



HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Mrs JR Miller MP (Deputy Chair)
Mr SW Davies MP
Dr AR Douglas MP
Mr JD Hathaway MP
Mr DE Shuttleworth MP

Staff present:

Ms S Cawcutt (Research Director)
Ms L Archinal (Principal Research Officer)
Mr K Holden (Principal Research Officer)

PUBLIC HEARING INTO THE QUEENSLAND MENTAL HEALTH COMMISSION BILL

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 13 FEBRUARY 2013

Brisbane

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Committee met at 10.26 am

CHAIR: I declare open this hearing of the Health and Community Services Committee into the Queensland Mental Health Commission Bill. My name is Trevor Ruthenberg. I am the member for Kallangur and chairman of this committee. Sitting next to me is Mrs Jo-Ann Miller MP, member for Bundamba and deputy chair. Sitting next to Mrs Miller is Mr Steve Davies MP, member for Capalaba. To my left are Dr Alex Douglas MP, member for Gaven; Mr John Hathaway MP, member for Townsville; and Mr Dale Shuttleworth MP, member for Ferny Grove. We also have staff from our secretariat and from Hansard here with us.

The committee is examining the Queensland Mental Health Commission Bill. Our purpose today is to hear from invited witnesses about the bill. The bill makes provision to establish the Queensland Mental Health Commission and amends the Mental Health Act to provide the health minister and the Director of Mental Health with additional powers in relation to patients on limited community treatment.

I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's Standing Rules and Orders. Under the standing orders the public may be admitted to, or excluded from, the hearing at the discretion of the committee. Witnesses are not required to give evidence under oath but I remind witnesses that intentionally misleading the committee is a serious offence. Please switch off your mobile phones or switch them to silent at this time.

The committee has resolved that the proceedings of the committee may be broadcast in line with the media broadcasting rules, which are available from committee staff. I inform everyone here that these proceedings are being broadcast live on the internet. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of today's proceedings unless there is good reason not to.

WALBANK, Ms Sarah, Policy and Research Officer, Carers Queensland Inc.

CHAIR: I welcome Ms Sarah Walbank. I invite you to introduce yourself and make a brief opening statement.

Ms Walbank: I am Sarah Walbank, policy and research officer for Carers Queensland Inc. I offer my apologies that Debra Cottrell, the CEO, could not be here today. Carers Queensland is a member of the national network of carer associations and has been advocating on behalf of carers since its inception in Queensland 22 years ago. We operate 13 offices providing specialist carer support services throughout regional, urban, rural and remote Queensland. We currently employ approximately 100 staff of which 75 per cent have the lived experience of being a carer. Our employees bring to the role an intimate understanding of carer issues, needs and concerns.

Today we represent the diverse needs and interests of the 494,200 people or the one in eight citizens of Queensland who identify as a carer. Carers Queensland acknowledges that this figure is probably an underestimation of the number of people who provide unpaid care and support as people do not necessarily identify as a carer for cultural or religious reasons or out of a feeling of duty. Data provided by the Mental Health Council of Australia indicates that carers are the primary providers of support for people with mental health problems. For some carers, caring for a person with mental health problems is more than a full-time job. Data suggests that some carers spend in excess of 100 hours a week providing care and support. That is twice as much as most of us normally work and get paid for. As such, and quite understandably, carers can and do develop a strong sense of responsibility for the person they care for and support and, over the course of their caring duty, develop a considerable expertise in understanding how the individual responds to their illness and their treatments, what works and what does not work.

Whilst current medical and nursing ideology acknowledges carers and emphasises the involvement of carers in the clinical setting, anecdotal evidence from our carers suggests that reality is far from ideology. For example, carers speak of mental health clinical services and service providers not as trusted agencies to whom they can turn for support and assistance as and when they need it but as gatekeepers to highly controlled and sometimes difficult services. Evidence from carers suggests that the attitudes and behaviours of some clinicians and practitioners are

tantamount to being draconian. Carers speak of being barred from visiting the person they care for and support when they are in hospital, of being challenged by allied health staff with allegations of improper treatment and of not being consulted in treatment and discharge planning processes. When carers have challenged this behaviour, clinicians and practitioners have often, and conveniently, hidden behind the facade of privacy and mental health legislation. Carers have stated that they feel that staff and services treat them as irrelevant or even as a problem. The only time they are deemed worthy is when the hospital or a service provider wants them to resume their caring role of supervising, supporting and assisting with essential but routine tasks of daily living.

Carers in Queensland subsidise the service delivery sector that can ill afford to meet the total demand within the community. Carers Queensland is most concerned that, whilst the draft legislation speaks to a platform of transparency and inclusive consultation processes, there is no commitment to the inclusion of carers with lived experience of caring for a person with mental health problems under the Queensland Mental Health and Drug Advisory Council or in the development and evaluation of evidence based policy and practice.

The ongoing marginalisation of carers at both the grassroots and at the policy and advisory level reinforces to carers that the perception of the locus of control is outside of our sphere of influence but that carers can and will do the grunt work to pick up the pieces whilst practitioners and policy makers make decisions without due regard to our competencies, knowledge, experience and our contribution to society.

Mr SHUTTLEWORTH: On page 5 of your submission you have indicated that you feel that carers are concerned about the principle outlined in the bill of giving some recognition to the carers in terms of the integral part they play in relation to wellbeing and should be engaged 'wherever possible' in treatment plans. You are saying that that could provide covertly unjustifiable discrimination. Could you expand on that?

Ms Walbank: The term that is used in the draft legislation is 'wherever possible'. That is not prescribed or described. So you may have situations whereby carers who have been providing the bulk of care and support day in, day out are excluded from treatment planning processes. When they come to challenge why they have been excluded and the legislation has a particularly vague, nondescript statement that says 'wherever possible', they have no argument either to request further information so that they can be a participant in the treatment planning processes or to argue why they have been excluded. There is no definition of 'wherever possible'. That is why the submission recommends that this be resolved as a policy issue and that these statements be made available to carers so that they at least know at what point they can argue to be included and at what point they have to accept that maybe they cannot be included. It is an ambiguity that could be resolved quite easily now rather than through a complaints process later.

CHAIR: A big part of your submission and what you have talked about just now is about a lack of representation. What boards, councils or commissions would you see as being useful for your organisation to have representation on?

Ms Walbank: We would certainly like to see carers—and carers are people who have the lived experience of mental health problems—have a dedicated position within the Mental Health and Drug Advisory Council.

Mrs MILLER: I have a question, Sarah. What do carers think about the idea of mental health patients having to wear ankle bracelets?

Ms Walbank: I am unable to comment on that. That is not something we have solicited from carers.

Mrs MILLER: No-one has commented on it to you?

Ms Walbank: No. I believe that might be the subject of other submissions but certainly not of mine. I can only speak to mine.

CHAIR: Committee, are there any other questions at this point? No. I think we have exhausted our line of questioning at this point. Thank you, Ms Walbank.

Ms Walbank: My pleasure.

MacBEAN, Ms Rebecca, Executive Officer, Queensland Network of Alcohol and Drug Agencies

CHAIR: Thank you, Ms MacBean, and welcome. Would you please make an opening statement, up to five minutes or so, and then leave time for the committee to ask you some questions?

