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Office of the President

1 August 2014

Our ref H&D – 2

Mr Paul Sheehy
Director
Mental Health Act Review
Department of Health
PO Box 2368
Fortitude Valley BC QLD 4006

By Post and Email to:

Dear Director

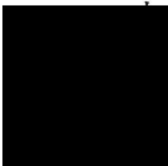
Review of the Mental Health Act 2000 Discussion Paper - May 2014

Thank you for the opportunity to comment on the Review of the Mental Health Act 2000 Discussion Paper – May 2014 and for granting the Queensland Law Society an extension of time to lodge submissions.

We provide our feedback in the ***attached*** submission. Please note that this submission is not intended to be an exhaustive review of the *Mental Health Act 2000* (MHA). We are happy for the submission to be published and would be pleased to be involved in any public forums, conferences and consultations with respect to the discussion paper.

Thank you for the opportunity to provide comments on these issues. Please contact our Senior Policy Solicitor, Ms Binny De Saram on Policy Solicitor, Ms Raylene D'Cruz on or Policy Solicitor, Ms Louise Pennisi on for further inquiries.

Yours faithfully



Ian Brown
President

Queensland Law Society

Submission

Review of the Mental Health Act 2000

Discussion Paper

Department of Health

A Submission of the

Queensland Law Society

1 August 2014

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Introduction

The objectives of the proposed changes to the legislation are set out at page 5 of the Discussion Paper:

1. To safeguard the rights of people with a mental illness;
2. To promote an individual's recovery and ability to live in the community without the need for involuntary treatment and care;
3. To strengthen the importance of family, carers and other support people to a patient's treatment and recovery;
4. To only adversely affect an individual's rights and liberties if there is no less restrictive way to protect the health and safety of the individual or others; and
5. To provide for simpler and fairer processes under the act.

The Society is supportive of these objectives as they focus on the individual, rather than on financial considerations. However the Background Paper expressly suggests that financial consideration informed its support for a number of the most significant proposed changes. This suggests that a conflict may have developed in the process, which, in the view of the Society, places a caveat upon the recommendations.

1. Involuntary Examinations and Assessments

1.1 General observations

The Society is supportive of increasing the threshold for involuntary examinations and assessments and considers that it is a positive step to streamline the process.

We also note that the paper recommends raising the test for capacity. This appears to be in line with United Kingdom legislation as well as the recommendations arising from the Victorian Legal Reform Commission's paper. We note that as this places a higher emphasis on the health practitioner to set out and clearly explain procedures and treatment to the patient, it would be of assistance if there were guidelines to assist health practitioners in this process.

1.2 Recommendation 1.19

Recommendation 1.19 adds two criteria for an authorised psychiatrist to maintain a person on an involuntary treatment order (ITO). A person "appearing to have" capacity to consent will continue to be subject to an ITO if the psychiatrist reasonably believes the patient will:

- cause harm to himself, herself or someone else, or
- suffer serious mental or physical deterioration.

The Society submits that recommendation 1.19 should be reconsidered as the recommendation appears to run contrary to objective above and is uncertain. A concern we understand has been raised by the Magistracy, with which the Society agrees, is that the test "appearing to have capacity" is very subjective and does not appear to be based on

any objective medical evidence or assessment. We also note that the proposed subjective assessment of "appearing to have capacity" is not a test in the *Criminal Code.*

We therefore make the following recommendations:

- that the reference to "appearing to have capacity" be removed and replaced with "has the capacity to consent"; and
- that there be only one criteria for this recommendation, namely that the patient will "cause harm to himself, herself or someone else."

In relation to our first recommendation, we also submit that any reference to "appearing to have…" in the Discussion Paper should be removed.

3. Assessment of Individuals Charged with an Offence

3.1 General observations

The Society is supportive of Chapter 7, Part 2, however has some reservations about how it is intended to be implemented.

3.2 Recommendations 3.1 – 3.6

Recommendations 3.1 to 3.6 focus on offences that can be heard summarily and must be heard on indictment. If enacted, we are concerned that these recommendations will significantly reduce the rights of involuntary patients facing criminal charges.

Although the state always has an interest in treating a person with an illness, the right to liberty remains paramount until a need for treatment is identified. In other words, a person is only subject to involuntary treatment when the person's state of health is so parlous that it must inform a diminished legal status.

