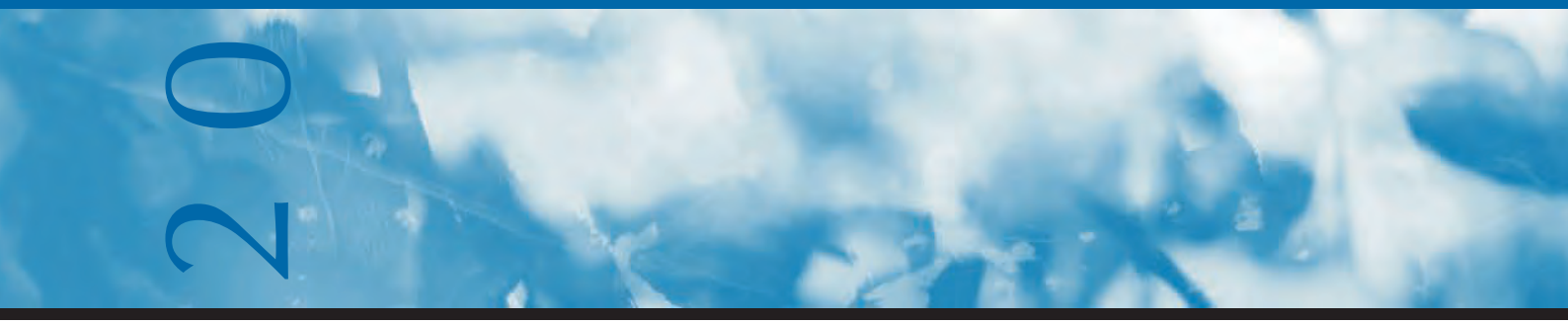
2006

Promoting balance in the forensic mental health system



Final Report

December 2006

Review of the Queensland
Mental Health Act 2000

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This report would not be possible without the contributions of many individuals and organisations.

I wish to express my gratitude to all those who gave of their time and effort to make a submission or to meet with me.

My particular thanks go to those victims, relatives of deceased victims, patients, former patients and carers who shared with me their personal experiences and provided their valuable perspectives on what is required. I was moved by the obvious anguish that mental illness has one way or another caused to so many victims and patients to whom I spoke.

Sincere thanks also go to all those in the medical profession, the Court, the Tribunal, non-government organisations, Queensland Health and other government agencies who met with me and patiently answered my questions.

I benefited greatly from the collective experience of the members of the Reference Group who attended a number of lengthy meetings with me. Their insights were invaluable in shaping the recommendations in this report.

Finally, I thank the members of the Mental Health Act Review Team, who were assigned from Queensland Health and the Department of Justice and Attorney-General to assist me. The Project Manager, Cheryl Furner, has been a constant and invaluable source of support and wisdom in regard to all aspects of the undertaking. Special mention goes to Jo Linde, Principal Legal Officer, for her dedication and productivity, particularly in the preparation of this report. Principal Policy Officer, Katherine Braddock-Hatfield's valuable contributions included ably assisting me on consultations in north Queensland. Vanessa Lidgard cheerfully and efficiently provided the administrative support so necessary to successful completion of the project. I am grateful for their hard work and professionalism.

Brendan Butler AM SC
December 2006

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EXECUTIVE SUMMARY

Context of the Review

On Tuesday 23 May 2006, the Honourable Stephen Robertson MP, Minister for Health, stated that the Government would conduct a review of the *Mental Health Act 2000*. On 14 June 2006, the Government announced the appointment of Brendan Butler AM SC to conduct the Review, which commenced on 3 July 2006.

Establishment of the Review was prompted by concerns raised earlier this year about the merit of allowing persons charged with serious criminal offences and found to be of unsound mind or unfit for trial due to mental illness or intellectual disability, to return to the community on limited community treatment (a form of leave). Concern was also expressed about the level of consultation and information afforded victims and their families when decisions about the approval of limited community treatment for forensic patients are made.