Ms MacBean: I would like to thank the committee for the opportunity to come and talk with you today. Often, alcohol and other drug issues get lost in the milieu of the broader primary health care system. I am the executive officer at the Queensland Network of Alcohol and Drug Agencies. We are the peak organisation representing the non-government alcohol and other drug treatment sector in Queensland. We have been working with our members to develop a consensus position around our involvement in the Mental Health Commission since it was first mooted with us about six months ago. That started with us developing a policy position, which we have made available on our website. When it became clear that we would be included, we participated actively in the consultation conducted through Queensland Health in November last year. I would like to acknowledge that the mental health transition team has been of great help to us in responding to our initial concerns around the inclusion of particular language that is reflective of what we in the sector use, which has, I guess, resulted in them including the word 'drug' in the advisory council name.

I trust that our submission was clear, but I would like to draw your attention to what we would consider to be the key points. The most important point for us would be that an effective AOD system is defined separately to a mental health system within the legislation. This is because we have a separate policy environment that has been in place in Australia for the past 30 years and that is built upon the basis of harm minimisation. It is reflected through the national drug strategy, so you have the three pillars of harm, supply and demand reduction. Our members work mostly in the harm reduction and demand reduction pillars. But the idea, of course, is that the most important thing is to keep people alive in the short term until they are in a position to make a reasoned judgement for themselves about their own substance misuse issue. Of course, our goal for everybody is abstinence, but at the same time that is not the goal that everyone will choose for themselves.

The difficulty for us is that the mental health system talks about recovery oriented systems of care, which we do share in the AOD sector. However, the experience in the UK has been that to use the term 'recovery' exclusively within the AOD sector can be used to preference abstinence-only services over harm-reduction services, such as needle and syringe exchange programs and blood-borne virus testing programs, which are probably some of our most effective evidence based interventions for injecting drug users, who are obviously very high-risk populations.

We also find that AOD issues are not terribly palatable for a lot of people to talk about, so wherever we are paired with other parts of the health system we find ourselves being the poor cousin a lot of the time. It is reflected in the way that we are funded; it is reflected in the way that we are dealt with at the bureaucratic level. Up until November last year we had a stand-alone alcohol and drug strategy unit within Queensland Health. We have now been merged with mental health. We have found that a lot of our policy knowledge has gone from the bureaucracy and we think it is important that the AOD policy environment is reflected in the commission through the appointment of a deputy commissioner for alcohol and other drugs and that also there is a requirement within the legislation to balance the membership of the advisory council to ensure there is alcohol and other drug expertise, as well as mental health expertise. I would be happy to answer any questions.

Mr DAVIES: Ms MacBean, in your submission on page 2 you state that the term 'substance misuse systems' should be replaced with 'alcohol and other drugs'. Where does that fall with items such as aerosols, paints and glues? Would they fall into that category? I suppose 'substance abuse' is quite a broad term and captures things that are not necessarily drugs.

Ms MacBean: That is true. We talk about substance misuse when we are talking about an individual and, you are quite right, that is to reflect things like volatile substance misuse as well as the illicit use of pharmaceutical drugs. I guess still at the national level, though, the terminology has stuck with the alcohol and other drug sector. There is no easy answer. I guess it is all semantics at the end of the day, but the term 'substance misuse system' could be seen to equally exclude the harm-reduction services. There are people out there who use substances but do not necessarily see themselves as having a misuse problem. We deal with health promotion, we deal with children in schools, and that is where the alcohol and other drug system is more inclusive of those. I do take your point. Neither is going to be exactly reflective of the system.

Mr HATHAWAY: You suggested a deputy commissioner for alcohol and other drugs. Could you expand on that? What steps should be taken to ensure the commission gives sufficient consideration to substance misuse issues?

Ms MacBean: Previously we have had a Queensland drug action plan, which specifically looked at alcohol and drug issues at the governmental level and how they would be addressed and how the harms would be minimised. Initially, when we were thinking about this, we talked with our members about having a separate whole-of-government strategic plan for AOD issues. In our discussions with the transition team we have amended our position to realise that probably the danger in having a separate whole-of-government plan is that it becomes the secondary plan or the substrategy, so it probably is better for us to have some integration with the one whole-of-government strategic plan. But there still then rests this need to make sure that AOD issues do not fall off the agenda, which is where we came back at. Our members were fairly adamant 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, I guess.

Mr SHUTTLEWORTH: I just make a point: in your submission you talked about section 45 and the conduct of meetings. You requested that a person who abstains from a vote should have a no vote recorded as opposed to a negative vote. I am wondering if you could expand on why that would be. My view on that would be that you would be trying to pursue more positive outcomes and, therefore, if something was put forward to a group of people and the abstaining vote was a negative vote, then clearly you had not won over sufficient support to obtain that. By simply abstaining, I think you could become rather procrastinated, rather than pursuing great outcomes. I am interested in what your reason behind that is.

Ms MacBean: I guess it really depends on the composition of the advisory council at the end of the day, but I was thinking from the point of view that, because there are issues that will be particular to the mental health sector or particular to the AOD sector, there may be occasions—for example, if I was on the advisory council and we were talking about limited community treatment orders, I might not feel like I had a particular mandate from my membership to express a view on that. If pressed, I am sure I could come up with one. But it just seems to me that with standard meeting procedure, the option to abstain would be more democratic, in a sense. But I take your point. I guess I had not considered it from the point of view that you had not made your case terribly well to win people over to the ‘yes’ vote.

Initially we talked with our membership about whether or not the provisions in the bill were a bit prescriptive around the conduct of meetings. I guess I like a bit of flexibility in a meeting setting and I like to think we can build our decisions around building a consensus without the need for formal voting. But I understand that sometimes in these sorts of structures you have to resort to more formal structures to keep people moving along. That was where that one came from, from our perspective.

CHAIR: Any more questions? Ms MacBean, I congratulate you on your submission. It was a well-constructed and easy-to-read submission and I thank you for that. As reflected in the lack of questioning, it contained a fairly well developed argument and I thank you for that. Please pass that on to your organisation. We have run out of questions for you, so thank you.

NELSON, Mr Richard, Chief Executive Officer, Queensland Alliance for Mental Health Inc.

CHAIR: Thank you, Mr Nelson. Please introduce yourself and then make an opening statement.

Mr Nelson: Thank you. I am Richard Nelson, the CEO of the Queensland Alliance for Mental Health. I will just talk a bit about what the Queensland Alliance for Mental Health is. You may know, but there are things I would like to highlight. I would like to indicate to you that I think I will be talking a little bit more about the Mental Health Commission rather than the amendments to the act, but I am happy to talk about those amendments if you have a question on those.

The Queensland Alliance for Mental Health is a community managed peak body that represents about 250 organisation members and another 20 to 30 individual members. We have that membership across Queensland. We have networks of memberships across Queensland. We also have national networks. We were really pleased to be able to speak here today. We have had quite a significant input, we believe, into the consultations to get us to this point. I personally was involved in the advisory council or committee that was originally set up by the previous government. Our membership has been particularly interested in the development of the commission and there is overwhelming support from our sector for the role of the commission. We look with great anticipation and hope to the work of that commission over the coming years.

One comment I will start with is that we are ready to partner with the commission. I think that is an important thing and I will use that theme throughout my opening comments today. We are ready to work side by side for strong visionary leadership and profound social change. We are committed to contributing to people's recovery to live full and rewarding lives. We know from the act and we believe from the act that that is exactly the intent of that act.

