CHAIR: But I am not sure asking for an opinion from the deputy director-general is where we need to be. We should be asking questions of clarification.

Mrs MILLER: Can you clarify that?

CHAIR: Could you answer from the perspective of providing clarification?

Mrs MILLER: I want to know about the monitoring devices. I am well aware of this. I have been a member of parliament for a long time. These anklet devices are monitoring devices that are used to protect the community. They are anklet devices. Will mental health patients have to wear similar anklet devices which paedophiles wear in our community? Is that the type of device that you are talking about?

Dr Cleary: Thank you very much for the question. The new provision provides for enhanced monitoring of patients and very specific classes of patients—forensic patients, classified patients and patients under section 273 orders. The monitoring provisions are there to provide safety and security for both the patients and the community. Monitoring can be undertaken in a range of mechanisms. One of those mechanisms could be for a telephone call to be made on a regular basis while a person is on leave or for a person to be at a predesignated spot at a particular time. It does not preclude the use of other monitoring devices. That is an area that will need some further exploration.

In terms of the monitoring devices that could be used, my understanding is that they have been used overseas and to very good effect and provide an ability for the patient—and these are forensic patients who are often patients of special notification who are perhaps on their first episode of unescorted leave on the grounds. In those circumstances, the technologies provide a range of benefits, one of which is being able to locate a patient if they do not return within a specified time frame. As I understand it, there is also the capacity for voice to be sent to be patients using the same technology to advise them that they may be out of the area that they are supposed to remain within. So it can be of benefit to the patients so that they know they have crossed a boundary or that they have entered an area that they are to be excluded from.

So, in terms of the types of technologies that are available, they will span from telephone with regular reporting in to being at a designated place or to other devices or other technologies that may be appropriate. I think it does provide both security for the patient and for the community. As we talked about earlier, it is about balance. That is what the Mental Health Act 2000 does. It is trying to balance the benefits of patients from care and the benefits to the community.

Mrs MILLER: So I assume from that that, yes, it will include anklet devices—that, yes, it could include that.

Dr Cleary: Yes, there is the possibility that monitoring devices could be used. The specific types of monitoring devices have not been explored.

Mrs MILLER: Can I go back to my earlier question in relation to the United Nations convention—

CHAIR: Just a second. How much more do you have, Jo?

Mrs MILLER: I have about another four questions and then I will be finished.

Mr DAVIES: Can I ask a question?

CHAIR: Just a second please. I am going to allow you to continue and finish. But I have some time frames to work within here and I would like to let some of the other members of the committee ask questions. So ask another couple of questions and then we will move on to someone else.

Mrs MILLER: I would like to ask about the United Nations conventions in relation to disabilities. For example, you talk about mental health patients—which are the subject of this act—and their particular concerns and protecting the community et cetera. But there are also United Nations conventions regarding persons with disabilities such as intellectual disabilities. So what I am asking is: in relation to the United Nations conventions, has the department or Parliamentary Counsel or whoever has devised this legislation taken into account those United Nations conventions and does this fall within that?

Dr Kingswell: There are probably two conventions that we would have had reference to—one is the UN Principles for the Protection of Persons with Mental Illness and the second is the Convention on the Rights of Persons with Disabilities. I would not think this legislation is contrary to either of those declarations in that it does not apply to a group of people with mental illness. It applies to an individual person undertaking limited community treatment usually for quite specific reasons, either the nature of the serious offending or the stage they are in their process through the mental health system.

Mrs MILLER: Thank you. In relation to the bracelet devices, would it be possible for a person to be able to take an action under the Anti-Discrimination Act if they believed they had an anklet device on them which would perhaps have the public thinking that they are either a very serious paedophile or a criminal, that the public would have that particular mindset, yet they are actually a mental health patient? How would that sit as far as the anti-discrimination legislation?