The consequence of recognising that a person's liberty may be determined by their state of health is that protection must be ensured from other legal processes which may have potential to erode the person's liberty. The mandatory process invoked by Chapter Seven, Part Two MHA ensures that the state consistently and fairly applies the law to a citizen subject to involuntary treatment. That process does not presume that the person was of unsound mind, or is unfit for trial. Rather, it ensures that the state enquires into those matters to protect the person from the presumption of soundness of mind and fitness applied to ordinary citizens.

We are concerned that under the proposals the state will regard a person subject to involuntary treatment in an inconsistent, arbitrary fashion. While denying the person's right to liberty on account of their health, upon the person being charged, the state will not be required to provide that person with protection against the ordinary presumptions of the criminal justice process.

The Discussion Paper expressly acknowledges that the proposed legislation will inform "increased potential for persons who may have a mental health defence to receive a criminal penalty". However this appears to be less important than resources being

“redirected” to “higher priority frontline services.”[1] This is an unfortunate example of a person being subjected to criminalisation without proper legal processes being ensured.

A sick person ought not to be regarded as criminal without being afforded due process. If however the proposed restrictions to Chapter Seven Part Two MHA are applied, a significant number of mentally ill persons will unjustly transition from the status of sick persons requiring treatment to the status of criminals subject to punishment.

The Society submits that the effect of the proposed changes will not be addressed through other parties assuming responsibility for the provision of the expert psychiatric reports currently supplied under Chapter Seven Part Two MHA. Firstly, those other parties may not have sufficient funds to do so. Secondly, psychiatrist requested by the patient to undertake an expert psychiatric report may not have sufficient access to the information required to properly report. Most importantly, the psychiatrist will not have any lawful obligation to do so – and when the person subject to criminal proceedings may not appreciate the need to properly determine those matters currently the subject of Chapter Seven Part Two MHA reports, given the effect of the illness determining their involuntary order.

The extent of the problem resulting from implementation of the proposal cannot be underestimated. It will fundamentally undermine the integrity of the criminal justice process.

It is respectfully submitted that the Chapter Seven Part Two MHA process ought not to be modified in any way. The existing process protects the person and the community from the negative consequences of the illness to which the involuntary patient is, or may be, subject.

If Queensland Health is concerned about the cost or the logistics of supplying reports on its involuntary patients it is suggested that consideration be given to establishing a panel of expert reporters available at reasonable notice and cost.

3.3 Recommendation 3.7

Establishing the abovementioned panel would also eliminate a difficulty which may partly inform this recommendation. The difficulty being that in a very limited number of cases mandatory reporting by the treating doctor may impose on the therapeutic relationship. In addition to a panel, the difficulty may be overcome by demanding that the expert reporting expressly reveal at the outset the nature of the interview proposed, and its possible consequences.

The recommendation establishes a potentially confusing, contradictory and futile process. If enacted it is likely to create injustice; not resolve it.

The first bullet point contained in recommendation 3.17 notes : “the purpose of the assessment is to provide an opinion on fitness for trial and unsoundness of mind…” The third and fourth bullet points contemplate that an informed conclusion about the patient’s capacity can be made *before* the reporting expert scrutinises the person about their involvement in the alleged offence; when this cannot properly be done.

[1] See Background Paper, *Impact of Proposals*, at page 4.

Capacity in the criminal justice process is informed by a number of factors. One is that the defendant must have the ability to "plead to the charge". A defendant will lack such ability if they have a defence of unsoundness of mind open to them, but so lacks insight as to be unable to appreciate it. To properly determine capacity under this criterion, the reporting expert first needs to enquire about the facts of the alleged offence, to determine if the defendant may have a defence of unsoundness of mind available.

A further criterion informing capacity is an ability to "make [one's] defence or answer to the charge." To satisfy this criterion the defendant must demonstrate the ability to decide which defence they may rely upon. A mentally ill defendant may not have sufficient insight into their illness to appreciate that a defence of unsoundness of mind is available. It is not possible to establish if the defendant can meet this criterion absent psychiatric evidence establishing whether or not they have a defence of unsoundness of mind to the charge. In other words, the defendant may in truth have an unsoundness defence, but due to their illness not appreciate it. Such a defendant cannot 'make his defence' because given the lack of insight into their illness, they cannot make a rational decision about how to defend the charges.