There is a consistent and loud message that I have been hearing and our members have been hearing and have been telling me very clearly. We have been hearing it from people with lived experience, we have been hearing it from people who are their supporters, we have heard it from leaders in the sector, we have heard it from peer support workers and allied health professionals. The point I am making in mentioning so many groups of people is that it is a loud and consistent message. I have heard it from doctors, psychiatrists and psychologists, hospital staff and administrators. That message is 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 that is implicit in the act, but it is not explicit. We would like to see it made more explicit and we have some suggestions for that, should you wish to discuss that with us.

We are ready for strategic and systematic change that contributes to longer and healthier lives. You would be aware that people with severe and persistent mental illness live to about 50 to 52, which is much shorter than those of Indigenous descent. In terms of lives being spent in the community with their families, people want to focus on prevention and early intervention; they do not want to spend their lives in hospitals. We are not prepared to continue for the rest of time to do the equivalent of repairing the washed-out bridge and putting it back in exactly the same place, only to have it flooded out the next time. Who was it who said that expecting a different result from doing exactly the same thing is a definition of madness?

The community managed health sector is designed to assist people stay in their community and keep out of hospital, yet we are significantly influenced by our relationship with government—and we think it is a good relationship, but we believe that the act can be more explicit in strengthening that partnership. I have made mention in our submission about where that might occur.

The advisory council will play an important role in understanding and managing what perhaps could be conflicting priorities for action. We submit that the membership of that council is critical—I know that Rebecca has already spoken about this—and that it should consist of people with a lived experience. Why? We believe that they will contribute to a deeper and more intimate understanding of issues and solutions and we also believe that the advisory committee will need broad experience and expertise to push boundaries and to challenge existing thinking. We have heard over and over again from community, carers and members that we do not want more of the same. It will need collaborators, it will need negotiators and we will need people to develop those relationships with people in community and organisations of influence. We believe it will also need expertise in the AOD sector.

If we expect this, then we need partners. We need to capitalise on national practice and make strong alliances with the National Mental Health Commission and those in WA and New South Wales. We understand from our discussions with government that we have been heavily influenced, in a good way, by some of the actions in other states, particularly New South Wales, and we applaud that. The act must recognise, however, that the partnership between state and federal governments is an important one and that the support of the Premier and COAG for reform is absolutely paramount.

We are ready to share responsibility—that is, the sector—and get involved and contribute. We understand that it is time for change. We also understand the need to listen, communicate and be obvious. That is why we welcome transparency in reports, and that they are tabled in parliament is something that we really welcome. We know that this is to be tried and tested and there is a lot of work to be done, but we are really happy to see that we are involved in that. We do understand the need for privacy and confidentiality at times, but we know that difficult decisions will be made and that special reports will be called for, but we do expect strong public debate—out in the open. It may at times afford us with some perhaps embarrassment, but we know that we are not going to move forward unless we actually get some of the major issues out on the table. We are ready for partnership and renewed collaborative vigour. We are aware of the enormity of the task ahead and we are acquainted with the need for adequate resourcing. Will and commitment are one thing; resources and funding are another, we say.

I make much of the value of partnership in this presentation; however, the act details an extensive list of functions that even the leanest and most focused of operations cannot hope to achieve. Our hope is that the government will resource the commission appropriately, but the sector has a wealth of resource 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.

It would be remiss of me not to highlight again the strong message from the beginning—that we are in this together. And as stated in the act, the advisory council's acts are advisory; however, we believe the commission would be strengthened if the council had powers of decision. And perhaps one of those examples could be the capacity to appoint commission staff—perhaps even a deputy commissioner, too, as mentioned in the previous presentation. We look forward to the passing of the legislation and the opportunity for Queensland to take a leadership role—and, we believe, a national and perhaps an international leadership role—in the reform of mental health practice in Australia. Thank you.

CHAIR: Thank you, Mr Nelson. Mr Hathaway?

Mr HATHAWAY: Thank you very much for your submission and presentation here today. You do mention a couple of words—collaborative and cooperative approach—throughout. But you also talk in your submission about ensuring the commission has coercive powers or some powers to ensure its directions are carried out. You mention, I guess, the appointment of deputy commissioners or staff. Are there any others? Can you please expand on what sorts of powers you would envisage being granted?

Mr Nelson: I think we understand the difficulty it is to produce a whole-of-government strategic plan and to understand fully that mental health cuts across our whole community. We find mental illness and mental health issues in all places in our community. We do understand that to actually work with government and across government will require a good deal of goodwill. We are quite conscious that often in the past—this is no reflection on the current government—we have found it difficult to actually recruit that goodwill necessarily or understanding when we have competing and conflicting interests. So we understand that if a policy or a funding decision needs to be made that might perhaps influence the work of Corrections, the police or Education it is not always going to be an easy thing to do. And perhaps we need to look carefully at how we might recruit that whole-of-government approach in a way that gives the commission powers to bring on board perhaps ways other than just goodwill—bring on board those people we believe should be very much a part of the strategic plan and the action that carries out from the strategic plan. So I think from the point of view of being able to coerce a government department or a commission or a statutory body that sits outside of government departments it would be very, very difficult. But we understand that the minister is very committed to the commission and will no doubt work with his colleagues to enable some of these things that will be quite difficult decisions to make, I think, and to enact over the years—to make those happen across government and across community. I do not know whether I have answered your question fully, but I do not know exactly the mechanisms.

Mr HATHAWAY: It is a broad question, I understand that. Thank you.

Dr DOUGLAS: I have two questions. My first question is: do you have a concern—you made a reference to the fact that you wished to have people chosen as deputy commissioners, choosing committee members—and can you explain what that concern is as to if you did not have a person like that on the board, or the commission itself, and explain to me what that concern is?

Mr Nelson: Around having the—

Dr DOUGLAS: The fact that you feel that you would like to have—is it just a legitimate request that you think it is a good idea or can you tell me why?

Mr Nelson: I think one of the issues is that, as I mentioned earlier, mental health is an issue that cuts across all of community. It is a very complex issue. I believe that we have lots of competing interests in our sector. I have come into this sector in the last two years and found it not dysfunctional necessarily, but it does have competing interests. I think we need visionary leadership, and to do that we need representation. I understand that the aim of the advisory committee is to help with that representation, and the building of subcommittees that the advisory committee can call on—to call for information—would be a very useful mechanism by which to actually garner community understanding or understanding about the issues in the community.

I think the role of a commissioner—a single commissioner—is a significant role, and I believe that the resource team that sits behind it is six people. 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.

Dr DOUGLAS: So you are not saying the possibility is that by having competing interests, as such, there is a risk of jaundice, for want of a better word, of those competing interests?

Mr Nelson: Jaundice?

Dr DOUGLAS: Jaundice, meaning that there is an unfair weighting towards specific areas. And if so, can you tell me what it is that you are referring to?

Mr Nelson: I think the previous speaker spoke about the issue around alcohol and other drug. We have a commission for both, and I think she makes a fair point, and their sector makes a very fair point, that over time I have seen that when an issue is brought to the table it is the mental health issue that will actually be addressed rather than the alcohol and other drug. And I think all we are trying to say there is that there will be a balancing act and that the deputy commissioner might assist us with that process.

