Parliamentary Committees

Queensland Mental Health Commission Bill 2012

Report No. 17
Health and Community Services Committee
February 2013

Health and Community Services Committee

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Chair's foreword

On behalf of the Health and Community Services Committee of the 54th Parliament of Queensland, I present this report on the Queensland Mental Health Commission Bill 2012 (the Bill).

The Bill was introduced into the Legislative Assembly by the Minister for Health on 27 November 2012. The committee was required to report to the Legislative Assembly by 27 February 2013.

The committee's task was to consider the policy to be given effect by the legislation, as well as the application of fundamental legislative principles – that is, whether the Bill has sufficient regard to rights and liberties of individuals and to the institution of Parliament.

The Bill establishes the Queensland Mental Health Commission and amends the *Mental Health Act 2000.*

On behalf of the committee I thank those individuals and organisations who made written submissions on this Bill and gave evidence at its public hearing, and others who have informed the committee's deliberations: the committee's secretariat, officials from Queensland Health and the Technical Scrutiny of Legislation secretariat.

I commend the report to the House.

Trevor Ruthenberg MP
Chair

February 2013

Abbreviations

the Advisory Council	the Queensland Mental Health and Drug Advisory Council
the Bill	*Queensland Mental Health Commission Bill 2012*
CALD	culturally and linguistically diverse
the committee	Health and Community Services Committee
the Director	The Director of Mental Health
HHBA	*Hospital and Health Boards Act 2011*
MHA	*Mental Health Act 2000*
the Minister	the Minister for Health
QMHC	the Queensland Mental Health Commission
the Tribunal	the Mental Health Review Tribunal

Glossary

authorised mental health service	Community based and impatient mental health facilities in Queensland declared by the Director of Mental Health.
Director of Mental Health	A statutory appointment made by the Governor in Council under the *Mental Health Act 2000.*
forensic order	An order made by the Mental Health Court, if the court decides a person was of unsound mind at the time of the offence, or that the person is permanently unfit for trial. This order authorises a person's detention in an authorised mental health service for involuntary treatment and care.
forensic patient	A person who is, or is liable to be, detained in an authorised mental health service under a forensic order.
classified patient	A person who has been admitted to an authorised mental health service for assessment and inpatient treatment from a court or place of custody.
involuntary treatment order	An order authorising the treatment of a person's mental illness without the person's consent. A person must meet the treatment criteria set out in the *Mental Health Act 2000* before an order can be made.
limited community treatment	Limited community treatment provides an opportunity for patients to receive treatment or care in the community. It is usually a graduated process, in line with improvements in the patient's mental condition or behaviour and successful periods of limited community treatment.

Mental Health Court	A court established under the *Mental Health Act 2000* to conduct an inquiry to determine whether an accused person is fit to stand trial or was of unsound mind at the time of an offence or, if the charge is murder, whether the person was of diminished responsibility. The court also decides appeals against decisions of the Mental Health Review Tribunal, and may investigate the detention of patients in authorised mental health services in Queensland. It comprises the president of the court and other Supreme Court judges who are assisted by two psychiatrists.
Mental Health Review Tribunal	An independent body established under the *Mental Health Act 2000* to conduct regular reviews of patients who are subject to involuntary treatment orders.
relevant agencies (Schedule to the Bill)	**Relevant agencies** means a: human service agency (a department or government agency or publicly funded non-government agency that delivers human services to a relevant person); or service delivery agency (a department, government agency or publicly funded non-government agency to the extent that they are involved in mental health or substance misuse services).
relevant patients (Schedule to the Bill)	**Relevant patients** are defined as a: classified patient forensic patient; and section 273(1)(b) patient.
relevant persons (Schedule to the Bill)	**Relevant persons** means people with mental health or substance misuse issues, and their families, carers and support persons. The term people affected by mental health or substance misuse issues is used to describe “relevant persons” in this report.
section 273(1)(b) patient	A patient subject to an order made by the Mental Health Court that he or she is fit for trial, but should be detained in an authorised mental health service until they are granted bail or returned to court for proceedings to continue.

Recommendations

Recommendation 9 **22**

The committee recommends that the Bill be amended to require the Director of Mental Health to give written reasons for his or her decision to require a relevant patient to wear a monitoring device, at the time the decision is taken.

Recommendation 10 **26**

The committee recommends that the Bill be amended to require the Director of Mental Health to take all reasonable steps to consult each patient's treating psychiatrist before making an order to suspend limited community treatment.

Recommendation 11 **26**

The committee recommends that the Bill be amended to require the Director of Mental Health to give written reasons for the decision to suspend limited community treatment, at the time the decision is taken.

Recommendation 12 **28**

The committee recommends that the Bill be amended to provide that the Mental Health Review Tribunal must review an order made by the Director of Mental Health to suspend a class of patients' limited community treatment within seven days after the order has been made.

1 Introduction

1.1 Role of the committee

The Health and Community Services Committee (the committee) was established by resolution of the Legislative Assembly on 18 May 2012, consisting of government and non-government members.

Section 93 of the *Parliament of Queensland Act 2001* provides that a portfolio committee is responsible for considering:

- the policy to be given effect by the Bill; and
- the application of the fundamental legislative principles to the Bill.

1.2 Process

The Queensland Mental Health Commission Bill 2012 (the Bill) was referred to the committee on 27 November 2012, and the committee is required to report to the Legislative Assembly by 27 February 2013. Queensland Health officials briefed the committee about the Bill on 17 December 2012. Submissions were invited, and 30 were received – five of which were in support of the Queensland Network of Alcohol and Other Drug Agencies' submission (see Appendix A). The committee held a public hearing on 13 February 2013 at Parliament House and heard from 6 witnesses (see Appendix B).

Transcripts of the briefing by Queensland Health and the public hearing, and submissions received and accepted by the committee are published on the committee's webpage at www.parliament.qld.gov.au/hcsc.

1.3 Policy objectives of the Queensland Mental Health Commission Bill 2012

Mental illness and substance misuse impact on the lives of many Queenslanders. The Explanatory Notes to the Bill state that an estimated one in five Queenslanders will experience mental illness (including substance misuse) in any one year, and almost one in two people between the ages of 16 and 85 will experience mental illness at some point in their lives. People suffering from mental health or substance misuse issues are also over-represented among recipients of human services, such as homelessness and child protection services. [1]

The government considers that there are currently a number of significant issues with mental health and substance misuse services in Queensland. The government's concerns centre on accessibility, continuity of support, early intervention, public awareness, and the delivery of integrated, evidence-based community support services – both from the public sector and publicly funded non-government agencies.[2]

1.3.1 Establishment of the Queensland Mental Health Commission

The Bill seeks to address these issues by establishing a statutory body called the Queensland Mental Health Commission (the QMHC) to drive reform towards a "more integrated, evidence-based, recovery-orientated mental health and substance misuse system".[3] The Government envisages that the QMHC will:

- lead co-ordinated action by public sector and publicly funded non-government agencies providing mental health or substance misuse services or other human services (for example housing, education, policing)

[1] Explanatory Notes, Queensland Mental Health Commission Bill 2012, p. 1
[2] Explanatory Notes, p. 2
[3] Explanatory Notes, p. 1

- drive best practice in the provision of services, including by supporting knowledge sharing, research, innovation and evidence-based policy and practice; and
- promote the mental health and well-being of Queenslanders, including by supporting prevention and early intervention initiatives and enhancing community awareness of mental health and substance misuse issues. [4]

The principle mechanism for achieving these objectives will be the QMHC developing, implementing, monitoring and reporting to the Minister for Health (the Minister) on a 'whole-of-government strategic plan' for the improvement of mental health and the limiting of harm associated with substance misuse.

Stakeholder engagement in the QMHC's strategic work will primarily be through the Mental Health and Drug Advisory Council (the Advisory Council). The role of the Advisory Council would be to advise the QMHC on any mental health or substance misuse issue within the QMHC's functions.

1.3.2 Amendments to the Mental Health Act 2000

The Bill also amends the *Mental Health Act 2000* (the MHA), following recent incidents involving forensic patients who absconded whilst on limited community treatment (LCT).[5] The amendments provide the Minister and Director of Mental Health (the Director) with additional powers aimed at avoiding future occurrences. These new powers include:

- the Director requiring a relevant patient (i.e. a classified, forensic or section 273(1)(b) patient) to be subject to a monitoring condition while on LCT
- the Minister directing the Director to investigate a matter relating to a patient under the MHA, if the Minister considers there is a serious risk to the life, health or safety of a person or a serious risk to public safety because of the matter
- the Director suspending a patient's, or a specified class of patients', LCT; requiring a review of all treatment plans and planned implementation of LCT; and review of procedures and protocols about the authorisation of LCT; and
- the Director authorising the publication of identifying information about individuals who are the subject of mental health proceedings, if doing so would lessen or prevent a serious risk of harm to the patient or public, or it is in the public interest to do so. [6]

[4] Explanatory Notes, p. 2
[5] Explanatory Notes, p. 2
[6] Explanatory Notes, p. 7

2 Examination of the Queensland Mental Health Commission Bill 2012

2.1 Should the Bill be passed?

Standing Order 132(1) requires the committee to recommend whether the Bill should be passed. The committee considered the main policy changes which the Bill would implement, as well as the application of fundamental legislative principles.

After its examination of the Bill the committee determined to recommend that the Bill should be passed. The committee has also recommended amendments to the Bill to address concerns raised by stakeholders.

Recommendation 1

The committee recommends that the Queensland Mental Health Commission Bill 2012 be passed.

3 The Queensland Mental Health Commission

3.1 Objectives and guiding principles

Clause 4 provides that the Bill's objective is to establish the QMHC to drive ongoing reform towards a more integrated, evidence-based, recovery-orientated mental health and substance misuse system. The main mechanisms for achieving this objective are:

- developing a whole-of-government strategic plan that provides for coordinated action in the delivery of services, promotes the best interests of people affected by mental health or substance misuse issues, and drives innovation and best practice
- monitoring, reviewing and reporting on issues impacting on people affected by mental health or substance misuse issues; and
- promoting prevention, early intervention and community awareness strategies.

