance and integrity of the total process in the best interests of the individual person;
- This process of assessment, intervention and coordination and individual plan management will operate collaboratively across the whole sector and will be available to and accessible by both DSQ and NGO service providers;
- The immediate establishment of suitable accommodation to enable an immediate and effective response in those cases that require emergency management; and
- The urgent and planned development of a range of accommodation options that respond to the need for secure care, transitional accommodation arrangements and community living for the target group.

This systemic response to people with intellectual disability or cognitive impairment who exhibit behaviours that put themselves or others at harm should have broad applicability, regardless of what point the person comes into contact with the system.

1.2 The current scheme

The current scheme for involuntary treatment of people with intellectual disability is now fragmented across the *Mental Health Act 2000* (forensic orders for people who have been found unfit to plead or unsound of mind); the *Disability Services Act 2006* and the *Guardianship and Administration Act 2000* (in approving the use of restrictive practices); the *Forensic Disability Act 2011* (detention in the Forensic Disability Service, including provisions for behaviour control medication) and the health care provisions of the *Guardianship and Administration Act 2000*.

This fragmentation creates confusion, leaves gaps and often results in less than optimal responses to people with intellectual disability who come into contact with the criminal justice system, as further outlined below.

³⁰ Brendan Butler AM SC, *Promoting Balance in the Forensic Mental Health System: Final Report Review of the Queensland Mental Health Act 2000* (2006) 101.

³¹ *Ibid* 102.

³² Carter William QC, *Challenging Behaviour and Disability: A Targeted Response*, (Report to Warren Pitt MP, Minister for Communities, 2006, 4.

³³ *Ibid* 87.

³⁴ *Ibid*.

³⁵ *Ibid* 9.

1.3 The need for an integrated system of care and support

The review should consider the current fragmentation of the system and explore ways to better integrate the provision of care and support to people with intellectual disability whose behaviours put themselves and others at risk of harm. Legislative reform will be just one aspect of the changes needed to better respond to this cohort.

The purpose of the *Mental Health Act 2000* “is to provide for the involuntary assessment and treatment, and the protection, of persons (whether adults or minors) who have a mental illness while at the same time safeguarding their rights and freedoms and balancing their right and freedoms with the rights and freedoms of other persons”.³⁶ Therefore, it is evident that the cohort to whom the *Mental Health Act 2000* is intended to apply is people with mental illness.

While the establishment of the Forensic Disability Service and the commencement of the *Forensic Disability Act 2011* went some way towards addressing the concerns raised in the Butler and Carter Reports by providing a more appropriate model of care for people with intellectual disability or cognitive impairment who are found to be unsound of mind or unfit for trial by the Mental Health Court, it is not sufficient. *The Forensic Disability Act 2011* only provides the legislative framework for the ten-bed Forensic Disability Service; it does not provide a holistic system response to enable coherent, consistent and integrated care and support options for this cohort.

Despite the Carter and Butler Reports being released over seven years ago, there continues to be people with intellectual disability and no “mental illness requiring involuntary treatment” who reside in mental health facilities. Some of these people are subject to a forensic order and some are not. Some people with intellectual disability are subject to approval for containment and seclusion by QCAT where they are held in detention-like conditions in the ‘community’. Some of these people are also subject to forensic orders and are receiving limited community treatment whilst subject to containment. I am also aware of a cohort of people who have come to reside on the site of the previous Basil Stafford Centre at Wacol, initially entering this accommodation because they were in ‘crisis’. Unfortunately, it now seems that this has become a destination for these people who remain there under restrictive practice approvals long after they should have ‘transitioned’ to sustainable long-term community-based arrangements..

There are also people where the nature of their criminal offences does not bring them before the Mental Health Court, yet whose pattern of escalating behaviours also indicates a need for support. People who commit summary offences, particularly multiple summary offences, may never come before the Mental Health Court but they may still be in need of support to mitigate against recurrent contact with the criminal justice system or escalating harmful behaviours.

There is an urgent need for this situation to be reviewed and for further support and accommodation to be provided throughout Queensland, including the provision of ‘step down’ or ‘transitional’ services to assist people to make the transition back to community living in less restrictive environments. Legislative reform for the entire cohort should be considered such that it would provide for a pathway to an integrated service system based on the type of disability-focussed model of care outlined by the Carter Report and provided by Disability Services.

ISSUE 2: Operation of the Mental Health Court and the Mental Health Review Tribunal

The review of the *Mental Health Act 2000* should consider whether additional experts should be provided to give advice to the Court and the Tribunal regarding persons with intellectual disability. The Court and Tribunal are currently advised by a variety of professionals with psychiatric experience; however, these professionals may not necessarily have experience with intellectual disability. The need for expert advice in relation to people with intellectual disability may be even more pronounced at the review stage before the Tribunal, where assessment of a person’s progress and future prospects would arguably require expertise in the field of intellectual disability.