Dr Cleary: I will just make a couple of general comments. Firstly, I think the monitoring provisions are provisions that may in fact be of benefit to patients. If you are thinking about the care and treatment being supported by limited community treatment, early access to limited community treatment, I think, is a positive benefit to the patients because they are then able to become more mobile and move towards

integrating back into the community. So, from that perspective, monitoring to allow people to have earlier access to limited community treatment is a positive in that it benefits the patients. In terms of the specific provisions of the legislation, they allow for appeal, and I might ask Rachel Welch if she could comment on the general provisions around appealing a decision.

Ms Welch: Yes. They can be reviewed by the Mental Health Review Tribunal, as we previously discussed. A patient can cause an action to the Mental Health Review Tribunal to seek a review of that condition being placed on their limited community treatment. The tribunal would be reviewing it every six months anyway, and the tribunal could cease that condition if they felt it was appropriate to cease it.

Mrs MILLER: But it would not stop them taking an anti-discrimination action either, would it? It would not preclude them from doing that.

Ms Welch: I do not know if the Anti-Discrimination Act would be triggered by that action. That is something you would—

Mrs MILLER: Can you take that on notice then?

Ms Welch: We would need to get legal advice on that.

CHAIR: Mr Davies.

Mr DAVIES: My question is to Dr Kingswell. I am just trying to work out how the commission will work in the real world as far as the integration of early identification of issues and public awareness are concerned. It is a strategic body, but how will it actually influence the day-to-day running of mental health services as far as early intervention and so forth are concerned?

Dr Kingswell: At the moment responsibility for the whole-of-government mental health sector and the intersection of the Queensland government with the federal government all sits within my branch. This legislation will establish the commission as an independent statutory body reporting directly to the minister and it will take out of my directorate a lot of those functions that we are currently responsible for. So the whole-of-government strategic plan around preventing suicide, for instance, would be a function of this commission. Beyond just the six people and the commissioner that it is currently envisaged to constitute this commission, they will also take program budgets from our department to be administered, and that will include the early intervention prevention project.

Mr DAVIES: So where does drug and alcohol abuse sit or how will that work as far as awareness programs are concerned? Will the commission actually take that completely?

Dr Kingswell: There is a whole-of-government Queensland Drug Action Plan, which is currently in abeyance waiting the establishment of the commission. We would expect that the commission would pick up that function—chair the interdepartmental committee, review the Queensland Drug Action Plan, review the priorities within that plan and establish some actions around it.

CHAIR: Does the commission take any broad direction from a federal body or federal direction in any way? For example, are there any COAG arrangements or agreements with regard to the strategic focus of the commission or is there purely a Queensland-centric focus?

Dr Cleary: At this stage the commission is a Queensland entity and is established as a statutory body within Queensland. Having said that, there has been a significant amount of work done nationally in aligning mental health with alcohol and drug services and the policy oversight of those areas. We now have a national group that reports to the Australian Health Ministers Advisory Council which takes up both those portfolio issues. Previously they were separated and at a lower level within the national governance framework. Within each state and territory we are now seeing the emergence of mental health commissions, and they all have some variation so they are not a standard arrangement. But they are certainly being developed in each of our states and territories or larger states and territories. And of course we have the national commission, which recently released its report.

When we were looking at establishing the legislation in Queensland, we had the benefit of being able to review the outcome of the policy and the legislative arrangements in each of the states and territories. We also looked overseas at Canada and New Zealand, which have had organisational arrangements that are considered to be world-class. So drawing on all of that information we then set about developing the policy framework and then the legislation for the Queensland commission. I believe—and I can say this with some independence not having been involved in the drafting—the framework we have has drawn on all the strengths from the overseas and interstate commissions.

We have also received very positive feedback from the community from carers, from patients and from advocacy groups around the proposed legislation. That has been very, very positive. So I think for Queensland we will have a very good framework to go forward. Nationally the report which was released recently was positive about Queensland in terms of it recognised that Queensland had provided the right framework for mental health services and was even reporting information to a higher level than some of the other states and territories around mental health services and their performance. I think the commission will further enhance that role because it will be able to access information from Queensland Health on service provision and again provide an independent view of the services provided not just in the public sector but also across government and in non-government sectors.

I am very positive about the commission. I think it will work very closely with the other commissions and with the national commission. But clearly it has a strong link to parliament and the minister.