Clause 5 of the Bill sets out overarching guiding principles, which all persons performing a function or exercising a power under the Act would be required to have regard. The guiding principles can be summarised as follows:

- people with a mental illness or who misuse substances:
    - should have access to quality services, care and support wherever they live
    - should be treated with dignity and respect
    - should be supported to participate fully in community life and lead meaningful lives; and
    - have the same right to privacy as other members of society
- Aboriginal and Torres Strait Islander people should be provided treatment, care and support in a way that recognises and is consistent with Aboriginal tradition or Island custom, and should be delivered in a culturally appropriate and respectful manner
- carers, family members and support persons are integral to the wellbeing, treatment and recovery of consumers, should be respected, valued and supported, and should be engaged, wherever possible, in treatment plans; and
- an effective mental health and misuse system is a shared responsibility of the government and non-government sectors and requires, for instance, a co-ordinated and integrated approach to service delivery, communication and collaboration and strategies that foster inclusive, safer, healthier families, workplaces and communities.

These principles are consistent with the principles in sections 4, 8 and 9 of the MHA.

3.2 Establishment and functions

Clause 8 of the Bill establishes the QMHC, as a statutory body, whose main functions are:

- preparing the whole-of government strategic plan, monitoring and reporting to the Minister on its implementation, and undertaking reviews of the plan
- reviewing, evaluating, reporting and advising on mental health and substance misuse system, other issues impacting on people affected by mental health or substance misuse issues, and other issues affecting community mental health and substance misuse
- promoting and facilitating the sharing of knowledge and ideas about mental health and substance misuse issues
- undertaking and commissioning research about mental health and substance misuse issues
- supporting and promoting strategies that prevent mental illness and substance abuse and provide for early intervention
- supporting and promoting the general health and wellbeing of people affected by mental health or substance misuse issues

- supporting and promoting social inclusion and recovery of people affected by mental health or substance misuse issues; and
- promoting community awareness and understanding about mental health and substance misuse issues.

The QMHC also has a broad power to take other action it considers appropriate to address the needs of people affected by mental health or substance misuse issues.[7] The QMHC may also issue guidelines about the operation of the proposed Act or QMHC's functions.[8]

Clause 11(2) sets out the actions the QMHC must take, and the factors it must take in account, when discharging its functions. They include: focussing on systemic rather than operational issues; engaging and consulting with stakeholders and partners; taking into account co-morbid issues, criminal justice issues, contemporary evidence and policy; and taking into account the views, needs and vulnerabilities of different communities. The QMHC's powers include the powers of an individual, for example to enter into contracts, acquire and dispose of property, engage consultants or contractors and appoint staff.

3.2.1 Support for the establishment of the Queensland Mental Health Commission

The majority of submissions supported the establishment of the QMHC and the development of a whole-of-government strategic plan.[9] In particular, submitters welcomed the focus on a co-ordinated approach to service delivery, the acknowledgement of the important role of carers, family members and support persons, and the need for an evidence-based mental health and substance misuse system.[10] The Queensland Alliance for Mental Health stated that:

> *the establishment of the QMHC is an important and exciting step along the challenging but important path to improve the lives of people who have or will experience mental illness in Queensland… There are expectations that the QMHC will have significant influence across Government to bring about compelling and bold change.*[11]

Submitters also supported the QMHC's focus on prevention, early intervention and promoting community awareness of mental health and substance misuse issues.[12] Submissions supported the development of broader community strategies, engagement and consultation with stakeholders and the requirement for QMHC to take into account the needs, views and vulnerabilities of culturally and linguistically diverse (CALD) communities.[13] The Public Advocate stated that she

> *commends the focus on promoting the best interest of the people it [the QMHC] serves to protect, to its recognition of the role that carers and other support people play in the lives of these individuals and to generating a robust and comprehensive evidence base to improve and guide policy and practice development within the sector.*[14]

One submission welcomed the state wide perspective to policy and planning for mental health services – especially for specialised services like forensic, indigenous and youth and paediatric mental health.[15]

[7] Queensland Mental Health Commission Bill, clause 11
[8] Queensland Mental Health Commission Bill, clause 54
[9] Submissions 2, 3, 5, 6, 8, 8A to 8F, 9, 10, 11, 13, 14, 17, 18, 19, 20, 21, 22, 24 and 25
[10] Submissions 9 and 10
[11] Submission 14
[12] Submissions 5, 9, 10, 13, 17, 19, 20, 21, 22 and 24
[13] Submission 10
[14] Ms Jodie Cook, Public Hearing, 13 February 2013, p. 10
[15] Submission 19

However, while supporting the principles of establishing the QMHC, a number of submissions raised concerns about the scope, powers, independence and resources of QMHC. Concerns were also raised about engagement with stakeholders and whether the new arrangements sufficiently recognise the specific nature of substance misuse issues.

3.2.2 Scope and focus

Three submissions considered that the Bill was too narrowly focussed on service delivery to people with mental illness or substance misuse issues. They considered that a more inclusive and outcomes-focussed approach to the delivery of human services would generate increased opportunities for improvement and integration. One of those submissions highlighted the example of the Western Australia Mental Health Commission whose objectives focus on the delivery of services and providing frontline assistance to those in need.[16] However, it should be noted that the Western Australia Mental Health Commission is part of a government department, rather than a statutory body such as the proposed QMHC.

Queensland Voice stated that QMHC must be customer focussed, rather than the present inward-looking provider and professional focus. If not, there is a risk that QMHC will be perceived as yet another bureaucracy that will not be respected by consumers and will fail to gain the necessary traction in driving reform and success.[17] The Queensland Program of Assistance to Survivors of Torture and Trauma was concerned that QMHC would not cover non-government services funded by the Commonwealth, therefore limiting its capacity to drive innovation and change.[18] There was also concern that QMHC's remit did not include private and non-publicly funded agencies that provide services to people affected by mental health or substance misuse issues.[19] One submission argued that if private organisations and those receiving Commonwealth funding were excluded, then true integration would be difficult to achieve, as it requires coordination across all sectors.[20]

The Queensland Aboriginal and Islander Health Council and the Queensland Alliance for Mental Health stated that the QMHC will need to ensure that its activities complement, rather than duplicate existing Commonwealth programs and initiatives, including the National Mental Health Commission.[21]

The committee recognises that there may be benefits from adopting a broader whole-of-government approach to the delivery of all human services; however, the scope of this Bill is to improve the treatment of a particularly vulnerable cohort. The committee notes that the Bill's primary focus is services provided by government departments, government agencies or publicly funded non-government agencies (see definition of "relevant agencies" in the schedule to the Bill), which covers both State and Commonwealth funding.

Many different agencies and organisations – across the public, private and non-government sectors – deliver mental health and substance misuse services and other services to people with mental health and substance misuse issues. It will therefore be important that the QMHC effectively engages with the private and non-government sectors. The committee notes that clause 11(2) provides that the QMHC must engage and consult with the government, non-government and private sectors.

The committee notes that the role of National Mental Health Commission, established in January 2012, is similar to the QMHC, albeit on a national scale. The National Mental Health Commission's objective is to promote good mental health and wellbeing, and its functions include annual reporting

[16] Submissions 3, 9 and 13
[17] Submission 18
[18] Submission 22
[19] Submissions 19 and 24
[20] Submission 24
[21] Submissions 11 and 14

through a "National Report Card on Mental Health and Suicide Prevention", monitoring and reporting on performance of the mental health system, engaging with consumers and carers in mental health policy and service improvements, and advising the Australian Government in consultation with other agencies.[22]

The committee considers that to achieve its objectives, the QMHC will need to ensure that it works in collaboration with the National Mental Health Commission, and that effective cooperation between the national and Queensland commissions is maintained.

Recommendation 2

The committee recommends that the Minister inform the Legislative Assembly during the second reading debate about how he envisages the relationship between the Queensland Mental Health Commission and the National Mental Health Commission, and what steps he will take to promote cooperation and collaboration.

3.2.3 Independence and adequate resourcing

One submission stated that the QMHC needed to be seen by stakeholders as an independent body, in order to fulfil its objectives, particularly in promoting a whole-of-government approach.[23] Two submissions were of the view that QMHC was being established in the health portfolio, and questioned whether such arrangements would place the QMHC in the most advantageous position to achieve its objectives.[24]

Three submissions also highlighted the need for QMHC to be adequately resourced and funded, in particular for its prevention and early intervention activities.[25] The Queensland Alliance for Mental Health questioned how the QMHC would prioritise its activities with only six staff and one commissioner and no additional allocation in the current budget.[26] The Chief Executive Officer of the Queensland Alliance for Mental Health, Mr Richard Nelson said that:

> *… the list of actions in the Act is a very long list. If you include research and innovation and a whole range of other things, it will be a lot of work to do for one person. So I guess in some ways we are saying that it is a lot of work for seven people.*[27]

Mr Nelson also stated that "… the sector has a wealth of resources at the commission's disposal. And I guess the invitation is out to the commission – to offer that resource and to take advantage of them".[28]

The committee wrote to the Minister on 14 February 2013 to request further information about the proposed resources of the QMHC. The committee notes that the Minister intends to respond during the second reading debate.

The committee considers that it would be appropriate for the QMHC to draw, at least initially, upon the existing expertise of Queensland Health. However, in order to achieve its objective of establishing a whole-of-government approach to mental health and substance misuse issues, the committee considers it will be important for the QMHC to quickly develop strong relationships with

[22] National Mental Health Commission: Annual Report 2011-12, p. 4
[23] Submission 6
[24] Submissions 18 and 19
[25] Submissions 8D, 20 and 21
[26] Submission 14
[27] Mr Richard Nelson, Public Hearing, 13 February 2013, p. 7
[28] Mr Richard Nelson, Public Hearing, 13 February 2013, p. 6

other departments, agencies and stakeholders working with people with mental health and substance misuse issues.