The fifth bullet point recommends that the person not be required to answer 'self-incriminating' questions. This is illogical, and likely to increase the prospect of injustice, for two reasons. Firstly, a psychiatric report about unsoundness or unfitness is virtually useless to the defendant unless they freely engage in a discussion of the facts said to have occurred at the time of the offence, including their mental state at that time. Under the current system, the defendant's right against self-incrimination is protected by Chapter Seven, Part Nine MHA. Adoption of the recommendation is likely to result in fewer people receiving defences of unsoundness of mind, or being found unfit for trial, because the person will be confused and frightened by the warning about self-incrimination, and stay silent, when responding truly might well be the person's best - or only - chance of avoiding conviction.

Second, the proposition invokes circularity. The answers will not incriminate if they reveal that the person was of unsound mind; they will exculpate. Determination of whether the answers are incriminating or exculpatory will depend on a detailed assessment of the person's involvement in the alleged offence and the person's mental condition at that time. If the person was indeed of unsound mind, refraining from being interviewed about those details may well increase the chance of conviction.

4. Orders and Other Actions Following Court Findings

4.1 General observations

We note the step down proposals and recommend that they be reconsidered.

4.2 Recommendation 4.1

We consider that the first bullet point is not required, given the operation of law prohibits continuance of the charge on the finding of unsoundness.

The second bullet point suggests that the state is not concerned about the risk of the person's illness when that is often the most potent of all risks. The right to be protected from one's own illness appears to have been overlooked seemingly on the basis that the risk posed to others is addressed.

4.3 Recommendation 4.2

The Mental Health Court (MHC) is the most appropriate place to resolve questions of criminal responsibility for mentally impaired defendants. Limiting its jurisdiction will, in the view of the Society, likely have unintended consequences. Both the MHC and its predecessor the Mental Health Tribunal were established following acknowledgement that the ordinary criminal justice process was insufficient to protect the rights of mentally impaired persons.

This position was arrived at over centuries, and was based on matters not immediately apparent to persons who have not immersed themselves in the administration of serious criminal charges.

Just as with a person of sound mind, when a mentally ill person is charged with a criminal offence the person enters the criminal justice system. Perception is utterly crucial in that system. There is a significant difference between perceiving a person as a criminal with a mental illness, and perceiving the person as a mentally ill person who has committed a criminal act.

Given the power of nomenclature, upon entering the criminal justice system the perception of the person transitions from a sick person needing protection to a criminal deserving punishment. The transition is particularly evident when a heinous act has been committed, but it applies in all other cases, too. The longer the person remains in the criminal justice system, the more the person is perceived as a criminal with a mental illness. That perception interferes with the determination of the person's criminal responsibility.

In Queensland, the existence of the MHC allows for proper delineation between defendants who may have committed a criminal act under the influence of a mental illness, and defendants who have not. The delineation is commenced shortly after the defendant is introduced to the criminal justice system.

Once the defendant is referred to the MHC the defendant is no longer perceived as a criminal with a mental illness. Two benefits accrue. Firstly, a proper determination of the influence of the defendant's illness at the time of the alleged offence can be made. Secondly, the momentum of the criminal justice system, which pushes defendants who have committed serious acts towards prison and not hospital, is able to be resisted. This makes it less likely for a defendant found to be of unsound mind to be placed in a prison.

In addition to the above benefits, the MHC is structured to allow proper attention to be placed on the clinical evidence. The MHC has two Assisting Psychiatrists and only one Judge. This numeration properly reflects the complexity of mental illness. The Assisting Psychiatrists provide direct, authoritative input to the Judge about the meaning and significance of the clinical evidence. The Assisting Psychiatrists focus the judge on the effect of the defendant's illness on their behaviour. Additionally, without the presence of the Assisting Psychiatrists, a judge may unduly focus on the apparent sanity of the defendant's

method of committing the alleged crime, and so test the defendant's thinking by standards appropriate to testing the thinking of a person of sound mind.

In addition to the above measures, by providing authoritative input to the judge about the meaning and significance of the clinical evidence, the Assisting Psychiatrists prevent spurious mental health defences from prevailing on a tribunal of fact lacking clinical expertise.