The purpose of the Review is outlined in the Terms of Reference as involving two important aspects.[1] The Review was charged with examining the efficacy of current legislative provisions and administrative arrangements that take account of the interests of victims and their families and whether these provisions need to be amended to further enable victims and their families to be involved in the decision making process.

The Review was also required to consider whether the *Mental Health Act 2000* and associated arrangements achieve an appropriate balance between the responsibility of the State to strengthen the safety and protection of the community with the provision of rehabilitation opportunities for patients under a forensic order.

The Terms of Reference established by the Minister for Health acknowledge the framework set out in the *Mental Health Act 2000*, the *National Mental Health Strategy* and the obligations under the *United Nations Principles for the Protection of Rights of People with Mental Illness and for the Improvement of Mental Health Care.* The Review was conducted within the framework established by these broader mental health initiatives.

During the term of the Review, the Government announced the transfer of portfolio responsibility for mental health policy and legislation from the Minister for Health to the Minister for Communities, Seniors, Youth and Disability Services. The Review recommendations have been developed with the possible ramifications of this change in mind.

Review Process

In conducting the Review, Mr Butler was supported by a small team comprising staff seconded from the Departments of Health and Justice and Attorney-General.

A Steering Committee comprised representatives from the Department of Premier and Cabinet, Treasury, the Department of Justice and Attorney-General, Queensland Health, the Department of Communities, Disability Services Queensland and the Queensland Police Service. The role of the Steering Committee was to ensure that time goals were met and there was adherence to the Terms of Reference.

An independent expert reference group assisted Mr Butler. The Reference Group membership included representatives of victims of crime, mental health consumers and carers, psychiatrists,

1 The Terms of Reference for the Review are set out in full in Appendix A.

police, the legal profession, government departments and non-government mental health organisations. The Reference Group met with Mr Butler on three occasions and provided information and advice on issues, assisted with identifying stakeholders who should be consulted and provided feedback on options and proposed recommendations.

The Review was conducted with a strong focus on consultation. A *Call for Submissions* paper was released in July 2006 and a *Discussion Paper* in September 2006. A total of 84 written and verbal submissions were received in response to these papers. Mr Butler conducted extensive face-to-face consultations with victims of crime and their families, staff of authorised mental health services, mental health consumers, and staff of relevant government and non-government agencies in Brisbane, Toowoomba, the Gold Coast, Townsville and Cairns.

The Review Team also conducted a literature review in relation to victims of crime and forensic mental health.

Structure of the Report

This Report is divided into seven chapters.

Chapter 1 provides information about the context of the Review and the process undertaken by the Review.

Chapter 2 provides information about the policy framework under which the Review was conducted and relates some of the key themes, including rights established under United Nations declarations in relation to victims of crime and people with mental illness and Queensland legislation implementing those rights, the defence of insanity under the Criminal Code and issues relating to community protection.

Chapter 3 outlines the Review's recommended approach for responding to the information and support needs of victims of crime where the offender has been found to be of unsound mind or unfit for trial and diverted to the mental health system. Key recommendations relate to:

- the provision of specified information to victims before and after a forensic order is made
- the establishment of a victim support service within Queensland Health to provide accurate and timely information and support to victims.

Chapter 4 deals with particular problems in the legal process leading up to the Mental Health Court hearing, in the procedures and constitution of the Mental Health Review Tribunal and in the process for references by the Director of Mental Health to the Attorney-General. Reducing the delays involved in the resolution of matters is emphasised as well as improving transparency and openness in decision making.

Chapter 5 discusses issues relating to people with an intellectual disability including the mismatch in legislative provisions compared with the provisions applying to people with a mental illness. The inappropriateness of holding people with an intellectual disability in facilities designed for treating mental illness is highlighted.