Dr DOUGLAS: My second question is a really brief one. You made a submission with regard to the tagging device and you are concerned that it should not be in the hands of the Director of Mental Health and it should be in the tribunal. Can you give me a reason or reasons why you think that is a better situation?

Mr Nelson: I do not have necessarily the expertise to be able to give a full answer, but I will give you an answer from my perspective. My perspective is that it is a very significant decision to make. It is one that does not seem to have evidence behind it for it to be made at that level and we believe it can be made more effectively at the tribunal. It should not be a decision that needs to be made at that level.

Mr DAVIES: As Mr Hathaway alluded to earlier, the word 'collaboration' is very strong in both your submission and what you have said today. Can you give us some examples of where collaboration—maybe in other jurisdictions or even within bodies where you are working—is working really well and probably areas where it is not working well?

Mr Nelson: I can give you an example of where it is working, I think, really effectively. That is in the flood recovery work we have been doing with the department of health and will continue to do hopefully with the Oswald incident. We worked very closely with the department of health on the ground to assist the coordination of services, particularly in this particular instance with Oswald. I will give you Bundaberg as an example. There are teams that come from the department of health—psychologists, allied health professionals—but we also have our own teams on the ground that work with community people, and they are there all the time. It is the connection between the community based services and those fly-in type services for these kinds of events that has been, I believe, an example of good practice. There are some issues with that—there are some improvements to make—but community working with acute care, and in this case perhaps, for example, psychologists and psychiatrists, is working reasonably effectively because of the work we have done over the past two years since the previous flood. So that is one example.

Another example might be in a hospital setting where I have heard hospital staff say to me, 'It would be really important for us to understand your work in the community so that as people leave hospital they have somewhere to go'—Allan Fels talks about accommodation services—'and services to go to for support.' We think we can improve that. We think we might be able to improve the capacity of our work to understand fully what health and hospital services' KPIs are, to keep people out of hospital and to ensure that when they do go into hospital they leave much quicker than currently they are doing. I believe that is an area of work we can do together more effectively.

Mr SHUTTLEWORTH: Mr Nelson, you talk in your submission—and you have spoken sensibly this morning—about collaboration between agencies and so forth, but you have also mentioned that you would like to see a little more power around ensuring that implementation of recommendations is being undertaken. So I read into that that you are looking for a more regulatory type approach to the commission as well. Could you just outline a bit further as to what you would like to see there?

Mr Nelson: There are a number of risks that our members have spoken about in terms of how this commission might operate. We have talked a little bit about transparency and the risk of ensuring that when debate is held people understand what the issues are. We do understand that there will be a range of conflicting priorities, we think—because we have got a lot of work to do; our resources are limited—and that decisions will need to be made, once the strategic plan is written, about what might be the priorities of that work and the commission's work.

When it comes to understanding what significant issues in the community are about, we think they may be issues that might reflect back on the past, to give you an example. And those issues might be embarrassing for some people. They might embarrass us and our sector. We have been looking hard at how we might measure outcomes. We might not have done that as effectively as we possibly could have, but we need to know that we have not done that as effectively as we could have and there is the maturity in the sector that allows us to actually move forward on that. 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. So I think that is the sort of thing we are referring to.

Mrs MILLER: Richard, thanks for being here today. I share your concerns in relation to the commission and six staff, and I note that the commissioner will not be a public servant, which means that the protections around the Public Service Act and the ethics involved—there will be no protection around that. In other departments, commissioners of certain areas are in fact public servants. It seems to me that having a commissioner and six staff only will be a recipe for failure in any case, because they will be expected to abide by all of the requirements of the Public Service in any case—strategic planning, financial auditing et cetera—with such a small number of staff. And therefore, the number of people who might even apply for these positions might very well fall off because they know they will be worked to death, so to speak. I am just wondering if you would like to comment on that, particularly about the commissioner not being a public servant and also whether the commissioner will even be full time, because that is not clear, either.

Mr Nelson: Mrs Miller, we hope so. We hope that that position will be full time because, as I said before, there is a significant amount of work to do. I have highlighted the visionary aspect to the commission and the Commissioner's work and the team that sit behind that. I do so deliberately because we do realise that resources are limited, but we understand that there is a billion dollars worth of investment in mental health in Queensland, a significant resource, perhaps at the disposal of the commission, and I think to be able to harness that resource as effectively as they possibly can they will need to have the influence. You could approach it similar to in New South Wales where they have provided about \$30 million for the commission. That may itself not be enough. I do not think the resources within the commission will ever be enough. I think the resources of the sector working together will probably be enough and how that future might look will be something very different than what we have currently got. So it is a commission-led but it is not a commission-only reform, it is a sector reform, and I think that that is the resource available to it.

Mrs MILLER: I have a supplementary question. In relation to the six officers that will support the commission, do you have any idea of what Public Service levels those particular officers may very well be, because six officers at a senior level is very different from six officers in a bureaucratic level?

Mr Nelson: I am not sure of their exact role or level within their current department or moving to a statutory authority. I am not sure, but I understand they are quite senior staff. That is probably as much as I could probably give you, I think.

CHAIR: Thank you all. We have run out of time. Mr Nelson, thank you very much for your submission and thank you for your time here.

Mr Nelson: Thank you for yours.

COOK, Ms Jodie, Public Advocate, Office of the Public Advocate

CHAIR: For the committee, this is submission No. 9.

Ms Cook: I am Jodie Cook. I am the Public Advocate for Queensland. I provide systems advocacy on behalf of people with impaired decision-making capacity within Queensland. The potential population that makes up that cohort, using recent data from the Survey of Disability, Ageing and Carers, is estimated to be 108,000 people within Queensland. Those figures include not only people with mental illness and people who misuse substances but also people who may have an intellectual disability or who may experience ageing conditions such as dementia et cetera.

Thank you for inviting me to appear before the committee this morning. I welcome the opportunity to talk to my submission on the Queensland Mental Health Commission Bill 2012 and the proposed amendments to the Mental Health Act 2000. I commend the Queensland government for its acknowledgement of and response to the needs of people who experience mental illness and those who misuse substances and for its recognition of the need for sector reform. I wholeheartedly support an enhanced focus on improving outcomes for these cohorts. However, pursuing reform in a manner that perpetuates the already fragmented nature of the Queensland human services system may limit the opportunities to facilitate improvement and integration within and across those sectors. Should consideration be given to bringing these systems together by designing a more inclusive and outcomes focused approach to the delivery of human services in Queensland, I would welcome the opportunity to contribute to discussions supporting reform in this area.

I will talk first today to the Queensland Mental Health Commission Bill 2012. As stated in my submission, I support the objectives and guiding principles outlined in the bill. In particular, I commend the focus on promoting the best interests of the people it 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.

The whole-of-government approach and the acknowledgement of the shared responsibility of both government and non-government in achieving reform are similarly strong features of the bill. However, I believe this responsibility also extends to community more generally and that it is not limited to areas of mental health and substance misuse. I therefore 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 disadvantage; for example, those with intellectual disability or people who are ageing with dementia. The recognition of Aboriginal and Torres Strait Islander people is notable, although I would respectfully submit that other marginalised groups, for example those from culturally and linguistically diverse backgrounds, deserve similar recognition.