Queensland's system is also far less expensive than the traditional method of resolving the criminal responsibility of persons with mental illnesses who are charged with criminal offences. The efficiency of the Court is evidenced by the very few successful appeals from the Court, notwithstanding that upon an MHC finding a right of appeal accrues to the person *and* the state.[2]

In short, the MHC has consistently demonstrated that it is an expeditious and cost-effective means of determining the criminal responsibility and fitness for trial of persons charged with criminal offences. The issues under consideration are subtle, complex and complicated. If those issues are by jurisdictional change more often referred to the ordinary criminal process for determination, costs of every kind will inevitably increase with the possible exception of Queensland Health. We understand that the Magistracy has expressed concerns about increasing the jurisdiction of the Magistrates Court to hear these matters and the impact it will have on:

- case load of the Magistrates Courts throughout the state;
- educating and training for the Magistracy and staff; and
- the impact rural and regional Magistrates Courts.

It is recommended that these issues be carefully considered, particularly in light of resourcing and assisting rural and regional Courts.

In the view of the Society the MHC is the preferred forum, particularly when considering the issue of minimising costs. We understand that Queensland's MHC is also well regarded internationally, which complements the objective 1.

4.4 Recommendation 4.3-4.8

Recommendations 4.3-4.32, appear to be inconsistent with the objective 5 of the Review to "Provide for simpler and fairer processes under the Act". Presently the MHA contains a succinct statement of the orders that may be imposed. We are concerned that enactment of the recommendations would establish a matrix of orders which will result in confusion and uncertainty.

Rather than try to address each of the various recommendations from 4.3-4.32, we consider it will be more expeditious and effective to address each of the "issues identified" and to touch upon specific recommendations where necessary.

- *"The range of offences for which forensic orders may be made is too broad"*

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[2] Note that the Review's "Summary of Key Data" curiously omits this most important statistic.

This proposal appears to be premised on an error: that the danger to the alleged offender or the community is proportionate to the nature of the charged offence. However in reality the danger is a function of the nature of the person's illness and not nature of the charged offence.

A forensic order is not a punishment informed by the nature or seriousness of a person's offence. It is an order designed to protect the community and the person charged from the potential adverse consequences of the person's illness.

The order does not require that the person subject themselves to treatment rather the order requires that treatment *be supplied by the state* to that person. The order is protective, not punitive. Once this is properly understood, it is submitted that the range of offences for which forensic orders may be made is not "too broad".

The current legislation allows a forensic order to be made only when a person has been found to be of unsound mind or unfit for trial on an indictable offence. This is a sensible place to delineate the nature of offences subject to forensic orders, given that it balances the need for individual and community protection against the right to liberty.

- *"Limited options for the Mental Health Court in actions it can take where a person is found of unsound mind or unfit for trial"*

Unfortunately this fails to recognise another matter fundamental to the forensic process and treatment. It is that a court order sets out the forensic process with the medical team tasked with treatment. That is the premise of a forensic order: to routinely allow the treating team the broadest possible discretion to meet the contingencies of the person's treatment as may arise. This is crucial for effective treatment, because the therapeutic relationship between the treating team and the patient, which is often determinative of any improvement in the person's condition, depends on the patient's acceptance of the authority of the treating team.

- *"Model of forensic orders does not allow a patient to 'step–down' from a forensic order to a less intensive order"*

This issue appears not to appreciate that a forensic order is an order of the court; made by the MHC. A Court order restricting the right to liberty ought only to be able to be revoked by the MHC or the MHRT.

- *"Possibility of forensic orders being revoked shortly after being made creates uncertainty"*

This issue appears to be in contrast to the preceding one and does not appear to reflect the nature of forensic orders. A sentence, imposed by a court determining criminal responsibility and punishment for an offender, must be certain. But an order designed to balance the need to treat a sick person with that person's right to liberty must acknowledge that treatment may be achieved sooner than expected; and that the reason for the order

may disappear earlier than expected. In most cases, to maintain a forensic order after it lacks any treatment utility would undermine the reason for making the order in the first place, and convert the order into a punishment.