Chapter 6 reviews the risk management practices for people placed on a forensic order. To better manage risk, the introduction of a legislative category for people charged with specific violent offences ('persons of special notification') is recommended. Additional legislative and administrative safeguards are also recommended to improve measures for risk assessment and management.

Chapter 7 examines community attitudes towards mental illness. The need to develop resources for community education about the forensic mental health system is discussed and specific recommendations are made for the development of resources.

Summary of Major Issues, Findings and Proposals for Reform

Victims of crime

After extensive consultations with a broad range of stakeholders the Review has formed the view that further reform is required to serve the legitimate needs of victims of crime and to enhance public confidence in the system dealing with forensic patients.

The Review considers that reform in the interest of victims can be achieved while preserving the rights of forensic patients. It is essential that both victims and patients be treated fairly. Fair and compassionate treatment of forensic patients need not limit the capacity to protect the public from harm and provide victims of crime with the support they need.

Balancing competing interests

It is fundamental that all mental health consumers, including forensic patients, be accorded basic rights and be treated with respect and humanity in accordance with the *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. Among the rights recognised by the principles are the right of persons with a mental illness to live and be treated, as far as possible, in the community and their right to have the confidentiality of their information respected.

Where, however, a person has committed a serious criminal act, particularly a violent act, consideration must also be given to the fundamental rights of others to protection and support. It follows that while the thrust of the *Mental Health Act 2000* in protecting the rights of all people with mental illness must be maintained, the needs of victims and the community must also be addressed. While the United Nations principles affirm the rights of patients, they also acknowledge that there are competing public safety considerations. The principles are subject to:

> … such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.[2]

The *United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power* sets out the fundamental rights of victims of crime. The principles provide for victims to be treated with compassion and respect for their dignity and to be provided compensation, restitution and assistance. Victims are entitled to information about the progress and disposition of their cases, to proper assistance throughout the legal process and to have measures implemented to protect their privacy and safety.

Where the offender is found to be of unsound mind, victims of crime have needs at least equivalent to those of victims in cases dealt with through the criminal justice process. As with other victims, these victims have a need for immediate practical support, to be assured that they are safe and for timely accurate information about the progress and outcome of the matter.

In common with other victims of crime in Queensland, they face difficulties in negotiating the criminal justice system, including the lack of an integrated service system and inadequate

2 United Nations, *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,* [1], GA Res 46/119 (1991).

provision of information. However, where the offender is mentally disordered, victims must deal not only with the criminal justice system but also with the forensic mental health system.

Obtaining information about a forensic patient is a significantly more complex and difficult process for these victims than it is for victims where the offender has been dealt with by the criminal courts. This should not be the case.

Improving victims' access to information

The Review proposes that primary victims and family members of deceased victims in Mental Health Court matters should have access to a similar level of information as victims in matters before the criminal courts and should not be required to establish the legitimacy of their need for information. Information should be available as of right to these victims except in the exceptional circumstance where its release is likely to cause serious harm to the patient's health or seriously endanger someone's safety. Other applicants will still be required to establish sufficient personal interest. However, the Review recommends a change to the matters that must be considered when deciding sufficient personal interest so that regard is had to the applicant's interests as well as the patient's.

The information provided should be that which is essential for the victim to feel secure, including information about release into the community as part of limited community treatment. It ought not include other personal health information about the patient. The information that should be provided is whether the forensic order for the patient has been confirmed or revoked, whether the patient has limited community treatment and certain related conditions, if the patient is absent from the authorised mental health service without permission, if the patient is transferred interstate or between authorised mental health services, and if the patient dies.

To this end, the Review proposes the establishment of a register to facilitate the provision of information to victims about classified and forensic patients.

Improving victims' ability to be heard

Under the *United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power*, victims are entitled to present their views and have their views considered by the courts and administrative decision makers. The existing process for victims to put forward their views to the Mental Health Court and the Mental Health Review Tribunal should be improved.