I believe, however, that the commission is limited by a number of features detailed in the bill. First, as a number of people have spoken to already, the commission lacks the authority to direct action, which may hinder the achievement of real change. This raises cause for concern should the recommended action relate to a significant risk or issue identified by the commission. Given the inability to direct action, it is incumbent upon the goodwill of an agency and/or the sector to respond to the issue, but by also allowing an option not to it has the potential to perpetuate the issue and/or exacerbate the risk that has been identified.

Second, while I support the ability of the commission to present both ordinary and special reports and the requirement for an ordinary report to be provided to any agencies to which it refers, I believe that practice change could be better achieved by sharing reports about issues impacting specific cohorts with all agencies that support individuals who either present with those issues or who identify as being part of those cohorts. This will also enhance overall understanding of the sector's limitations and its opportunities and give greater transparency to the operations of the commission.

Third, the requirement for the minister to be notified prior to preparing an ordinary report allows for the perception of political influence which has the potential to damage the credibility of the commission. I also believe that there needs to be specified time periods for the tabling of an ordinary report in the Legislative Assembly to militate against that same perception.

In the interests of ensuring a shared understanding of systemic issues impacting these cohorts, any reports relating to people with impaired decision-making capacity should be shared with me in my role as Public Advocate. Further to this, and in the spirit of partnership, I look forward to working with the commission, particularly with respect to pursuing research and sector reform for issues impacting people within that cohort.

The establishment of the Queensland Mental Health and Drug Advisory Council is an important inclusion in the bill. However, I reiterate my earlier comments that the scope is limited by its focus to the identified cohorts, particularly when many of the issues are similarly experienced by other marginalised and vulnerable groups within Queensland.

I will now move on to my concerns in relation to the proposed amendments to the Mental Health Act 2000. I strongly oppose the proposal for tracking devices to be used to assist in monitoring limited community treatment patients. While I appreciate that there would be an intention to use such an approach judiciously, the stigma that is likely to arise for people should they be forced to wear such devices is likely to have a negative impact on their successful reintegration into society. I am also concerned that their use contravenes a number of international conventions and national standards, not the least of which is the United Nations Principles for the Protection of People with Mental Illness and the National Standards for Mental Health Services 2010.

I also hold significant concerns about the proposed ability to suspend limited community treatment, LCT, for a class of relevant patient. This proposal is also in conflict with a number of international conventions and national standards, as I have articulated in my submission. For the committee's information, I have summarised the relevant references from these conventions and standards and I will table that before you today. 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 risks and/or hinder recovery for many individuals. The proposed use of tracking devices and of suspending LCT for a class of patients not only infringes upon the rights of the people to whom they are applied but is also counterintuitive to achieving the outcomes.

In closing, I would like to reiterate my support for the Queensland government's focus on improving outcomes for people who experience mental illness or who misuse substances, even while I re-emphasise my concerns about the limited scope of these provisions and some of the specific inclusions proposed for these legislative instruments. Once again, I would like to thank the committee for allowing me to speak today and I welcome the opportunity to respond to any questions that you may have about my submission.

CHAIR: Thank you, Ms Cook. In relation to the document that you want to table, how is that different from page 5 of your submission? Is it the same document?

Ms Cook: No. It provides further detail on the references within the conventions and standards that we have referenced and we have added emphasis with the underlining of some of those particular statements.

Mrs MILLER: In your position as the Public Advocate, particularly in relation to the ankle bracelets as well as the breaching of fundamental human rights, did your office brief up internally through the department in relation to this matter?

Ms Cook: I only started within the office in August last year. I have not since that time been provided the opportunity to actually talk to anything prior to the ability to make a submission.

Mrs MILLER: Do you know whether, prior to your time, anybody else within the office or within the department generally briefed up internally within the department about these issues of concern?

Ms Cook: I cannot speak to that. I do not have any specific knowledge about that, no.

Mrs MILLER: If you find out, would you be able to let the committee know?

Ms Cook: I can certainly make inquiries to that effect, yes.

Mrs MILLER: When Australia is a signatory to many of these international agreements on human rights, it seems quite strange that the Queensland government appears to be basically flying in the face of these issues.

Ms Cook: As you would be aware, I am a statutory officer and not a public servant, which certainly goes to your references earlier with the previous speaker.

Mrs MILLER: Yes, I know.

Ms Cook: I am part or associated—affiliated, I guess, in many respects—with the Department of Justice and Attorney-General, so I guess with that linkage I will certainly make inquiries and see if I can find that information for you.

Mrs MILLER: Yes, because it seems to me that normal Public Service process would be that you would be asked to make a submission internally in any case or that your views would be known. That is why I am interested as to the process that has been carried out internally within the Department of Justice and Attorney-General. Thank you.

Mr SHUTTLEWORTH: Ms Cook, on page 4 of your submission you say that greater advancements could be made and focus broadened to be an inclusive and outcomes focused approach to human services. Would you expand a little bit more in terms of what you would like to see there?

Ms Cook: Certainly a lot of what I see within the work that we do in the office is that many of the different groups—and as I said before, we represent people who have impaired decision-making capacity—experience similar issues and experiences in interacting with the system. I guess for me, having worked for quite some time previously in the department of communities and other systems, it seems that repeatedly people fall through the cracks and I think it is about how we bring together a system that enables a response that ‘it does not matter what your diagnosis is; it is about the nature of your impairment, not the type of impairment. How do we respond to the way that you experience your impairment in a way that is consistent, regardless?’ The cohorts that I reference are those with impaired decision-making capacity, and many of the issues they encounter are the same regardless of whether someone experiences mental illness or whether they are ageing with dementia. The actual effect of that impairment on the way that they interact in community and society, with systems, with government, does not hold that many differences.

Mr DAVIES: On the tagging issue, given the fact that tags can be under clothing and will not be seen by people, how would that affect a person's wellbeing or anything? I have seen the ones that they are using now. They are actually quite discreet; they are not hanging around a person's neck or anything like that.

Ms Cook: Not knowing the devices that would be utilised—and many of them may well be discreet, so I certainly take your point on that—in many cases it is the feeling of the person who is wearing that device and what that might mean for them as well as the stigma that might be attached to someone visually seeing that.

Mr DAVIES: As a follow-up question to that, a number of people have absconded from facilities. You were saying ‘two’; that is a number. A number of people have absconded.

Mrs MILLER: But with respect, two is very minimal.

Ms Cook: Given the large number of people who are subject to LCT.

Mr DAVIES: Sure, but it is a number.

CHAIR: Continue with your question.

Mr DAVIES: Some of these people are on forensic orders and the public has a right to feel secure. Is what is set up now good enough? In your view and in your agency's view, is the system we have now acceptable?

Ms Cook: I think that is a far broader question than obviously being just limited to tracking devices and whether they have any clinical efficacy. I think if we look at the system as it stands and its intention, it is about treatment. I think that needs to remain the focus. I think it needs to remain the focus that treatment is about an individual and I think everything needs to be approached in that way. If the use of tracking devices is pursued, I think it is about ensuring that as far as possible we militate against any of those risks that might be there for the person in terms of how they feel about themselves and how that might impact on their recovery or their rehabilitation. Again I commend the establishment of the commission for what it potentially offers to actually improving the system. I think the system as it currently stands still has limitations and I think that is the very reason we are here today: to enable a way of response that helps us not only identify what those issues may be but also identify the causal factors underpinning those issues and to be able to do something about them.