3.2.4 Engagement of stakeholders

The Ethnic Communities Council of Queensland welcomed the broader community strategies and engagement with a range of stakeholders, in particular, the recognition of the needs, views and vulnerabilities of culturally and linguistically diverse (CALD) communities.[29] Carers Queensland supported the Bill's acknowledgement of the important role of carers to the wellbeing and recovery of people with mental health or substance misuse issues.[30] Four submissions also commended the acknowledgement of Aboriginal and Torres Strait Island people in the Bill's guiding principles, but questioned the omission of CALD communities.[31]

However, submissions and witnesses at the public hearing thought more could be done to ensure that stakeholders are engaged in the QMHC's work. For instance, there was a concern that consumers and carers with "lived experience" may not be actively engaged[32] and that the views of providers, such as general practitioners and private and community sectors would not be adequately taken into account.[33] Mr Nelson stated that "… people with a lived experience must be involved in making the decisions of the commission and be involved in providing advice at the very core of the commission. We believe that this is implicit in the Act, but it is not explicit".[34]

One submission suggested engagement with stakeholders could be better achieved through including in the Bill provisions similar to the engagement obligations set out in the *Hospital and Health Boards Act 2011* (the HHBA).[35] The HHBA requires a Hospital and Health Service to develop and publish a strategy to promote engagement with health professionals, health consumers and members of the community. In developing those strategies, the Hospital and Health Service must consult certain organisations and groups.[36] The *Hospital and Health Boards Regulation 2012* provides details of the content of the engagement strategies.[37]

The committee recommends that the Bill be amended to include similar provisions to those in the HHBA and *Hospital and Health Boards Regulation 2012* to provide greater clarity and transparency about stakeholder engagement in the QMHC's work. Such provisions would, in particular, require the QMHC to develop strategies for engagement with people affected by mental health or substance misuse issues; agencies and individuals in the public, private and non-government sectors that deliver services to this cohort; community groups; representatives of Aboriginal and Torres Strait Islander people and CALD communities.

Recommendation 3

The committee recommends that the Bill be amended to include a requirement, similar to section 40 of the *Hospital and Health Boards Act 2011*, for the Queensland Mental Health Commission to develop and publish engagement strategies.

[29] Submission 10
[30] Submission 2
[31] Submissions 9, 10, 13, 22
[32] Submission 7
[33] Submission 19
[34] Mr Richard Nelson, Public Hearing, 13 February 2013, p. 5
[35] Submission 19
[36] *Hospital and Health Boards Act 2011*, section 40
[37] Hospital and Health Boards Regulation 2012, sections 12 – 14

3.2.5 Specialist nature of substance misuse issues

Representatives of the alcohol and other drugs sector sought amendments to the Bill to make separate provision for the substance misuse sector.[38] Two other submissions raised concerns about the potential erosion of the identity, integrity and influence of the substance misuse sector under the QMHC.[39] One suggestion to ensure leadership and a focal point in the QMHC for substance misuse issues was the appointment of a deputy commissioner for substance misuse issues.[40] Ms Rebecca MacBean of the Queensland Network of Alcohol and Drug Agencies stated that "… if they had a single point of contact, a single individual whose responsibility it was to drive AOD issues within the commission, that would be the best way to make sure our agenda was addressed…".[41]

The committee considers it will be important that the QMHC ensure that the specific needs of both mental health and substance misuse are adequately recognised, including in its management structure, policies and procedures. However, the committee considers that the QMHC will need flexibility and discretion in order to achieve this and such matters should not be prescribed in the Bill.

A number of submissions raised issues about the terminology used in the Bill about substance misuse.[42] The Queensland Network of Alcohol and Other Drugs Agencies stated that the term "substance misuse system" should be replaced throughout the Bill with "alcohol and other drugs systems".[43] Lives Lived Well suggested that the term "substance misuse" be replaced with "substance disorder".[44]

One submitter also questioned whether there was a potential gap in the definition of "substance misuse", in that it did not appear to include the misuse of volatile substances, for example adhesives, aerosols, paints and painter thinners.[45] The committee notes that various terms are used to describe the substance misuse system, however, it considers that the terminology in the Bill adequately covers the main types of substance misuse, including alcohol, drugs (both illegal and pharmaceutical) and other substances, such as paints, adhesives and aerosols.

One submission suggested that clause 11(1)(g)(ii) of the Bill, which provides for the QMHC's functions, incorrectly uses the term 'substance abuse'.[46] The committee notes that clause 11(1)(g) provides for the QMHC to promote strategies to facilitate early intervention for mental illness and 'substance abuse', and to promote strategies to prevent mental illness and 'substance misuse'.

The committee considers that the terminology used is appropriate and invites the Minister to clarify the proposed functions of the QMHC during the second reading debate.

3.3 Development of a whole-of-government strategic plan

In his explanatory speech on the Bill, the Minister explained that the main mechanism for achieving the Bill's objectives will be through the QMHC developing:

> *… a whole-of-government strategic plan for the improvement of mental health and limiting harm associated with substance misuse. This strategic plan will be used to guide funding, policy setting, service development and delivery; guide relevant government and non-government agencies in performing functions; aid the Director-General of Queensland*

[38] Submissions 8 and 8A to 8F
[39] Submissions 20 and 22
[40] Submissions 8 and 8A to 8F
[41] Ms Rebecca MacBean, Public Hearing, 13 February 2013, p. 4
[42] Submissions 1, 8, 10, 18, 20 and 24
[43] Submission 8
[44] Submission 20
[45] Submission 1
[46] Submission 8

> *Health as the system manager for public health systems in negotiating service agreements with hospital boards; and function as a cornerstone of a shared reform agenda.*[47]

The Bill requires the QMHC to develop, implement, monitor and report to the Minister on a whole-of-government strategic plan for the improvement of mental health and limiting the harm associated with substance misuse.[48] The meaning of the term whole-of-government strategic plan and its content is set out in clause 7 of the Bill. In summary, the whole-of-government strategic plan should:

- provide strategic guidance and direction on outcomes of Government funding of, and policy development and implementation about, the mental health and substance misuse system
- establish benchmarks and performance measures for evaluating the effectiveness of the mental health and substance misuse system
- foster development and strengthening of partnerships and integration of services across relevant agencies
- foster development of evidence-based policy and promote innovation; and
- include strategies for increasing participation by people affected by mental health and substance misuse issues, supporting and promoting mental health and wellbeing of those persons and the community, prevention and early intervention and enhancing community awareness.

The QMHC will also have the power to include in the whole-of-government strategic plan other matters which it considers necessary to exercise its functions under the Act.

The strategic plan must be developed in consultation with consumers, carers, families, and support persons, and with human services and service delivery agencies, both government and non-government.[49] The QMHC must review the whole-of-government strategic plan at least once every five years, or earlier, if directed by the Minister.[50]

3.3.1 Submissions

Submissions supported the development of a whole-of-government strategic plan, including the consultative approach to its development.[51] A number of submitters sought to actively engage in development of the whole-of-government strategic plan, including the Queensland Nurses Union, clinicians, community and other health care providers, and representatives of Aboriginal and Torres Strait Islander people and CALD communities.[52]

Some submitters also suggested issues that should be included in the whole-of-government strategic plan. These issues included measuring the impacts of integration and cooperation and strategies to address any imbalances in investment between public and non-government sectors.[53] One submission suggested the QMHC produce subsidiary strategies to deal with specific issues.[54]

Submissions also raised the frequency of reviews of the whole-of-government strategic plan. Some submitters supported more frequent, independent reviews, for example, every three years,[55] while others supported the five year review provided for by the Bill.[56]

[47] Minister for Health, Explanatory Speech, Hansard, 27 November 2012, p.2756
[48] Queensland Mental Health Commission Bill 2012, clauses 25 to 33
[49] Queensland Mental Health Commission Bill 2012, clause 25
[50] Queensland Mental Health Commission Bill 2012, clause 27
[51] Submissions 10, 24 and 25
[52] Submissions 2, 4, 10, 11, 18, 22 and 24
[53] Submissions 8, 8A to 8F and 10
[54] Submission 20
[55] Submission 10
[56] Submission 24

3.3.2 Committee's view

The committee considers that a whole-of-government strategic plan will contribute to a coordinated and evidence-based approach to the delivery of mental health and substance misuse services. This may include the development of subsidiary strategies to address specific issues. The committee also considers that the five year review period provided by the Bill, with the option for the Minister to direct an earlier review, is appropriate to ensure that the whole-of-government strategic plan is current and fit for purpose, while not distracting from its implementation.

3.4 Cooperation and implementation of a whole-of-government strategic plan

Clauses 34 to 36 make provision about cooperation between the QMHC and public agencies and the implementation of the whole-of-government strategic plan.

Relevant agencies must have regard to the whole-of-government strategic plan and the guiding principles in exercising their functions and consult with the QMHC on their activities, expenditure and initiatives.[57] The Explanatory Notes state that this provision will ensure that agencies – both public and private – in the mental health and substance misuse system are not operating in isolation, but are properly co-ordinated and integrated as part of a broader co-operative effort.[58] Clause 34 provides that while it is Parliament's intention that relevant agencies comply with this provision, failure to do so does not create rights or legally enforceable obligations.

The chief executive of Queensland Health must also take the whole-of-government strategic plan into account when negotiating service agreements with Hospital and Health Services to the extent that they relate to mental health and substance misuse services.[59]

If a report on the implementation of the whole-of-government strategic plan (an ordinary report – see section 3.5.1) contains a recommendation that relates to a particular agency, the QMHC must provide a copy of the report to that agency. The relevant agency must respond to the QMHC detailing any steps it has taken or plans to take. Alternatively, the agency may inform QMHC that it plans to take no action; however, it must give reasons for this decision.[60] A department or public sector unit is also required to provide the QMHC with information, unless the disclosure of the information is prohibited or impracticable to provide.[61]

3.4.1 Submissions

A recurring theme in the submissions and at the public hearing was the concerns that the QMHC had limited functions and levers to enact change. A number of submissions stated that the QMHC would have no executive powers to ensure that agencies accept and action its recommendations or implement the whole-of-government strategic plan. Submitters were concerned that without powers, the QMHC will rely heavily on gaining the respect of stakeholders and being perceived to be a truly independent voice. [62] The Public Advocate stated that "… the commission lacks the authority to direct action, which may hinder the achievement of real change." [63]

3.4.2 Committee's view

In light of submitters' concerns, the committee wrote to the Minister on 14 February 2013 to ask what mechanisms the QMHC will have at its disposal to ensure that once developed, the whole-of-

[57] Queensland Mental Health Commission Bill 2012, clause 34
[58] Explanatory Notes, p. 26
[59] Queensland Mental Health Commission Bill 2012, clause 35
[60] Queensland Mental Health Commission Bill 2012, clauses 31 and 32
[61] Queensland Mental Health Commission Bill 2012, clauses 36
[62] Submissions 7, 13, 18 and 25
[63] Ms Jodie Cook, Public Hearing, 13 February 2013, p. 10

government strategic plan is implemented and adhered to by agencies. The committee notes that the Minister intends to respond during the second reading debate.