- *"Individuals found unfit for trial did not get the opportunity for a jury to determine whether the person did the alleged unlawful act"*

This is a difficult issue and should be addressed. On the one hand, an individual is presumed innocent until proved guilty; but on the other an individual who is unfit for trial cannot be made subject to the ordinary trial process without resulting unfairness. Yet there are many cases in which the Crown will not be likely to prove guilt, but which the Crown for its own reasons refuses to discontinue. Such cases deserve attention.

To resolve the problem, provided the findings are independent of any instructions that may be supplied by the defendant, specific findings of fact could be made by a judge who may then establish whether there is a case to answer.

- *"Magistrates courts have no express powers to deal with individuals of unsound mind or unfit for trial"*

Magistrates do have 'express' powers to deal with individuals who are found to have been of unsound mind or who are found to be unfit for trial. Magistrates currently have power to make each of those findings and to dismiss the charge. The powers are derived from the *Criminal Code* and the common law.

The recommendations suggest that Magistrates ought to have power to impose orders of involuntary treatment on defendants who are found to have been of unsound mind or unfit for trial. Contrary to this proposal, it is submitted that the current legislation achieves a sensible balance between protection and rights, by only allowing forensic orders to be imposed by the MHC on indictable offences.

In light of the unintended consequences of the issues and recommendations, the Society notes the response to recommendations 4.24-4.29 below.

4.5 Recommendation 4.24

This recommendation allows a Magistrate to place a person on an involuntary order simply because the person "appears" to have been of unsound mind, or unfit for trial.

As we have stated above, the Society has fundamental concerns in relation to this recommendation. A person with a mental illness should enjoy the same rights before the law as people without mental illness. Accordingly they have a right to decide the fate of their charges provided they are fit for trial. To take that right away without proper investigation of fitness or soundness, and to potentially place a citizen on involuntary treatment for 12 months, is both dangerous and draconian. Also, if an involuntary

treatment order is imposed by a Magistrate, without some degree of certainty that the person subject to the order actually has a mental illness, this then imposes unnecessary burdens on the person and on the mental health service if they do not have an illness. Proper investigation of fitness or soundness can only be made by *ensuring* a report is obtained from a qualified expert. We consider this recommendation be reviewed and amended.

Recommendations 4.25-4.29 are, on their face, complicated and unclear. If Magistrates are to make involuntary orders, then the regime should be simple. Such forensic orders should only be made subject to the considerations currently expressed by section 288 MHA. For the reasons abovementioned, attaching a "non—revoke period" to an involuntary order confuses treatment with punishment, likely resulting in a negative outcome for the patient and the community.

We consider a forensic order should be reviewable every three months, rather than every six months, which is the current review timetable for most forensic orders made by the MHC.

Further, we are concerned that recommendation 4.29 is proposing that the Magistrate refer the matter to the Director of Mental Health or the Director of Forensic Disability for assessment whether the matter should be referred to the MHC. We understand that Magistracy has expressed similar concerns. In our view any referral of a matter should be subject to the Magistrates' discretion. We suggest this recommendation be reviewed and amended.

5. Treatment and Care of Involuntary Patients

The Society does not support mandatory fixed periods of involuntary orders. Capacity and rehabilitation are fluid states which require flexibility and should be specifically tailored to a patient's needs.

7. Support for Involuntary Patients

7.1 General observations

It is unclear whether the new proposals provide a legal practitioner access as of right. In line with the objectives and affording a person natural justice, we consider that the proposal clearly state that the legal practitioner has access to involuntary patients as of right.

7.2 Recommendation 7.8

We recommend that the phrase "unless excluded by the Tribunal" be removed from recommendation 7.8.

8. Support for Victims

8.1 Recommendation 8.8

The Society is supportive of providing a statement of reasons but does not consider the summary of risk assessment is necessary.

9. Mental Health Act Review Tribunal

9.1 Recommendation 9.2

Recommendation 9.2 (right to legal representation) is laudable and the Society is supportive of this initiative.

9.2 Recommendation 9.6

As stated above, a patient's capacity and rehabilitation are fluid processes that require flexibility and should be specifically tailored to a patient's needs. Therefore the proposal to have a 12 month review (after an initial 6 week review) runs contrary to this and the stated objectives above. We recommend a regular review process at these intervals for "new" orders:

- 6 weeks;
- 3 months;
- 6 months;
- 9 months; and
- 12 months.