ISSUE 3: Classified Patients

Where a person displays indicia of mental illness and is before a court, in custody or in detention, they may be made a ‘classified patient’ and taken to an authorised mental health service for assessment. If assessment reveals that treatment is warranted, they may be detained at the service and provided with treatment. Alternatively, in instances where a person voluntarily seeks inpatient treatment for mental illness, the person may apply for and be granted bail on the condition that they will reside at the treating mental health service.

³⁶ *Mental Health Act 2000* (Qld) s 4.

The ‘classified patient’ provisions of the *Mental Health Act 2000* would not apply to persons with intellectual disability unless they also display signs of mental illness. There are no equivalent provisions in the *Mental Health Act 2000* or the *Forensic Disability Act 2011* that allow a person with intellectual disability who is remanded in custody and subject to a forensic order (mental health court disability) or a reference to the Mental Health Court, to be moved to a disability support service and provided with any necessary care and support.

This can result in two scenarios. First, persons with intellectual disability who may be subject to a forensic order and commit a subsequent offence may be remanded in prison while they await a hearing in the Mental Health Court. Second, people with intellectual disability and no forensic order may be either remanded to a prison while they await their hearing, or sentenced to prison following a hearing.

In the first scenario I believe the review should give serious consideration as to whether there should be provision (other than the granting of bail) that should allow for a person with intellectual disability to be transferred to more appropriate secure accommodation while they await their hearing in the Mental Health Court.

The second scenario raises more complex issues. Evidence suggests that unfortunately there are a high number of people with mild to moderate intellectual disability in our prisons.

However even if such provisions existed, I recognise that there is currently a lack of appropriate secure disability support services that could be utilised for this purpose. Similarly, although legislation does not prevent a person with intellectual disability from applying for bail on the condition that they will reside at an appropriately secure disability support service, they are unable to do so due to the lack of available services.

Again this suggests that there is a need to look into a holistic system of response for people with intellectual disability who come into contact with the criminal justice system.

ISSUE 4: Definition of ‘treatment’ and involuntary treatment of people with intellectual disability

A forensic order (mental health court disability) made under the *Mental Health Act 2000* provides authority for the detention and care of a person, but not involuntary treatment.³⁷

This is appropriate given that people with intellectual disability, but no “mental illness requiring involuntary treatment”, do not require ‘treatment’ for a mental illness and instead need access to services that appropriately address their needs within the context of their intellectual disability.

However, many people with intellectual disability are still being administered medication of some type or another. This is often medication for ‘health care’ as defined by the *Guardianship and Administration Act 2000*. In this case, if a capacity assessment determines that the person is unable to consent to the medication, then the usual hierarchy of decision makers would apply in section 66 *Guardianship and Administration Act 2000* and section 63 *Powers of Attorney Act 1998*.

Where it becomes more problematic is when the medication being administered may not be strictly for ‘health care’ purposes (that is to diagnose, maintain or treat the adult’s physical or mental condition),³⁸ but instead is being used for the purposes of controlling the adult’s behaviour.

In Queensland, since 2008 and the commencement of Part 10A of the *Disability Services Act 2006* and Chapter 5B of the *Guardianship and Administration Act 2000*, it is now recognised that some medication is administered primarily for behaviour control, and is not therefore considered to be ‘health care’. Ambiguity in relation to whether the administration of what is now known as ‘chemical restraint’ could be authorised as ‘health care’ has previously been raised by the Guardianship and Administration Tribunal (the predecessor of QCAT)³⁹ and by the Queensland Law Reform Commission.⁴⁰

While a person is detained in the ten-bed Forensic Disability Service, the *Forensic Disability Act 2011* provides for the administration of behaviour control medication⁴¹ but this is not applicable to the majority of those under a forensic order (mental health court disability) who are not detained in that service.

³⁷ *Mental Health Act 2000* (Qld) s288.

³⁸ *Mental Health Act 2000* (Qld) Schedule 1, Part 2, s5.

³⁹ *Re AAG* [2009] QGAAT 43.

⁴⁰ Queensland Law Reform Commission, *A Review of Queensland’s Guardianship Laws* (Report no 67, 2010) chapter 19.

⁴¹ *Forensic Disability Act 2011* s50.

It seems there may be further ambiguity about how a person with intellectual disability subject to a forensic order (mental health court disability) should be administered medication for mental illness if they do not have the capacity to consent to it themselves and do not meet the threshold of involuntary treatment for a mental illness under the *Mental Health Act 2000*.⁴² In *re DKB*, her Honour, Justice Lyons asked the following questions about a man who had a significant intellectual impairment and epilepsy, and who was being administered medication for depression (in addition to also being prescribed Risperidone and Androcur).