CHAIR: Thank you. We have time for one more question.

Dr DOUGLAS: You may not know the answer to this, but is there any other First World country that is using a similar tagging system that we are proposing in this bill for these types of patients?

Ms Cook: Having not explored that to its fullest, I cannot say definitively. However, to my understanding, for these devices to be used with this cohort—I do not know of any examples.

CHAIR: Thank you, Ms Cook. Thank you for your submission and thank you for turning up here today. We appreciate it.

Ms Cook: Thank you.

MARKWELL, Dr Alex, Australian Medical Association Queensland

CHAIR: Dr Markwell, thank you for turning up and thank you for your organisation's submission. Could you please introduce yourself and then make an opening statement?

Dr Markwell: My name is Dr Alex Markwell. I am an emergency physician and I am President of AMA Queensland. Today I welcome the invitation to speak on behalf of the submission which has been developed in consultation with our members including psychiatrists. Clearly I am not a psychiatrist but I do have experience in some matters with mental health, but I do provide the perspectives of our membership.

There are two aspects today that I would like to touch on. Firstly, I will speak to the initial part of the bill which is to establish the Queensland Mental Health Commission. I certainly support the creation of the Queensland Mental Health Commission. We feel that there are very positive aspects of this. In particular, we certainly support the development of a whole-of-government strategic plan for mental health services. It is important that there is an inclusion of guiding principles. We particularly welcome the fact that the commission will provide a state-wide perspective to policy and planning, particularly in very specialised areas of mental health such as forensic mental health, Indigenous and youth mental health and paediatric mental health. This is particularly the case considering the move to the 17 hospital and health service boards across Queensland. It is unreasonable to expect that each of those areas will have the expertise in every single area to treat all those patients. We also welcome the role of the advisory council and the insight and input that that will provide to the commission.

There are some areas of concern, however, with the Mental Health Commission and I will run through those now. The first one, which previous speakers have already highlighted and one that I echo, is that there is currently limited ability within the bill to actually effect change. Section 34 does not create an actionable obligation. It requires that relevant agencies 'have regard to' the plan and the principles of the bill, but subsections (3) and (4) actually remove any enforceable obligation which certainly waters down the strength of that particular section.

The second area of concern is that, although it is a whole-of-government proposal, the fact that the commission will sit under the Health portfolio may impact on the ability to influence change, especially across agencies. Again, I believe this has been previously raised by other speakers. There are ways where this could be overcome, particularly if there were some strengthening of the proposed bill to require that there is an enforceable nature of the commission and the direction of the commission. It is also incredibly important that we include engagement with clinicians in that process. There is currently legislation in the Hospital and Health Boards Act which does outline quite nicely the processes for engagement with clinicians as well as consumers, and we suggest that this bill could mirror that wording.

Thirdly, currently it does not appear that the Mental Health Commissioner will have a role in directing the scope, mix, quantity and the price of mental health services within Queensland, and that is an area of concern. This commissioner is being put forward as the expert and the commission is the coordinating body for mental health, and we think they should have a strong role in guiding the purchasing framework and service level agreements that take place throughout Queensland.

Fourthly—and I mentioned this before with respect to the previous legislation that requires engagements with clinicians and consumers—other than the term 'service providers', there is currently no direction to engage with and we do not have any enforceable way of engaging with all providers across the mental health sector, and that includes GPs, allied health providers and a range of other workers as well.

Fifthly, there currently is a very detailed and well-regarded Queensland Plan for Mental Health 2007-2017, which I understand lost funding in 2011. Until the whole-of-government strategic plan can be fully developed and implemented, we would recommend that there be ongoing funding to ensure this existing plan be continued. Currently there is an absence of funding for this plan, and that does raise concerns about the coordination of mental health services across agencies and throughout Queensland.

I will now move on to the proposed amendments of the Mental Health Act 2000. There are three main areas of concern that we raised in our submission and that I will highlight now. Firstly, there are concerns about the proposal to suspend limited community treatment orders for a class of

patients and that this can be done at the whim of the Director of Mental Health. Currently there are very strict processes that are followed using the Mental Health Review Tribunal and the Mental Health Court and we would support the continuation of those processes. If in fact it is determined that there should be a suspension of leave, then that should follow the existing processes that are robust and supported clinically and also recognised internationally.

We also have 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. At the moment if a patient has their LCT suspended because they fall into a particular class, their right of appeal is only to challenge that they fall into that class, not that they as an individual do not pose a risk to the community. If it were deemed that the suspension order would continue, we would strongly recommend that a right of appeal would exist for an individual who could then put forward an argument to say that they on an individual basis are not a risk to the community.

The final area of concern is around the use of monitoring devices. Currently in Queensland the only people that these devices are used on are nonprisoners who are under the Dangerous Prisoner (Sexual Offenders) Act. There is an incredibly rigorous process, again, Supreme Court approval is required and it is done in extreme cases where the community would be reasonably concerned about the risk of reoffending and also the safety of the community. I think we would agree that that is a reasonable position to be in. The current proposal is that these devices be used potentially on any patient under a forensic mental order. There does not appear to be any distinction as to—they have not been convicted of a crime—an offence they may have committed under their forensic order. This is going to significantly affect the rehabilitation of these patients back into the community. It certainly extends the stigma, which is currently a huge concern with mental health patients and there has been a many-decades-long approach to trying to reduce stigma and improve the treatment of mental health patients.

If there were to be any use of these 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. Again, it comes back to reassuring the community that the risk is very low. I think those are the main points that we have highlighted in our submission. I am very happy to take questions.

Dr DOUGLAS: Dr Markwell, can you give me any idea of where the AMA saw any deficiency in the original plan—that is, the 2007-2017 mental health strategy for Queensland?

Dr Markwell: I am not familiar with the detail, the finer points, of that plan. The members of our organisation who are psychiatrists have unanimously put forward that plan as being a very well-regarded plan, and my understanding is that across other agencies that is also supported. I am very happy to investigate if there are any areas of deficiency and we can provide that information at a later date.

Dr DOUGLAS: Is the AMA aware of where this proposal to suspend limited community treatment for people may have come from? Has anyone suggested where this has been discussed elsewhere?

Dr Markwell: Sorry, Dr Douglas. You are asking if I know why this particular—

Dr DOUGLAS: No. Has there been anything said—these would be people who would have looked at this a lot more closely than everybody else. Is there anything that you have had reported to you that you can add to help us come to a conclusion about this?

Dr Markwell: Of all the people that we have consulted with within our membership there is no support for the suspension of the LCT as has been proposed. There are currently very good processes that occur and the recommendation is that they be continued. Certainly my psychiatry colleagues have not provided any suggestion that that would be a reasonable course of action. So I am not sure where the original thought has come from, but it is not supported within the medical community at this stage.

Mrs MILLER: With the mental health patients and their families that I have been speaking with, it seems quite clear to me that in relation to the tagging devices there is a concern that the patients could very well be bashed in the community, that we are setting them up for failure, as you have pointed out as well. So you are saying that there is no support for these tagging devices in the medical fraternity?