3.5 Reporting by the Queensland Mental Health Commission

3.5.1 Ordinary reports

The Bill provides that the QMHC may prepare an ordinary report on matters about:

- the preparation and implementation of the whole-of-government strategic plan
- systemic issues; and
- funding.

An ordinary report may contain a recommendation to one or more relevant agencies. Clause 29 seeks to provide a safeguard to ensure the QMHC uses this broad power to make recommendations appropriately, including having adequate regard to financial implications. For example, the QMHC must notify the Minister before preparing an ordinary report and must consult with affected bodies during the preparation of an ordinary report. Clause 30 provides that an ordinary report must be provided to the Minister who must table the report in Parliament.

3.5.2 Special reports

Clause 28 provides that the Minister may direct the QMHC to prepare a special report on any significant systemic issue. The Explanatory Notes state that special reports are intended to function as a strategic tool for the Minister to glean frank, expert advice about issues of significant concern and to understand in detail the implication of any mitigating measures.[64] It will be open to the Minister to publish a special report, including by tabling a report in Parliament.

3.5.3 Annual report

The Bill provides that the QMHC must prepare an annual report containing:

- each direction given to the Commissioner of the QMHC by the Minister during the financial year and action taken as a result of the direction
- each formal recommendation made by the Advisory Council to the QMHC during the financial year, and action taken by the QMHC in response; and
- each formal recommendation issued to a public sector agency by the QMHC during the financial year and any action taken by the agency in response.

The QMHC must table its annual report in Parliament. The Explanatory notes state that requiring the QMHC to include the above information in its annual report will maximise transparency.[65]

3.5.4 Submissions

A number of submissions raised issues about transparency and the importance of ensuring that issues relating to mental health and substance misuse, including reports of the QMHC, were made widely available to the public and interested agencies.[66] Mr Nelson said "I think tabling those kinds of issues in parliament and making it clear to our public that we are trying to deal with some very difficult issues the best way we can is one way of ensuring that, even if they are perhaps embarrassing – they might show up that we have not been as effective as we could have been –they are out in the public and they are open for public debate."[67]

[64] Explanatory Notes, p. 24
[65] Explanatory Notes, p. 4
[66] Submissions 5, 6, 9, 10 and 18
[67] Mr Richard Nelson, Public Hearing, 13 February 2013, p. 8

The Public Advocate also suggested that QMHC's reports about a particular cohort should be made available to all agencies who work with that cohort, not just the agency that is the focus of the report.[68] The Public Advocate stated that "I encourage the commission to share its learnings and identify ways in which its findings may be used to benefit other cohorts that may experience similar disadvantages … ".[69] The Public Advocate also raised concerns about the independence of the QMHC in light of the provision in the Bill requiring it to notify the Minister before preparing an ordinary report.[70]

3.5.5 Committee's view

The committee recognises the importance of transparency and of promoting knowledge sharing and community awareness about mental health and substance misuse issues. The committee encourages the QMHC and the Minister to ensure that steps are taken to make information about QMHC's work, including research and reports, widely available and accessible. The committee also encourages the Minister to consider publishing all or part of special reports, particularly if the QMHC recommends that they be published, unless there are strong reasons not to. The committee requests that the Minister provide further information about the how the QMHC's reports and research will be made publicly available and in an accessible format.

Recommendation 4

The committee recommends that the Minister inform the Legislative Assembly during the second reading debate about how he will ensure that Queensland Mental Health Commission's reports and research will be made widely available.

3.6 Commissioner and other staff

The Bill provides that the QMHC is headed by a commissioner appointed by the Governor in Council, on the recommendation of the Minister, for a three year term which may be renewed.[71] The Minister must be satisfied that the recommended person has the necessary skills, knowledge, experience, public standing. The commissioner must also not be a member of the Advisory Council.

The commissioner's main functions are to manage the QMHC in an effective and efficient manner and make recommendations to the Minister.[72] The commissioner is to be appointed under conditions decided by the Governor in Council, is not a public servant, and may be suspended by the Minister for up to 60 days.[73] The commissioner may also be removed by Governor in Council. QMHC staff are to be appointed as public servants.

3.6.1 Submissions

One submission suggested that deputy commissioners should be appointed for operational reasons and to deal with specific issues.[74] Submissions stated that the commissioner and senior members of staff should have lived experience as a consumer or carer.[75] A number of submissions referred to

[68] Submission 9
[69] Ms Jodie Cook, Public Hearing, 13 February 2013, p. 10
[70] Submission 9
[71] Queensland Mental Health Commission Bill 2012, clauses 15 and 18
[72] Queensland Mental Health Commission Bill 2012, clause 19
[73] Queensland Mental Health Commission Bill 2012, clause 21
[74] Submission 14
[75] Submissions 5, 6, 15 and 18

Mental Health Commission Act 2012 (NSW) which provides that the commissioner or at least one deputy commissioner must be a person who has or has had a mental illness.[76]

3.6.2 Committee's view

The committee considers that it may be beneficial for deputy commissioners to be appointed, similar to the provisions in the NSW legislation. Such deputy commissioners could be appointed on a time limited basis to oversee the implementation of specific QMHC activities. The committee therefore recommends that the Bill be amended to enable Governor-in-Council to appoint deputy commissioners to the QMHC.

Recommendation 5

The committee recommends that the Bill be amended to enable the Governor in Council to appoint deputy commissioners to the Queensland Mental Health Commission.

3.7 Governance and accountability

Clauses 9 and 10 provide that the QMHC is to be subject to the financial and reporting standards the *Financial Accountability Act 2009* and the *Statutory Bodies Financial Arrangements Act 1982*, and is to be considered as a unit of public administration under the *Crime and Misconduct Act 2001*.

The Bill provides that, in managing the QMHC, the commissioner is subject to the direction of the Minister and must comply with any direction given by the Minister.[77] One submission stated that the Minister's ability to direct the commissioner inhibits the QMHC's ability to act independently.[78]

3.8 Queensland Mental Health and Drugs Advisory Council

3.8.1 Role and Functions

The Bill provides for the establishment of the Queensland Mental Health and Drugs Advisory Council (the Advisory Council) to advise the QMHC on mental health or substance misuse issues and make recommendations about QMHC's functions. It is envisaged that the Advisory Council will be the primary mechanism through which stakeholders engage with the strategic work of the QMHC.

The majority of submissions supported the creation of the Advisory Council.[79] One submission stated that the Advisory Council should be able to independently present special reports to Parliament.[80] Another submission suggested that the Hospital and Health Services model should be adopted giving the Advisory Council the power to appoint senior staff of the QMHC.[81] The submitter also raised the importance of adequately resourcing the Advisory Council and supported the use of wide range of techniques to ensure stakeholders are engaged, including focus groups and citizens panels. [82]

Representatives from the alcohol and other drugs sector recommended that two separate Advisory Councils should be established – one for mental health issues and one for substance misuse issues.[83]

[76] *Mental Health Commission Act 2012* (NSW), section 8
[77] Queensland Mental Health Commission Bill 2012, clause 13
[78] Submission 13
[79] Submissions 9, 10, 18, 19 and 22
[80] Submission 5
[81] Submission 14
[82] Submission 14
[83] Submissions 8 and 8A to 8F

The committee does not consider that it would be appropriate to form two separate Advisory Councils, however, it notes that clause 47 of the Bill provides that the Advisory Council may establish committees to deal with specific matters (see section 3.8.3).

3.8.2 Membership

The Bill provides that the Minister will decide on the appropriate number of members of the Advisory Council and will be responsible for their appointment. However, the Minister must ensure that membership reflects the diversity of the Queensland community; and that members have appropriate skills, knowledge or experience. Members are to be appointed for a maximum term of three years which may be renewed. The Minister may also appoint a chairperson and deputy chairperson from council members. Fees and allowances of members are to be decided by the Governor-in-Council.[84]

The Minister may remove a member from office, if the Minister is satisfied the member has been guilty of misconduct, is incapable of performing their duties, has neglected their duties or performed them incompetently or has been absent, without permission of the chairperson, for three consecutive meetings. The Minister may suspend a member for up to 60 days if there is an allegation of misconduct or the Minister is satisfied a matter has arisen that may be grounds for removal.[85]

One submission supported the requirement for members to have knowledge of issues faced by carers and consumers and reflect Queensland's diverse community, including Aboriginal and Torres Strait Island people and CALD communities.[86] A number of submitters suggested selection criteria for recruiting council members. Submissions also proposed that the Bill be more prescriptive about the membership of the Advisory Council, and include requirements to have a specified number of members who:

- have "lived experience" as a carer and consumer
- are from non-government organisations
- have expertise in alcohol and other drugs issues
- have mental health expertise; and
- are from regional and culturally diverse backgrounds.[87]

The committee agrees that the membership of the Advisory Council should reflect the various communities and stakeholders involved in mental health and substance misuse issues, to enable it to perform its advisory role effectively. The committee considers that this will be best achieved by providing the Minister with some flexibility to reflect the diversity of the Queensland community, and that members have appropriate skills, knowledge or experience.

3.8.3 Governance and accountability

Clauses 42 to 47 make provision about the conduct of business by the Advisory Council, including decisions on the quorum for meetings, minutes, and establishing time-limited committees. The Explanatory Notes state that where the chairperson and Commissioner are unable to agree on the way the meetings are to be conducted, clause 42 provides for the Minister to direct the Advisory Council about how it is to conducts its business, including its meetings.[88] One submission questioned the independence of the Advisory Council, given the Minister's ability to direct it about how it conducts its business.[89]

[84] Queensland Mental Health Commission Bill 2012, clause 39
[85] Queensland Mental Health Commission Bill 2012, clauses 40 and 41
[86] Submission 5
[87] Submissions 2, 5, 6, 8, 8A to 8F, 9, 14 and 18
[88] Explanatory Notes, p. 29
[89] Submission 10

The committee notes that the Minister's power to direct at clause 42 is broad and is not limited to circumstances where the Chairperson and QMHC are unable to agree on the way the Advisory Council conducts its meetings. The committee recommends that clause 42(3) be amended to more closely reflect the policy intention in the Explanatory Notes.

Recommendation 6

The committee recommends that the Bill be amended to provide that the Minister may only direct the Advisory Council about the conduct of its business, if the Chairperson and the Commissioner have been unable to reach an agreement.