“It may be that consent for mental health treatment can be provided under the substitute decision-making regime. The question would seem to be whether DKB can be involuntarily treated for a mental illness through the substitute consent regime of the *Guardianship and Administration Act 2000* (Qld)? Can the Adult Guardian consent to treatment for a mental illness where a person is incapable of consenting himself, particularly given the clear indication in s 13(2) and s 14(2) of the *Mental Health Act 2000* that a substitute decision-maker cannot give the relevant consent for either assessment or treatment as required for those sections?”⁴³

While I recognise the inherent ambiguities here, I am concerned that we do not simply authorise a system of involuntary treatment for people with intellectual disability, similar to that which currently exists for people with mental illness. We have come a long way towards challenging the medical model for the care and support of people with disability, however I do not think we are quite there yet.

Evidence suggests that people with intellectual disability continue to be administered a range of medication including psychotropic medication even where they do not have a mental illness. I am of the opinion that this medication is often administered in lieu of appropriate support services designed to address ‘challenging’ but purposeful behaviours that have been learnt over time and that put themselves and others at risk of harm.

The review of the *Mental Health Act 2000* should further explore the issues that have arisen with the introduction of the forensic order (mental health court disability). However I advise a very cautious approach towards seeking a ‘quick fix’ by amending the *Mental Health Act 2000* to allow involuntary treatment to form part of the forensic order (mental health court disability).

Ultimately the overall aim must be the provision of adequate and integrated systems of support that are able to be tailored to the specific needs of the person with intellectual disability with a view to reducing and/or eliminating the use of medication as a means of attending to complex needs that might more appropriately be addressed by different models of support.

ISSUE 5: The use of restrictive practices for limited community treatment

My attention has recently been drawn to arrangements that are being used for people who cannot be accommodated in the forensic disability service, and which for me is indicative of the issues I have discussed above in relation to the lack of appropriate services, including ‘transitional’ services and a generally fragmented systemic response.

I am aware that people with intellectual disability who are subject to a forensic order (mental health court disability) have theoretically been granted limited community treatment, but have also been made subject to containment under the restrictive practices regime and are held in the ‘community’ in circumstances of detention. I am of the view that this arrangement is manifestly inappropriate, particularly given that limited community treatment is intended to gradually return a person to the community and enable them to experience less restrictive conditions under their forensic order. This clearly cannot be achieved when a person is made subject to continuing detention. It is apparent that the restrictive practices regime is being improperly used in lieu of appropriate services and supports for people subject to a forensic order (mental health court disability), including in the provision of ‘transitional services’ and/or in emergency and crisis situations.

This improper use of the restrictive practices regime impacts significantly upon the human rights of people who are detained in the community. Not only does this practice infringe upon their right to equal treatment, both generally and before the law, but it also arguably impacts upon their right to access habilitation and rehabilitation services and their right to participate and be included within the community.

⁴² *Re DKB* [2012] QMHC 6.

⁴³ *Re DKB* [2012] QMHC 6 [58] Lyons J.

While I can envisage situations where the use of restrictive practices may be necessary in transitioning a person to community-based living, while ensuring the safety of the person and others, I do not think that containment should be used where a person should really be in circumstances of detention and receiving proper care, habilitation and rehabilitation aimed at their offending behaviours.

I would therefore suggest that the review consider whether it is appropriate to rely upon the restrictive practices regime in addressing the limitations of the forensic order (mental health court disability). If deemed to be an appropriate systems response to the needs of this cohort, attention must then be given to the way in which the restrictive practices regime should interact with the system for limited community treatment under the *Mental Health Act 2000* while still ensuring due consideration for human rights and seeking to achieve beneficial outcomes that address individual needs and reduce recidivism.

Concluding Comments

The complex interplay of legislation that underpins many of the issues outlined in my submission is by no means an easy thing to address. Arguably it could be said that the situation has arisen as a by-product of the fragmented and inequitable human services system in Queensland.

Queensland adults with impaired decision-making capacity, including those with mental illness, intellectual disability and cognitive impairment, are among the most disadvantaged people in the community. An unacceptably high level of disadvantage is experienced across a range of social and economic indicators. This disadvantage significantly reduces quality of life and increases the risk of these adults coming into contact with the criminal justice system and, in many cases, subsequently appearing before the Mental Health Court.

Recognition for the inherent human rights that must be afforded to people with mental illness, intellectual disability or cognitive impairment is at the core of my submission, and will continue to be central to my consideration of any reforms that may be proposed in the course of this review.

With this in mind, I am pleased to lend my support to the Department as it progresses this important review in the interests of improving the *Mental Health Act 2000* and, by association, the way in which the Queensland mental health system upholds the rights of those individuals it purports to serve. I look forward to engaging further with the Department in the course of the review and to expanding on the points made in this submission should there be an opportunity to do so.



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