Dr Markwell: There is certainly no support and there is no use of these devices in Australia within the forensic mental health system. From the advice I have received from my forensic psychiatry colleagues—it is obviously a very specialised area of medicine—their feeling is that currently in Australia it does not occur except for the use of nonprisoners, which we have discussed before. There is a feeling that it would interrupt the therapeutic relationship that occurs and is built up gradually over time with these particular patients. Because of the fact that we only use these devices in a very, very particular group of prisoners—and, in fact, I believe one is being released tomorrow under a similar arrangement and will be fitted with a monitoring device—it automatically creates a very, very high level of stigma and a high concern within the community. So, as it stands, there is no support within the forensic psychiatry faculty. There is also no support from the other members of the profession, who are concerned that this is really a breach of basic human rights.

Mr HATHAWAY: I have a limited understanding of what limited community treatment is, but my understanding is—and correct me if I am wrong—that it is normally a transitional plan where you might be assisted as an inpatient et cetera, then you are moved to different areas of that facility escorted and then unescorted, and then you are moved out into the community escorted and then unescorted. Just at the end of your last answer, you touched on the fact that the use of monitoring devices is rare—and let's face it: this is new and evolving technology. But if there were greater use of them, rather than suspending somebody from LCT they may be able to continue to be monitored and actually receive the treatment, assistance and support that they need in an unescorted fashion. Is that a possibility?

Dr Markwell: Again, it is not my area of practice so I am relaying information that I have been provided with, but my understanding is that these devices do not reduce the rate of reoffence and they certainly do not justify the expense, if nothing else. They are GPS tracking devices, so they determine the location of an individual at any point in time. Within the current LCT program, my understanding is that, through that—

Mr HATHAWAY: Transition.

Dr Markwell:—step-wise process, there includes also processes for regular contact with the treating team. There are appropriate monitoring mechanisms in place already for determining where people are and making sure that they are safe.

The risk of reoffence, or recurrence of these original scenarios, is very, very low in this particular group. They are much lower than what you would see in a normal criminal population. The feeling of the forensic psychiatrist is that there is no evidence to show that it will increase community safety. It increases the stigma associated with these patients as they transition. I think with the cases that previously had left without leave, they were located very quickly because they went to the places that they knew they would go to. So it would not have changed the outcome in those two patients, anyway. That is my understanding.

So as it is currently proposed, it seems to be of little benefit and high cost, both financially and in ongoing stigma. So I cannot see any way that it would be supported and how it will improve the treatment of these patients and the risks.

Mr HATHAWAY: I have one follow-up question. You may not be able to answer this. Part of your statement in that last answer was indicating that there is little evidence to support that, with the aid of a monitoring device, it will not cause the patient to reoffend or otherwise. I do not know how long these devices have been employed—I think it is less than a year already. So what we are trying to say is that, in regard to the sexual offence prisoners, there is very limited data—is that a fair question?—to say that these have stopped, or saved, or improved public awareness, because we are only looking at it over a short period of time.

Dr Markwell: I do not have any experience with their use in the criminal justice system, but within medicine and within forensic psychiatry my understanding is that they have not been used anywhere else in Australia and that use internationally—I am not aware of their use and there is no medical evidence to support their use in this particular group of patients.

Mr HATHAWAY: Okay.

CHAIR: Unfortunately, committee, I am sorry, but we have come up against time here. Dr Markwell, thank you for your attendance and please thank your organisation for their submission.

Dr Markwell: Thank you.

DOLEY, Dr Rebekah, Forensic psychologist

CHAIR: Dr Doley is representing a submission from a group of clinical and forensic psychologists. Dr Doley, would you please introduce yourself and then give us an opening statement.

Dr Doley: Thank you. I am Dr Rebekah Doley. I have a Master of Science in Investigative Psychology, a Master of Psychology in Clinical and a PhD in Clinical. I am also the Chair of the Australian Psychological Society College of Forensic Psychologists here in Queensland. I am speaking on behalf of a group of colleagues. We are all forensically trained and have been working in the area for quite some time.

I am happy to be following the previous speaker, because I think she has eloquently listed a number of our main concerns, but I would like to take just five minutes of your time to recap. As most people have said, certainly we welcome the Mental Health Commission. We welcome that initiative. Our concerns revolve around some of the amendments that have already been raised here. The reason we are concerned is that we feel that the amendments concerning tracking devices and the suspension of LCT violate a number of national and international principles, as has already been outlined. They are not in keeping with the principles of due process in the way that this has come about and they are potentially harmful to individual patients as well as to their engagement in the treatment. In many ways, particularly with the tracking, these are not evidence based processes and I can speak to some of those issues that have just been raised. We believe that those two aspects of the amendments require further consideration and consultation with relevant bodies.

So to summarise, the introduction of the GPS system for those on forensic orders under the Mental Health Act is not appropriate for a number of reasons. There is a detrimental impact on the individual which has been spoken about in the literature including possible interaction effects with mental illness. There is a lack of literature or evidence to support the use or effectiveness with this particular population. As has been said before, there is a risk of further stigmatisation of a very vulnerable patient group. We consider such steps potentially discriminatory when compared to the rehabilitation and risk management strategies that are available for people without mental illness.

The level of risk that has been addressed by the measure of tracking devices is very low. This group, as was mentioned previously, is in fact a group with mental illness rather than convicted offenders. Their reoffence rate is much lower than for general offenders. Their illness can respond to treatment, which further reduces their risk to the community. The number of AWOL incidents from high-secure inpatient services is very low, as there have been thousands of successful instances of unescorted leave with only two AWOL incidents in the past three years.

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 treatment process. By that I mean things like underreporting of symptoms, which prevents us from monitoring effectively. We risk the therapeutic rapport, and the evidence demonstrates that that is an extremely important part of the effectiveness of treatment. Additionally, we further stigmatise them through the use of monitoring devices, thereby complicating their reintegration and their ability to build prosocial, protective factors that are the very things that keep them from reoffending.

Our second point concerns the ability for the Director of Mental Health to review and suspend LCT particularly, as has been raised before, as it pertains to a class of patients. In our opinion this does not adhere to the principles of due process or sound decision making based on individualised risk assessment and management. Such steps are potentially harmful to both the individual and the community by disrupting progress that is in place, the stability of risk-ameliorating factors such as employment and housing, and damaging further engagement with the mental health system.

In summary, overall it is our opinion that the amendments do not achieve their intention effectively such that the risks outweigh the potential benefits of implementation. In this regard, the brevity of the consultation process and the speed at which the amendments have been proposed is of concern to us. It is suggested that a more thorough consultation procession may better inform and may also identify more effective alternatives that are potentially less damaging to this group of patients in our care. Thank you.

Mrs MILLER: Dr Doley, thank you very much for your submission and your comments today. It appears to me to be that the tagging system seems to be almost an hysterical response to newspaper articles, so to speak. I, too, am very, very concerned about this issue. Could you provide us with any international experience of these tagging devices?

Dr Doley: From our research there have been only three studies looking at the effectiveness of tagging devices in terms of reducing reoffending and two of those studies found it to be not significantly effective. So there is some evidence there—not a lot; only three studies. As far as I am aware, there is no First World nation that uses these devices in this way.