The Review proposes a number of reforms to assist victims in providing their views and to offer better guidance to the Court and Tribunal in how victims' views should be taken into account. Victims making statements will be acknowledged in their own right and no longer referred to as 'non-parties'. Other interested persons will continue to be able to submit statements. Legislation will clarify the purpose of statements and what they may contain. Unlike at present, statements will be available to the treating team to ensure they are aware of the victims' concerns.

Improving support for victims

In dealing with both the criminal justice and forensic mental health systems, victims need a significant level of information and ongoing support, which is currently only provided in an ad hoc manner. The Review proposes the establishment, within Queensland Health, of a Victim Support Service to maintain the register and provide information and support to victims across the State. This proposal builds on the existing Queensland Health Victim Support Coordinator position.

The proposed state-wide service will be staffed by professional officers with experience in the mental health system and who have an understanding and sensitivity to victims' needs. These officers will provide a single point of contact to assist victims and inform them of the processes in the Mental Health Court and Mental Health Review Tribunal. These officers will liaise with police and prosecutors, make referrals to counselling, assist victims preparing statements and personally release information to those on the Register. They will liaise with Indigenous organisations to ensure Indigenous victims are not overlooked. The Review also suggests better systems to ensure the new Queensland Health Victim Support Service makes contact with victims at an early stage.

Victims need to be fully informed about what to expect when the case is heard in the Court and Tribunal. The Review recommends prosecutors be available to meet with victims prior to the Court hearing to inform them about the process, learn of their concerns and assist with victim statements. Similar assistance should be available from the Attorney-General's counsel before Tribunal reviews. The Queensland Health Victim Support Service will provide court support to victims.

Reducing delay

A major problem for victims is the delay in matters coming before the Mental Health Court. In the past, victims had no entitlement to information during this period, which could exceed 12 months. In a significant reform, the Review recommends that primary victims and relatives of deceased victims be provided with access to information about the defendant during the period prior to the Mental Health Court hearing.

The availability of information at this earlier time will be of considerable assistance to victims but, in addition, the Review proposes reforms to address a number of the reasons for delay. Although some delay will be unavoidable, a number of reforms are proposed to reduce waiting times, including:

- the establishment of more efficient processes for the provision of police information to clinicians preparing assessment reports
- the allocation of additional sitting time for the Mental Health Court.

Community Safety

Public concern has been expressed about a number of high profile cases where forensic patients have had limited community treatment (LCT) approved for community visits or to live in the community. These concerns should not be lightly dismissed. The expression of these concerns is an indication of the way a few high profile cases can affect public confidence in the provision of forensic mental health services.

Maintenance of public confidence is important to the integrity of the forensic mental health system and to the peace of mind of victims and patients. For there to be trust in the system the public need to be assured that their safety is given appropriate priority. Members of the public are entitled to expect that where mentally ill persons have committed criminal offences, particularly serious violent offences, the system will take the necessary steps to ensure treatment of the person has full regard to the need for public safety in managing the risk of re-offending. This means striking the right balance between the individual rights of the patient and those of the community.

Queensland Health is already in the process of implementing a number of recommendations from earlier reports addressing these concerns. The Review supports that process but considers

that further steps need to be taken to improve the management of risk in regard to forensic patients and to build public confidence in the mental health system.

Promoting safe recovery

The research literature supports the view that effective treatment is the preferred strategy for violence prevention in the case of people with a mental illness. The treatment of active symptoms of mental illness and the management of other vulnerabilities associated with the active illness, such as substance misuse, social dislocation and personality deterioration, provides the best way of ensuring violent behaviour does not recur. The aim of such a treatment program is the recovery of the patient and their eventual, successful return as a productive member of society. Recovery will be achievable for most patients but some will need lengthy in-patient treatment and a few will require long term care.

The Act requires the patient have a treatment plan and be subject to regular assessments by an authorised psychiatrist as required under the plan. These requirements continue throughout the term of the forensic order.