3.8.4 Co-operation between the Queensland Mental Health Commission and the Advisory Council

During his introductory speech, the Minister stated that "the advisory council will be the key mechanism through which stakeholders will engage with and influence the commission".[90]

The Explanatory Notes state that "the Advisory Council will operate as a high level, strategic body through which the sector can be involved in shaping the long term reform agenda and activities of the QMHC".[91] The Bill makes specific provision to ensure the QMHC is accountable to the Advisory Council for the performance of its statutory functions and that the Advisory Council has the opportunity to provide input to the QMHC. Those provisions include, accountability and reporting mechanisms (clause 48), a requirement for QMHC to consult the Advisory Council on the whole-of-government strategic plan and any special or ordinary reports (clause 49), a requirement for QMHC to respond to formal recommendations of the Advisory Council (clause 50) and a requirement for QMHC to include such recommendations in its annual report tabled in Parliament (clause 51).

Five submissions supported the provisions at clauses 48 to 51 which were seen as giving legitimacy to the important role of the Advisory Council.[92]

[90] Minister for Health, Explanatory Speech, Hansard, 27 November 2012, p. 2756
[91] Explanatory Notes, p. 4
[92] Submissions 9, 10, 18, 19 and 22

4 The Mental Health Act 2000

The Bill amends the *Mental Health Act 2000* (MHA). This section summarises relevant parts of the MHA to provide context to the proposed amendments.

4.1 Overview

The MHA provides for the involuntary assessment, treatment and protection of persons (whether adults or minors) who have a mental illness, whilst at the same time safeguarding their rights and freedoms, and balancing their rights and freedoms with the rights and freedoms of other persons.[93] The MHA does not generally provide for the voluntary treatment of mental illness. The MHA establishes:

- the position of Director of Mental Health (the Director)
- authorised mental health services to provide treatment of persons with mental illnesses
- the Mental Health Court to determine whether an accused person is fit to stand trial or was of unsound mind at the time of an offence or, if the charge is murder, whether the person was of diminished responsibility; and
- the Mental Health Review Tribunal (the Tribunal) to review the status of patients receiving involuntary treatment.

The MHA includes a set of principles which apply to the administration of the Act.[94] The principles are based on the *United Nations Principles for the Protection of Rights of People with Mental Illness and for the Improvement of Mental Health Care*.[95] Section 9 of the MHA also provides that a power or function under the Act relating to a person who has a mental illness must be exercised so that:

- the person's liberty and rights are adversely affected only if there is no less restrictive way to protect the person's health and safety or to protect others; and
- any adverse effect on the person's liberty and rights is the minimum necessary in the circumstances.

4.2 Categories of patients

The amendments made by the Bill to the MHA only relate to the treatment of the following specific categories of patients. This category of patient is referred to in the Bill and the rest of this report as a "relevant patient". The categories are:

- a **classified patient** - a person who has been admitted to an authorised mental health service for assessment and inpatient treatment from a court or place of custody. A classified patient may, subject to meeting certain criteria, receive involuntary treatment. If a classified patient has been sentenced to imprisonment or detention, then he or she must be escorted while on limited community treatment (LCT).
- a **forensic patient** – a person who the Mental Health Court has decided was of unsound mind at the time of the offence, or is permanently unfit for trial. The order authorises a person's detention in an authorised mental health service for involuntary treatment.
- a **section 273(1)(b) patient** – a person who the Mental Health Court has deemed fit for trial, but should be detained in an authorised mental health service until they are granted bail or returned to court for proceedings to continue. A section 273(1)(b) patient may, subject to meeting certain criteria, receive involuntary treatment. A section 273(1)(b) patient must be escorted while on LCT.

[93] *Mental Health Act 2000*, section 4
[94] *Mental Health Act 2000*, section 8
[95] Queensland Health, Mental Health Act 2000: Resource Guide, June 2012, Chapter 1, p. 2

4.3 Functions of the Director of Mental Health

The Director is appointed by the Governor in Council and their functions are:

- to the extent that it is reasonably practicable, ensuring the protection of the rights of involuntary patients
- to the extent that it is reasonably practicable, ensuring the involuntary admission, assessment, treatment and care of persons complies with the MHA
- facilitating the proper and efficient administration of the MHA
- monitoring and auditing compliance with the MHA
- promoting community awareness and understanding of the administration of the MHA; and
- advising and reporting to the Minister on any matters relating to the administration of the MHA.[96]

4.4 Authorising limited community treatment

Currently, under the MHA, a two stage process applies to authorising LCT as part of a relevant patient's treatment plan. First, the Director (for classified patients), the Mental Health Court or Tribunal (for forensic patients) or the Mental Health Court (for section 273(1)(b) patients) must approve or order the LCT. Once approval or an order is given, an authorised doctor may then authorise LCT as part of a patient's treatment plan. In authorising LCT, the authorised doctor is responsible for ensuring that appropriate conditions are established and the authorisation occurs within the parameters established by the Mental Health Court or Tribunal (for forensic patients) or the Director (for classified patients).[97]

When approving LCT for a classified patient, it is currently open to the Director to impose any conditions he or she considers appropriate. The Mental Health Court or Tribunal may impose any conditions considered appropriate, when approving or ordering LCT for a forensic patient or a section 273(1)(b) patient. The authorised doctor may also include specific conditions considered necessary for the clinical management of the patient and to protect the health or safety of the patient or the safety of others.[98]

Queensland Health advised the committee that "Limited community treatment is a staged way and may include escorted excursions to the hospital canteen, unescorted visits to the facility's gardens through to integrated unescorted leave into the community for extended periods to undertake employment or attend study".[99]

[96] Queensland Health, Mental Health Act 2000: Resource Guide, June 2012, chapter 2, p. 4
[97] Queensland Health, Mental Health Act 2000: Resource Guide, June 2012, chapter 9, p. 5
[98] *Mental Health Act 2000*, section 131(1)(b)
[99] Dr Michael Cleary, Public Briefing, 17 December 2012, p. 5

5 Amendments to the Mental Health Act 2000

5.1 The Director's new power to require monitoring conditions

Clause 61, amends section 131 of, and clause 62, inserts proposed sections 131A and 131B into, the MHA to provide the Director with a new power to require monitoring conditions for a relevant patient undertaking LCT. Young patients (i.e. an involuntary patient under 17 years of age) are explicitly excluded from this power. Clause 62 sets out the following examples of patients whose treatment plans may include a monitoring condition:

- a forensic patient who is undertaking LCT for the first time
- a classified patient who has previously attempted to abscond while on LCT; or
- a forensic patient who is transitioning from escorted to unescorted LCT.

Clause 62 gives examples of the type of monitoring conditions which may be imposed, including, that the patient:

- telephone a stated person before moving from one location to another
- provide a detailed plan of where they will be, and with whom they will be, while on LCT; or
- wear a monitoring device while on LCT.

Proposed section 131B provides that information obtained as a result of a monitoring condition is confidential under the *Hospital and Health Boards Act 2011.* A designated person, under the *Hospital and Health Boards Act 2011,* may however disclose the information to the Queensland Police Service for the purpose of an investigation or prosecution, or to the Mental Health Court or Tribunal.[100]

The Explanatory Notes state that while conditions currently available to the Director, the Mental Health Court, the Tribunal or the authorised doctor provide a range of protections for both the patient and the community, the new power for the Director to require monitoring conditions will strengthen the mental health services' ability to minimise potential risk and provide a mechanism for early action in response to adverse incidents.[101]

5.1.1 Submissions

The submissions which commented on this issue all opposed giving the Director a new power to require a patient to wear a monitoring device. Three submissions considered that requiring relevant patients to wear monitoring devices was a disproportionate reaction to recent incidents of patients absconding.[102] Other submissions raised concerns about the lack of evidence of the effectiveness of monitoring devices, particular about their use on persons with mental health issues.[103] Four submissions stated that the use of monitoring devices would have a negative impact on the treatment and recovery of patients and would be in conflict with ethical and practice standards for clinicians.[104] Dr Rebekah Doley stated that:

> *By introducing monitoring devices we may serve to increase risk. We risk alienating patients from the treatment system. We risk reducing their engagement in the treating process. By that I mean things like underreporting of symptoms, which prevent us from monitoring effectively. We risk the therapeutic rapport, and the evidence demonstrates that that is extremely important part of the effectiveness of treatment.*[105]

[100] Queensland Mental Health Commission Bill, clause 62
[101] Explanatory Notes, p. 32
[102] Submissions 7, 9 and 18
[103] Submissions 12, 16, 19 and 25
[104] Submissions 14, 16, 18 and 23
[105] Dr Rebekah Doley, Public Hearing, 13 February 2013, p. 16

Four submissions also raised concerns about the cost of using monitoring devices on relevant patients and considered that it would place an unmanageable strain on health and law enforcement.[106]

Ten submissions stated that requiring relevant patients on LCT to wear monitoring devices is incompatible with international conventions and national statements, including the *United Nations Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care*, *United Nations Convention on the Rights of Persons with Disabilities*, *National Standards for Mental Health Services 2010*, *National Statement of Principles of Forensic Mental Health* and the *Mental Health Statement of Rights and Responsibilities.*[107] Two submissions also stated that the amendments raised fundamental legislative principles issues.[108] Fundamental legislative principles issues are discussed in Section 6 of the report.

A number of submissions highlighted that the only persons in Queensland currently required to wear monitoring devices are serious sex offenders under *Dangerous Prisoners (Sexual Offenders) Act 2003*. Submissions stated that mental health patients are not necessarily criminals and argued that requiring them to wear monitoring devices would criminalise their behaviour, increase the stigma of mental illness, lead to social exclusion and be detrimental to their recovery.[109] In a letter dated 18 February 2013, the President of the AMA Queensland, Dr Alex Markwell stated that forensic order patients in Queensland experienced better outcomes than those in the criminal justice system: they have been found to reoffend less frequently, commit less offences in total, and commit less violent and less serious offences than those released from the criminal justice system.[110]

A significant number of submissions stated that any power to impose monitoring devices should only be used in limited circumstances and be subject to clear guidelines, criteria and safeguards to ensure that decisions are accountable and transparent. They highlighted the importance of including a patient's treating team in decisions to require monitoring devices and for the Director to give detailed reasons for his or her decision.[111] Dr Markwell stated that:

> *If there were to be any use of these devices [monitoring devices], we would suggest that they only be used on patients who would otherwise have been charged under the Dangerous Prisoner (Sexual Offenders Act had they not been under a forensic order and that thorough processes that would mirror what happens with the Supreme Court approval would also apply through the Mental Health Review Tribunal or the Mental Health Court, again on an individual basis with full reasoning and exploration of risk to the community.*[112]

Four submissions stated that any decision to require monitoring devices should be taken by the Mental Health Court or Tribunal, not the Director.[113]

5.1.2 Committee's view

The committee acknowledges that, in certain circumstances, it may be appropriate for the Director to require monitoring conditions for a relevant patient on LCT. Such monitoring conditions could range from requiring the patient to provide updates on their location by telephone to wearing a monitoring device. The committee notes that in reaching a decision on whether to require

[106] Submissions 12, 14, 21 and 25
[107] Submissions 6, 7, 9, 12, 15, 16, 18, 19, 23 and 25
[108] Submissions 12 and 13
[109] Submissions 7, 9, 12, 13, 14, 15, 16, 17, 19, 23 and 25
[110] Letter from President of AMA Queensland dated 18 February 2013
[111] Submissions 12, 13, 14, 15 and 23
[112] Dr Alex Markwell, Public Hearing, 13 February 2013, p. 14
[113] Submissions 12, 14, 19 and 21

monitoring conditions, the Director must have regard to the principles in sections 8 and 9 of the MHA.