I think the issue of stigmatisation is extremely concerning when I consider the risk and protective factors that are relevant to achieving a successful treatment outcome and, specifically, using a device that the community recognises as being associated with dangerous prisoners is concerning when you are applying it to people who have a much lower rate of reoffending generally and whose illness can, in fact, be treated. It is a worry.

Mr DAVIES: If these things are not being seen, where is the stigmatisation? If it is an ankle bracelet or whatever that is no bigger than a watch that under your jeans or pants, or socks for that matter—

Dr Doley: I completely understand your point. I take your point clearly. The issue, I believe, lies in the perception. It is not so much whether you can see it; it is about stereotypes. Already people who are challenged with mental illness are experiencing sufficient stigmatisation as a result of those stereotypes. If it is now known in the community—and with all due respect I am not sure that many people will understand the nuances of the fact that a bracelet is applied to some people and not others—it risks putting everyone with a mental illness in a category where they should be wearing a bracelet and the people we know who do wear bracelets are dangerous people.

Mr DAVIES: Not all of them. When Derryn Hinch—some would say that he is dangerous—was under house arrest he had to wear a bracelet as part of his order. It happens for white-collar criminals all the time and they are not dangerous offenders; they are not sexual offenders. In Derryn's case it was the fact that he was under house arrest. As John Hathaway said earlier, it is new technology. It is just starting. Obviously, it has been used widely in the sexual offences area in the past but more and more I think this technology will be used in the general populace.

Dr Doley: Yes, I understand your point. I think the issue again relates to what is the benefit in terms of reducing risk and I am not sure that understanding somebody's GPS location will impact positively on that risk versus the clear potential damaging effects that applying such a measure will have on that person's progress through treatment.

CHAIR: Dr Doley, I acknowledge your expertise in this area. My question would be from a layman's perspective. Where do we find a balance between the protection of people in the community and the care regime for a person who is ill? My understanding and reading of the bill and of the explanatory notes would be that the Director of Mental Health would be required to review something typically considered to be in a fairly extreme circumstance—in other words, a patient has gone AWOL for a period of time and there is some concern that that person could have the potential to be dangerous to themselves or other people in the community.

Mr HATHAWAY: Or access to their meds.

CHAIR: Where do we find that balance, because we have seen in the last several years where that exact circumstance has played out. There are two questions here. Under that circumstance typically from a care regime, how would you address that? What does the system currently afford in a circumstance where a person has gone AWOL for a period of time? How do you find them? I am not trying to be obtuse here; I am just trying to understand the mechanisms that are currently used versus the intent of the bill to try to protect either the person and/or the public.

Dr Doley: I think the weight of evidence at the moment is that, with two AWOL incidents and thousands of successful events, that is an important point to remember. Having said that, I understand our need to address community concerns regardless of the statistics. So I take your point with that.

The current monitoring process involves a series of check-ins and so on. The way the last couple of people who were AWOL were found was through police intervention. They were brought back to the system appropriately. I can provide you with proper details at a later date if you are interested in the specific mechanics of it. What I want to highlight in the time that we have available is simply to suggest to you that the system is working. The fact that two people went AWOL in the last three years does not mean that the system is not working.

CHAIR: Please take this for what it is. From a public perception, is it not prudent to give the minister and ultimately then the Director of Mental Health an opportunity to immediately investigate whatever the care regime is and determine potentially that that person at that particular point may cause damage or is in danger?

Dr Doley: I absolutely support the process that is currently in place in terms of being able to review individual cases. So we have the LCT review committee that sits to monitor those aspects and the information that is provided. We then have the Mental Health Review Tribunal that makes those decisions. That system needs to stay in place. That is our effective mechanism for monitoring that. Anything that is applied to a class of patients negates the impact on an individual. It is a class, and applying that philosophy ameliorates the effects of everything the treatment currently stands for.

CHAIR: Please excuse me, I am going to go down this line a little more. The application of a class, as I understand from reading the bill, typically would be to a particular facility. So in other words, the director may have some questions about potentially there being a systemic problem at that particular facility and, therefore, a review may be conducted. The review does not necessarily mean an order would come. In both instances, whether a review was done on either an individual or a class and an order was put in place, the mental health tribunal has authority to turn that order around from the director. Practically speaking, I am looking at a very specific circumstance where the public and/or the minister is concerned for the person and or the public. How do you find that person in that instance? Given that the tribunal has ultimate authority in turning those decisions around, I would see there to be a reasonable check and balance in place.

Dr Doley: Again, I understand where you are coming from. One of the concerns we have raised is the length of time that it takes for that process that is being proposed to play out. The time that somebody loses in terms of housing, employment opportunities and so forth is significant in terms of their rehabilitation. They may well lose that job; they may well lose that housing opportunity while this process of checks and balances is being carried out. The current system seems to be quite time effective, time efficient. It seems to be working in terms of the statistics. Without further consultation and research, which is what we would suggest should happen, I am not sure that these two amendments in particular are actually going to be beneficial for the group of patients we are talking about.

Mrs MILLER: My electorate is very close to The Park. The people who work at The Park including the doctors, the nurses and all of the people there go to great lengths to reintegrate patients into the community. Quite often these patients are seen around the St Ives Shopping Centre. The fact is that if only two patients have gone AWOL in three years that is an enormous success for their strategies in bringing people back into the community. Secondly, if these patients go missing or they are not there, the police are given the responsibility of finding them. If you talk to the Queensland Police Service they will tell you that they hate having to be diverted from their normal jobs to go and actually find these patients because nine times out of 10 they are okay. Sometimes they will actually come back themselves—

Dr Doley: That is right.

Mrs MILLER:— because they regard The Park or wherever they are as being their home. I think this committee also needs to talk to the Queensland Police Service about the diversion from their core responsibilities. Dr Doley, you would be aware that there are quite incredible protocols in relation to having these patients go back into the community which, if they can, is the ultimate care plan for a lot of these patients. The hysteria that I was talking about before and also the hysteria whipped up in relation to Australia's reputation around the world to be breaching international human rights conventions seems to me to be an hysterical reaction to what could be a perceived cause in the community. What I am trying to get is your opinion on this, given the police diversions—having these patients come back into the community is not the great issue that I think people think it is.

Dr Doley: That would be my opinion based on my experience and training and certainly the opinion of my colleagues. The research does suggest that the most important factor in someone's rehabilitation is maintaining those protective factors and building a prosocial approach into their lifestyle. Tagging people and removing leave that they have earned the right to have does not fit neatly within that treatment model as an effective approach to managing risk.

Dr DOUGLAS: My question is hypothetical. In practical terms, are you saying that if we bring this in that the most likely thing is it will not be the compliance issue of the individual; it will be the compliance issue of the whole system around it and that will defeat the intent of it? Is that possible?

Dr Doley: That is a big question. If these amendments are brought in, I am saying that the evidence suggests that there is more risk to doing that than there is evidence to say it will achieve what it is proposed to achieve. Whether that risk comes from the system failing or whether it comes from an individual or a group of individuals, it could be any of those things. All I can safely speak to is what the evidence tells me, and the evidence we have from international research suggests that there is insufficient research to indicate that this is a good way to go.

CHAIR: I am sorry, we have to close this hearing. Our time has well and truly elapsed. Dr Doley, thank you for your submission and please thank your colleagues for the work that they have put into the submission. I now declare this hearing closed.

Committee adjourned at 12.07 pm