For people on existing orders, the current regime is seen as adequate and should not be reduced.

11. Forensic Disability

We consider that people with a dual diagnosis require legal representation given the potential impact of their conditions upon the range of orders that may be made affecting them.

12. Guardianship and Attorneys

We encourage greater definition between health and mental health care. Consumers who are under both an ITO (Involuntary Treatment Order) and a Guardian most likely experience a "double-dipping" effect regards decision making, greatly restricting the consumer's autonomy

Consumers who are under both regimes should also automatically have legal representation, for both.

For example, should someone who requires general health and community services in their own home, but refuses them on the grounds of their mental illness, need to attend both QCAT and MHRT, as they are currently required?

13. Restraint and Seclusion

We consider that prolonged use of restraint and seclusion should be able to be reviewed by the Mental Health Review Tribunal

14. Regulated Treatments

Neurosurgery for mental illness is a contentious area, and requires a panel with a very high degree of expertise. We recommend that further attention be given to the Victorian scheme, where a specially formed panel with the relevant neurological expertise can appropriately assess requests for neurosurgery.

17. Indigenous and Multicultural Issues

Often there has been insufficient assistance for indigenous consumers with high secure care needs to be returned to "country" on their discharge. We consider there be more emphasis on discharge planning, involving local services to re-engage indigenous consumers back in their local community.

20. Other Legal Issues

20.1 Recommendation 20.2

The current fitness for trial test is the outcome of a long and studied evolution. As the test is well established and comprehensive, decisions about fitness are very rarely appealed. The current test is largely informed by the common law, allowing for development informed by experience in other jurisdictions.

A new, statutory-based test is not only unnecessary; it may be inconsistent with the long established common law, and may lose the benefit of sensible developments in other jurisdictions.

Additionally, it is almost inevitable that a new, statutory-based test will provoke interpretive litigation, and hence, appeals. These will be expensive and time consuming.

Turning to the terms of the proposed test, there is undue reliance on the word "rational". Rational is not a word susceptible to consistent meaning or application across every context, or within any context and is therefore not easily applied.

Further, the proposed test does not sufficiently express the common law: see *Eastman v Director of Public Prosecutions of the ACT & Others.*[3] Hence, the proposed test expands the meaning of "fitness", and to the detriment of justice and defendants, many of those unfit within the existing law will likely be found fit under the proposed law.

20.2 Recommendation 20.2

We consider that there should be no change to the existing provision, which fairly and sensibly limits the effect of intoxication to that which existed at or about the time of the alleged offence. This limitation expresses long-established common law, which protects those who have by ingestion of substances acquired an illness informing their criminal responsibility.[4] The proposed change to the MHA may undermine this long-established principle.

20.3 Recommendations 20.4 and 20.5

The recommendations in these sections are expressly premised on the assumption that the MHC decides unsoundness of mind or fitness for trial, "*much more efficiently than juries because of its accumulated knowledge and understanding of both mental illness and the law relating to mental illness.*"[5]

This assumption is inconsistent with recommendation 4.2, which proposes a very significant *reduction* in the jurisdiction of the MHC. We recommend that this be reconsidered.

It is respectfully submitted that the current legislative scheme for dealing with disputes is a better model than any of the options proposed by the review. *Hansen v DPP & Anor* [2006] QCA 396 is the exception proving this rule. There is very little litigation derived from the current dispute provisions, and that is not simply due to the brevity of their terms. It is largely because a person should not be subject to a qualified acquittal and an indefinite detention under the MHA unless it is clear that he has committed the charged offence.

Safeguarding, "the rights of people with a mental illness" is an express primary object of the review, so the proposed option of having a judge of the MHC sit as arbiter of disputed facts is ludicrous, given it will deprive the defendant of exercising his fundamental right to be tried and fully acquitted by his peers.

It is submitted that given the complexity of the underlying issues and the resultant forensic nuances a solution dealing with every contingency will never be found, and that the current legislation is the best model to resolve disputes of fact.

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[3] [2003] 214 CLR 318.

[4] *Reg. v. Davis* (1881) 14 Cox C.C. 563, cited with approval by *R v Stapleton* [1952] 86 CLR 358 at 367.

[5] Background Paper, item 20.2.7