However, in light of the significant concerns raised by submissions about human rights issues, the potential stigma of wearing a monitoring device and potential adverse impact on a patient's recovery, the committee considers that the Director's power to require a monitoring device should be restricted to a much narrower category of patient, and should only be used in the interest of providing protection to the community or the patient's rehabilitation, care or treatment.

To achieve this, the committee recommends that the Bill be amended to provide that the Director may only require a relevant patient to wear a monitoring device, if he or she reasonably believes that without a monitoring device there would be an unacceptable risk that the patient would not return to the authorised mental health service, would commit a serious sexual offence or would endanger the safety or welfare of the patient or others. These amendments should be based on provisions in the *Dangerous Prisoners (Sexual Offenders) Act 2003* and the MHA.

Recommendation 7

The committee recommends that the Bill be amended to provide that the Director of Mental Health may only require a relevant patient to wear a monitoring device, if he or she reasonably believes that allowing limited community treatment without a monitoring device would give rise to an unacceptable risk that the patient:

- would not return to the authorised mental health service
- would commit a serious sexual offence
- would endanger the safety or welfare of the patient or others.

The amendments should be based on existing provisions in the *Dangerous Prisoners (Sexual Offenders) Act 2003* and the *Mental Health Act 2000.*

To ensure that patient's treatment is taken into account, the committee also recommends the Director should be required to take all reasonable steps to consult the patient's treating psychiatrist before reaching a decision about requiring a patient to wear a monitoring device.

Recommendation 8

The committee recommends that the Bill be amended to require the Director of Mental Health to take all reasonable steps to consult with the patient's treating psychiatrist before deciding that a patient be required to wear a monitoring device.

Given the concerns raised in submissions about accountability and transparency, the committee also recommends that the Director should be required to give detailed reasons for requiring a relevant patient to wear a monitoring device, at the time the decision is made. The committee considers that providing detailed reasons will also assist patients who wish to appeal and help the Tribunal decide appeals.

Recommendation 9

The committee recommends that the Bill be amended to require the Director of Mental Health to give written reasons for his or her decision to require a relevant patient to wear a monitoring device, at the time the decision is taken.

5.2 Appeals against monitoring conditions

The MHA currently makes provision for the Tribunal to periodically review a patient's involuntary treatment order or forensic order. A patient, or a patient's representative, may also request a review at any time; however, the Tribunal has discretion to refuse to undertake the review, if it considers the request is vexatious or unnecessary.[114]

Clauses 63 amends section 191 of the MHA to provide that the Tribunal may, when reviewing a classified patient's or section 273(1)(b) patient's involuntary treatment order, amend or revoke a monitoring condition required by the Director. Similarly, clause 64 amends section 203 to provide that the Tribunal may, when reviewing a forensic order, amend or revoke a monitoring condition required by the Director. However, clause 65 amends section 204 to provide that the Tribunal may not amend or revoke a forensic patient's monitoring condition unless it is satisfied the patient does not represent an unacceptable risk to the safety of the patient or others.

The above review mechanisms will not apply to classified or section 273(1)(b) patients who are not also on an involuntary treatment order, as the review by the Tribunal is a review of a patient's involuntary treatment. The Explanatory Notes state that patients who are detained solely as a classified patient or a section 273(1)(b) patient who are accessing mental health treatment in an authorised mental health service are doing so on a voluntary basis and therefore their treatment does not require the same level of independent review (that is, the patient consents to the treatment, and can decide to refuse treatment).[115]

5.2.1 Submissions

Two submissions raised concerns about the capacity of the Tribunal to consider appeals against the decision to require a monitoring device. In particular, they were concerned that appeals against a decision to require monitoring conditions may mean that other matters, such as reviewing a patient's involuntary treatment order, may be delayed.[116] Submissions also raised concerns about a patient's capacity to make appeals, especially if the Director is not required to give reasons for their decision.[117]

5.2.2 Committee's view

The committee wrote to the Minister on 4 February to seek his views on a potential drafting error in clause 63 of the Bill which amends section 191 of the MHA to provide that the Tribunal may review monitoring conditions placed on a classified or section 273(1)(b) patient. The Minister responded on 20 February stating that he proposes to rectify the drafting error by moving an amendment during the consideration in detail stage of the Bill.

[114] Mental Health Act 2000, section 187
[115] Explanatory Notes, p. 15
[116] Submissions 12 and 15
[117] Submission 15

5.3 The Minister's power to direct the Director to undertake a review

The Bill amends the current role and functions of the Director. Clause 70 amends section 498(1)(a) of the MHA to provide that in ensuring the protection of the rights of involuntary patients, the Director must balance those patients' rights with the rights of other persons. The Explanatory Notes state that

> *the amendment to this function aligns the functions of the Director of Mental Health with the overarching purpose of the MHA, which is to provide for involuntary assessment, treatment and protection of persons who have a mental illness while at the same time safeguarding their rights and freedoms and balancing their rights and freedoms with the rights and freedoms of others.*[118]

Clause 73 inserts new sections into the MHA, to provide the Minister with a new power of direction. Proposed section 493AC of the MHA would empower the Minister to direct the Director to immediately review and investigate a 'significant matter' (defined as a matter in relation to one or more patients) where the Minister considers there is a serious risk to the life, health or safety of a person or a serious risk to public safety (the related risk).

In reviewing the matter, the Director must decide whether to take action in relation to the risk, and consider whether there are systemic issues that need to be addressed to avoid the risk recurring. The Minister may also direct the Director to consider taking any of the actions listed in new section 493AE of MHA, including ordering the suspension of LCT for a patient or class of patients, to prevent the matter recurring. The Director must then report back to the Minister on the outcome of the review and any actions taken as a result.

The Bill clarifies that while the Minister may direct the Director to review, investigate and report back on a matter, the Director is independent from the Minister with respect to deciding what action, if any, is required.[119] The Explanatory Notes state that

> *… while the Minister may direct the Director of Mental Health to review and investigate a matter, the amendments make explicit that the Director remains independent from the Minister with respect to the decisions about any action that may be taken as a result of the investigation.* [120]

Clause 76 applies the existing protection from civil liability to include the Minister as an official for the purposes of protection from civil liability in connection with the power to direct the Director to undertake a review.

5.3.1 Submissions

The Public Advocate stated that the Director, after reporting to the Minister, should be required to provide a written copy of the report to relevant agencies.[121] Two submissions raised concerns that the power for the Minister to direct the Director would politicise the mental health service, and allow the Minister to override the judgment of mental health professionals.[122]

5.3.2 Committee's view

The committee considers that it is appropriate for the Minister to direct the Director to investigate a matter if he or she considers there is a serious risk to the life, health or safety of a person or a serious risk to public safety. The committee notes that the Minister's power is limited to directing the

[118] Explanatory Notes, p.35
[119] Explanatory Notes, p.36
[120] Explanatory Notes, p.35
[121] Submission 9
[122] Submissions 7 and 18

Director to review or investigate a matter. The Bill is clear that the Minister has no role in deciding what action, if any, should be taken.

5.4 The Director's powers after review

Proposed section 493AE sets out the actions available to the Director, if he or she considers there is a significant matter and related risk. The following actions are open to the Director regardless of whether or not the Minister has directed a review or investigation:

- order the suspension of a relevant patient's, or class of relevant patients', LCT, including those ordered or approved by the Mental Health Court or the Tribunal
- order an administrator to provide a report on the circumstances that led to the significant matter and related risk
- review, or order an administrator to review and report back on, any treatment plans relevant to the significant matter or related risk or a possible similar matter or risk that might arise in the future
- review any guidelines, policies and protocols about the use of LCT; and
- take any other action necessary to prevent a similar significant matter and related risk from arising again.

Clause 72 amends section 492 of the MHA, so that the Director's new powers to take action in response to a serious matter and related risk may be delegated only to a health executive or a senior executive in Queensland Health.

5.5 The Director's power to suspend limited community treatment

The Explanatory Notes state that it is intended that the Director's power to suspend LCT will facilitate a more rapid response to an identified risk, including the resolution of any systemic problems that may be able to be addressed in order to minimise or prevent such risks from reoccurring.[123] An individual patient's or a class of patients' LCT may be suspended by order. The Bill provides the following examples of the type of class of patients which may be specified in an order:

- all forensic patients in an in-patient facility within an authorised mental health service
- all forensic patients on LCT who have been in the community for less than three months; or
- all classified patients treated by a stated psychiatrist.[124]

5.5.1 Submissions

The main focus of all the submissions on this matter was the Director's power to suspend LCT for a class of patients. Submissions raised similar concerns to those raised about the Director's power to require monitoring devices. A number of submissions stated that the suspension of a class of patient's LCT was an overreaction to recent incidents of patients absconding, was unlikely to address any systemic problems and would place a further strain on the mental health service.[125]

Submissions also stated that suspending LCT for a class of patients, irrespective of whether an individual patient had complied with their conditions, would frustrate patients, lead to a breakdown of trust between the patient and clinicians and reduce a patient's chances of recovery. Submissions also stated that applying restrictions to a class of patients was contrary to various international human rights conventions, including the *United Nations Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care*, and *United Nations Convention on the*

[123] Explanatory Notes, p. 36

[124] Queensland Mental Health Commission Bill, clause 73 (proposed section 493AF of the *Mental Health Act 2000*)

[125] Submissions 7, 12, 15 and 17

Rights of Persons with Disabilities and national statements, such as *National Standards for Mental Health Services 2010* and *National Statement of Principles of Forensic Mental Health*.[126] One submission also raised fundamental legislative principles.[127] The fundamental legislative principles issues raised by these amendments are discussed in Section 6.

5.5.2 Committee's view

The committee wrote to the Minister on 14 February 2013 requesting details of what consideration was given to the compatibility of the MHA amendments with international conventions and national mental health statements and standards and the conclusions that were reached. The committee notes that the Minister intends to respond during the second reading debate.

5.6 Limits on the use of the power to suspend limited community treatment

The Bill includes a number of safeguards in relation to the Director's power to suspend LCT. For instance, the Director will be bound by the guiding principles of the MHA, in particular, section 9 when reaching a decision. Section 9 of the MHA provides that a power under the Act must be exercised so that the person's liberty and rights are adversely affected only if there is no less restrictive way to protect a person's health and safety or to protect others, and any adverse effect on the person's liberty and rights is the minimum necessary in the circumstances.[128]

The Bill also provides that before making an order to suspend a patient's, or class of patients', LCT, the Director must:

- consult with the relevant administrator of the authorised mental health service on the likely impact of the order on the service's operations, the affected patients and, if the patient is a child, the best interests of the child
- consult with the Police Commissioner, if the order is likely to impact on police resources; and
- notify the Attorney-General.

The Explanatory Notes state that the above requirements will ensure decisions are made with the highest regard to a person's rights and liberties and ensure the Director is appropriately informed of potential impacts on the treatment and care of affected patients before making an order to suspend LCT.[129] If an order affects a young person (under 17 years of age), the Director must also notify the chief executive of the Department of Communities, Child Safety and Disability Services.[130]

Proposed section 493AF also provides that an order to suspend LCT must contain the following information:

- if the order relates to a specific relevant patient, the name of the patient
- if the order relates to a class of relevant patient, sufficient detail to identify the class of patient
- the period of the suspension; and
- if the order requires a relevant patient or class of relevant patient to return to an authorised mental health service, the name of the service and time or date by they must return. This may include a different authorised mental health service than the one in which the patient is usually detained.

[126] Submissions 9, 12, 15, 17, 18, 23 and 25
[127] Submission 13
[128] Explanatory Notes, p. 36
[129] Explanatory Notes, p.36
[130] Queensland Mental Health Commission Bill, clause 73 (proposed section 493AD of the Mental Health Act 2000)

The Explanatory Notes state that providing for specific detail in an order to suspend LCT will ensure that the order is applied to the minimum number of patients required for the serious risk that triggered the action to be addressed.[131]

5.6.1 Submissions

Submissions stated that irrespective of whether LCT was suspended for an individual patient or a class of patients, clear criteria should apply to the Director's decision. Such criteria should include taking into account an individual patient's treatment needs.[132] The Public Advocate stated that "Decisions around the planning, implementation or restriction of a treatment plan, such as suspending LCT, should always be based on individual assessment and to do otherwise is likely to result in increased risk and/or hinder recovery for many individuals".[133]

Submissions also stated that suspending a class of patients LCT, without adequate consideration of individual circumstances is discriminatory and a breach of individual liberties, and that the Director should be required to consult about the patient's best interests.[134] One submission stated that any action taken by the Director that impacts on the LCT of a patient must be done in a manner consistent with natural justice, including providing a statement of reasons, taking into account the individual patient's circumstances and being subject to a right of appeal.[135]

5.6.2 Committee's view

In light of the significant concerns raised in submissions, the committee recommends that the Bill be amended to help ensure an appropriate balance is struck between the individual rights and freedoms of the patients and the safety of the public. The committee recommends that, in addition to consulting the administrator of the authorised mental health service, the Director should be required to take all reasonable steps to consult with a patient's treating psychiatrist. The committee considers that this will ensure that the Director takes the individual treatment needs of each patient into account before a decision is reached to suspend LCT.

Recommendation 10

The committee recommends that the Bill be amended to require the Director of Mental Health to take all reasonable steps to consult each patient's treating psychiatrist before making an order to suspend limited community treatment.

The committee also recommends that the Director be required to give detailed reasons for his or her decision in the order to suspend a relevant patient's, or class of patients', LCT.

Recommendation 11

The committee recommends that the Bill be amended to require the Director of Mental Health to give written reasons for the decision to suspend limited community treatment, at the time the decision is taken.

[131] Explanatory Notes, p. 38
[132] Submissions 9, 16 and 18
[133] Ms Jodie Cook, Public Hearing, 13 February 2013, p. 11
[134] Submissions 15, 23 and 25
[135] Submission 25

5.7 Review by Tribunal of suspension of a class of patients' limited community treatment

The Bill provides that the Director may set the period that LCT is suspended. The Director may also extend the suspension period, whilst the order is in place, if he or she reasonably believes the significant matter or related risk still exists (proposed section 493AG of the MHA).

The Explanatory Notes state that it is intended that the ability to suspend LCT will enable the Director to respond to an identified risk, including the resolution of any systemic problems that may be able to be addressed in order to minimise or prevent such risks reoccurring.[136]

5.7.1 Submissions

One submission highlighted that the current legislation already permitted the suspension of LCT. However, the decision rested with the Mental Health Court or Tribunal, not the Director. The submitter was concerned that the new powers would transfer decision making from the judiciary (i.e. the Mental Health Court and the Tribunal) and the patient's treatment team, to the Director, who in turn could be directed by the Minister.[137] Two submissions stated that if a suspension of LCT is proposed, the onus should be on the Director to make the case that a serious matter and related risk exists and the Tribunal should reach the decision.[138]

In its submission, AMA Queensland stated that there may be some limited and emergency circumstances where suspension of LCT for a class of patients may be necessary. The AMA Queensland suggested, however, that the power of the Director to suspend LCT must be subject to strict and short time limits before it lapses or must be approved by the Tribunal or Mental Health Court.[139] Dr Alex Markwell stated that she has "… concerns about the duration of the suspension that may occur. There are no limits around how long this would take and what the processes of appeal are."[140] Another submission suggested that the Director should be compelled to end a suspension order as soon as the significant matter or related risk ceases to exist.[141]

5.7.2 Committee's view

In light of the concerns raised in submissions about the important role of the Tribunal and limiting the period of suspensions, the committee considers that a class of patients' LCT should only be suspended for the absolute minimum time required to resolve the significant matter or related risk. The committee recommends that the Bill be amended to provide that a decision by the Director to suspend a class of patients' LCT must be reviewed by the Tribunal within seven days after the Director has made the order. After its review, the Tribunal should be able to reach the following decisions:

- that order should remain in place
- that the Director incorrectly decided there was a significant matter and related risk, and end the order; or
- that the Director incorrectly decided that a patient should be included in the specified class of patient, and either order that the Director's order does not apply to the patient or amend the Director's order to more appropriately define the class of patient.

The committee considers that Tribunal should also be able to end the order, if it considers that the significant matter and related risk no longer exists. The committee recommends that this review mechanism should only apply to an order suspending LCT for a class of patients. It is not intended

[136] Explanatory Notes, p.13
[137] Submission 12
[138] Submissions 12 and 17
[139] Submission 19
[140] Dr Alex Markwell, Public Hearing, 13 February 2013, p. 14
[141] Submission 15

that this recommended review mechanism replace the provisions dealing with individual appeals against suspension of LCT in proposed section 493AH (see below).

Recommendation 12

The committee recommends that the Bill be amended to provide that the Mental Health Review Tribunal must review an order made by the Director of Mental Health to suspend a class of patients' limited community treatment within seven days after the order has been made.

5.8 Individual appeals against suspension of limited community treatment

Proposed section 493AH of the MHA puts in place an appeals mechanism for relevant patients who have had their LCT suspended. A relevant patient may appeal to the Tribunal on the following grounds:

- the Director incorrectly decided that there was a serious risk to life, health or safety of a person or a serious risk to public safety; or
- the Director was incorrect in including the patient in the order.

The Tribunal must end the order, if it considers that the Director incorrectly decided there was a significant matter and related risk. If the Tribunal decides the Director incorrectly included the relevant patient in the class of patient specified in the order, then the Tribunal may rule that the order does not apply to the patient or amend the order to more appropriately describe the class of patient subject to the order, or end the order.

Clauses 66 to 68 make consequential amendments to the MHA to enable the Tribunal to hear appeals against orders suspending LCT and make provision about the membership for hearings. Clause 69 provides for the right of appearance at hearings, including the patient's right to legal representation.

5.8.1 Submissions

Submissions generally supported these amendments. However, concerns were raised about the capacity of the Tribunal to hear the potential number of appeals.[142] Submissions also raised concerns about the capacity of patients to lodge appeals, particularly, if the Director was not required to give reasons for his or her decision to suspend LCT.[143] One submission also questioned whether the Mental Health Court could consider appeals against the decision of the Tribunal.[144]

5.8.2 Committee's view

Recommendation 11 recommends that the Director be required to give detailed reasons for his or her decision in the order to suspend a relevant patient's, or class of patients', LCT. The committee considers that this will ensure transparency and accountability, assist patients who wish to appeal and help the Tribunal to reach decisions on appeals.

5.9 The Director's power to authorise the publication of identifying information

Section 526 of the MHA currently provides that it is an offence for a person to publish information about a person who is the subject of, appears as a witness at, or is mentioned at a Mental Health Court or Tribunal hearing.

[142] Submissions 8 and 19
[143] Submissions 15 and 17
[144] Submission 15

Clause 75 amends section 526 of the MHA to provide that a person does not commit an offence, if the Director gives written authorisation for the publication of information. The Director may only give such an authorisation if he or she reasonably believes the publication is necessary to assist in lessening or preventing a serious risk to the life, health or safety of a person or public safety, and the publication is in the public interest. Queensland Health advised the committee that "… this will allow the Director of Mental Health or the police to provide the public with information about a person who has absconded while on limited community treatment."[145]

5.9.1 Submissions

Submissions stated that privacy is particularly important to mental health patients due to stigma and stereotyping about mental illness. One submission was concerned about the possible further erosion of patient confidentiality and considered there were already sufficient mechanisms in place to ensure adequate information is provided to authorities when a patient absconds.[146] There was also concern that clause 75 had the potential to inspire over reaction from the public, leading to poorer outcomes for patients, their recovery and ability to reintegrate into society.[147] One submission raised concerns about the potential impact on young patients, including on their ability to find a job or housing in the future.[148]

5.9.2 Committee's view

The committee considers that the publication of such information raises fundamental legislative principles issues which are discussed in Section 6 of this report.

[145] Dr Michael Cleary, Public Briefing, 17 December 2012, p. 5
[146] Submission 25
[147] Submission 15
[148] Submission 13

6 Fundamental legislative principles

6.1 Introduction

Section 4 of the *Legislative Standards Act 1992* states that 'fundamental legislative principles' are the 'principles relating to legislation that underlie a parliamentary democracy based on the rule of law'. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals; and
- the institution of parliament.

The committee considered the application of fundamental principles to the Bill. It noted that the Explanatory Notes state that the Bill is generally consistent with fundamental legislative principles. However, the committee considers there are potential issues with the Bill and makes the following comments.

6.2 Queensland Mental Health Commission

6.2.1 Are administrative powers sufficiently defined?

Clauses 21, 40 and 41 of the Bill provide for the removal or suspension of the Commissioner and Advisory Council members. The committee notes that the Minister may only suspend or recommend the removal of the Commissioner in circumstances specified in the Bill. These include misconduct, being incapable of performing duties or neglecting or incompetently performing duties. The Bill provides that the Minister may only suspend or remove an Advisory Council member in similar circumstances. The committee notes that these decisions are subject to judicial review.

6.2.2 Immunity from proceedings

Clauses 53 and 76 of the Bill provide protection from liability for QMHC staff and for the Minister when performing functions under the Bill and the MHA. The committee notes that clause 53 is a standard provision designed to allow officials to undertake their statutory duties without fear or personal liability (excluding dishonesty and negligence), while providing an avenue for legal redress against the State for an aggrieved person. The committee also notes that similar protections for Ministers can be found in other legislation, including the *Tourism Act 2003* and the *Surveyors Act 2003*.

6.3 Amendments to the Mental Health Act 2000

6.3.1 Power to require monitoring conditions - rights and liberties of individuals

Clauses 61 and 62 provide that the Director may require monitoring conditions to be placed on a relevant patient undertaking LCT. The committee considers that the imposition of monitoring conditions can have a significant impact on a person's right to liberty and freedom of movement. The committee notes, however, that such liberties and freedoms are not absolute. For example, the former Scrutiny of Legislation Committee (whilst considering prisoners, not mental health patients) raised no objections about empowering a court to require a prisoner to wear an electronic monitoring device.

The Explanatory Notes state that enabling a patient on LCT to be subject to monitoring conditions is consistent with the stated object of the MHA to ensure that the treatment needs of an individual who has a mental illness are balanced appropriately with the need to protect that individual and the community. In most cases, the decision to require monitoring conditions is also subject to review.

The committee notes that in reaching a decision the Director will need to have regard to the guiding principles of the MHA. However, in light of concerns about potential fundamental legislative principles issues, the committee has recommended that the Bill be amended in relation to the

requirement to wear a monitoring device. **Recommendation 7** recommends that the Bill be amended to restrict the Director's power to require a monitoring device to a much narrower category of patient and to be used only in the interest of providing protection to the community or the patient's rehabilitation, care or treatment. **Recommendation 8** would require the Director to take all reasonable steps to consult a patient's treating psychiatrist before requiring a monitoring device. **Recommendation 9** recommends that the Bill be amended to require the Director to give written reasons for his or her decision.

6.3.2 Power to suspend limited community treatment - rights and liberties of individuals

Clause 73 provides that the Director may suspend a patient's or class of patients' LCT. The committee considers that the Director's power raises potential fundamental legislative principles issues. In particular, if a patient's LCT is suspended by virtue of being specified in a class, their rights and liberties may be affected, regardless of whether they have complied with their conditions.

The Explanatory Notes state that suspending a class of patients' LCT is consistent with the stated object of the MHA, as the potential impact on a patient whose LCT is suspended because they are within a class of patients is balanced with the need to protect that individual and the community from the serious risk identified by the Director.

The committee notes that the Bill limits the exercise of the power to suspend LCT to circumstances where the Director reasonably believes there is a significant matter and a related risk to the life, health or safety of a person or a serious risk to public safety. The Director would also be required to have regard to the guiding principles in the MHA. The committee also notes that the Director is required to consult the administrator of the authorised mental health service before making an order and that the decision is subject to review by the Tribunal.

However, in light of concerns about potential fundamental legislative principles issues, the committee has recommended that the Bill be amended. **Recommendation 10** would require the Director to take all reasonable steps to consult each patient's treating psychiatrist before making an order to suspend LCT. **Recommendation 11** would require the Director to give detailed written reasons for his or her decision. **Recommendation 12** would require the Tribunal to review an order suspending a class of patients' LCT within seven days after it has been made.

6.3.3 Power to authorise publication of identifying information - rights and liberties of individuals

Clause 75 provides that the Director may authorise the publication of identifying information about persons who are the subject of mental health proceedings. The committee considers that this power has the potential to impact on the right to privacy of information of individuals.

The committee notes that the Director's power to authorise the publication of identifying information is limited to where he or she reasonably believes that it is necessary to lessen or prevent a serious risk to life, health and safety of an individual, or a serious risk to public life, or is in the public interest. However, the committee is concerned that the Bill offers no guidance to the Director in reaching a decision. The committee is also concerned that clause 75 would provide the Director with greater powers than the Mental Health Court or Tribunal who are prevented from authorising the disclosure of identifying information. The committee draws this matter to the attention of Parliament.

6.4 Explanatory Notes

The Explanatory Notes generally conform to the requirements of section 23 of the *Legislative Standards Act 1992.*

Appendices

Appendix 1 – List of Submissions

Sub #	Submitter
1	Narelle Pasco
2	Carers Queensland Inc.
3	Adult Guardian
4	Queensland Nurses Union
5	Elanora Carers Group
6	Tony Martin
7	Jan Kealton
8	Queensland Network of Alcohol and other Drug Agencies (QNADA)
8A	IWC Limited
8B	QuIHN
8C	Fresh Hope Therapeutic AOD Rehabilitation Home
8D	Alcohol and other Drugs Council of Australia
8E	Mater Child and Youth Mental Health Service - ADAWS
9	Office of the Public Advocate
10	Ethnic Communities Council of Queensland
11	Queensland Aboriginal and Islander Health Council
12	The Australian Association of Social Workers Queensland Branch
13	Queensland Law Society
14	Queensland Alliance for Mental Health Inc
15	Queensland Advocacy Incorporated
16	Rebekah Doley on behalf of a group of forensic psychologists
17	Legal Aid Queensland
18	Queensland Voice for Mental Health Inc
19	AMA Queensland
20	Lives Lived Well
21	Queensland Public Interest Law Clearing House Incorporated

22	Queensland Program of Assistance to Survivors of Torture and Trauma Inc
23	Queensland Council for Civil Liberties
24	Checkup
25	The Royal Australian & New Zealand College of Psychiatrists, Queensland Branch

Appendix 2 –Witnesses at public hearing

Ms Sarah Walbank, Carers Queensland Inc.
Ms Rebecca MacBean, Queensland Network of Alcohol and other Drug Agencies (QNADA)
Mr Richard Nelson, Queensland Alliance for Mental Health Inc.
Ms Jodie Cook, Public Advocate
Dr Alex Markwell, AMA Queensland
Dr Rebekah Doley, forensic psychologist

Statement of reservation

JO-ANN MILLER MP
SHADOW MINISTER FOR HEALTH, NATURAL RESOURCES AND MINES, AND HOUSING
MEMBER FOR BUNDAMBA

STATEMENT OF RESERVATION

QUEENSLAND MENTAL HEALTH COMMISSION BILL 2012

I submit a Statement of Reservation to Report 17 of the Health and Community Services Committee on the Queensland Mental Health Commission Bill 2012.

While accepting the Mental Health Commission Bill with some reservations, I opposed the Government amendments to the Mental Health Act in their entirety.

The Mental Health Commission Bill has not made sufficient provision to ensure the interest of consumer and carers are explicitly represented in both the Commission and in the Advisory Council. The specialist field of alcohol and other drug services also requires an effective voice within these bodies. The appointment of Deputy Commissioners to represent these interests should be considered. [Recommendation 5]

Given the scope of responsibilities of the Commission, the adequacy of a staff establishment of six positions must be reconsidered. The Bill also lacks specific reference to the relationship of the Queensland Mental Health Commission with the National Mental Health Commission. [Recommendation 2]

The intent of the Amendments to the Mental Health Act is to enable the Minister, by directing the Director of Mental Health, to require forensic patients on limited community treatment to be monitored electronically by wearing a location device.

Further, the Minister seeks to obtain the power, not currently held, to suspend limited community treatment for entire classes of forensic mental health patients. Amendments also dilute the current protections of privacy and confidentiality afforded patients under the Mental Health Act. Effectively the Minister will be able to instruct the Director of Mental Health to publically identify forensic patients if it is considered "in the public interest".

While the recommendations of the Report of the Health and Community Services Committee on the Mental Health Commission Bill suggest a number of constraints on these new Ministerial powers, these recommendations seem unlikely to be effective in curtailing the Minister's stated intentions.

Submissions to the Committee on these matters have made it very clear that there is no evidence anywhere in the world for the effectiveness, or cost effectiveness, of these measures in improving patient recovery or in reducing absences without permission. Many hundreds of patients have successfully undertaken limited community treatment to aid their recovery. There are only two cases of unauthorised absences in Queensland in recent years, both of which were quickly resolved.

The Minister has used legitimate public concerns about the management of serious sexual offenders to play on community fear for political purposes. Queensland Health has developed a model of care for patients with serious mental illness that balances the safety of the community with the treatment needs of patients.

The amendments to the Mental Health Act proposed by the Government will undermine the therapeutic relationship between a patient and their Psychiatrist and mental health care team. Evidence provided to the Committee stated that the requirement for electronic monitoring was likely to undermine the effectiveness of limited community treatment and may prompt relapse or serious consequences for the patient and for the community.

The power to suspend limited community treatment for a whole class of forensic patients is an unwarranted step that may harm patients and be open to legal challenge as a breach of basic human rights.

Yours sincerely

Jo-Ann Miller MP
Shadow Minister for Health
Member for Bundamba