For this recovery-based model of treatment to achieve community support, it is necessary that clinicians keep firmly in mind the goal of minimising violent behaviour by patients. The failure of treatment to adequately manage the behaviour of patients to avoid recurrence of violent offending not only impacts upon the victims of that behaviour and erodes public confidence, but also represents a serious setback to the recovery of the patient. It follows that treatment plans must, in the interests of both the patient and the community include all necessary steps to manage any risk of violent behaviour.

Managing risk for serious violent offenders

In 2002, Queensland Health established the administrative category of Persons of Special Notification (PSN) to provide greater oversight of individuals who have committed serious violent offences. The Director of Mental Health issued a policy to give effect to a higher level of oversight and risk management for PSN.

In general, the Review is impressed by the added safeguards incorporated in Queensland Health's PSN Policy.[3] Clinical practice standards and guidelines can play an important part in reducing risk. However, information provided to the Review indicates the Policy has not been effectively implemented in all parts of Queensland.

The Review considers it is essential to strengthen these safeguards. To this end the Review supports amendment of the *Mental Health Act 2000* to strengthen policy and practice guidelines for forensic patients generally and PSN patients in particular. It is recommended the PSN category be defined in legislation in terms of the offence types by which it is presently administratively defined. The proposed amendments will place a legal obligation on mental health services to implement policy and practice guidelines.

This Review and coronial findings indicate the need for clinicians to ensure the safety of vulnerable individuals, including children, are taken into account in treatment planning for PSN who receive LCT. A specific recommendation requires clinicians to focus on the safety of vulnerable individuals who may reside with the PSN.

3 Queensland Health, Mental Health Branch, *Policy for management, reviews and notifications for a Person of Special Notification* (2005). See Appendix D (Key Concepts).

Other measures recommended by the Review to bolster risk management at key decision points include legislative provisions to require the Tribunal to obtain an independent psychiatrist's report when making a decision about whether to revoke a forensic order for a PSN.

Changes are recommended in recruitment of Mental Health Review Tribunal members and in the composition of Tribunal panels to ensure broader community representation and sufficient forensic expertise is available on forensic panels. In addition, a better resourced and more proactive role in representing community interests is envisioned for the Attorney-General's representative in Tribunal hearings.

Managing risk for patients on LCT

The ability to allow gradual reintroduction of a patient to the community can form an important part of the patient's treatment. However, use of LCT should be subject to careful assessment of the risk involved and should be conducted in a way that carefully manages for any risks that might arise.

A patient on a forensic order is allowed to have LCT only if the Court or Tribunal is satisfied they do not pose an unacceptable risk to the safety of the patient or others.

The success of a patient's recovery and compliance with LCT conditions is dependent on the support that is in place for the patient in the community. Conflicting information has been provided to the Review about the nature and extent of information provided to the Tribunal to assist with decisions about LCT. This discrepancy points to a need for relevant policy and practice guidelines to be amended to ensure reports to the Court and Tribunal for people on forensic orders record whether the necessary treatment and support required by the patient is available prior to ordering or approving LCT. Further, it is recommended that treatment plans incorporate information from carers, support persons and service providers.

The Review has found that clinicians' responses to non-compliance with LCT conditions vary across the State. This lack of consistency is a particular concern in relation to forensic patients who have committed serious offences. A more coherent approach is proposed with changes in clinical guidelines to include a requirement that where a PSN has not complied with LCT conditions in a significant way or symptoms re-emerge, the patient is required to undergo a full mental health assessment before LCT is allowed to continue.

Comprehensive risk management

A comprehensive program of risk management for forensic patients needs to be adopted state-wide that includes strategies on reducing or removing risk factors (such as substance misuse), managing symptoms, and interventions to address psychological and social issues. In addition, the Review has emphasised the need for the development of state-wide standardised processes for mental health assessment and treatment to incorporate specific reference to forensic mental health issues and information.

The Review supports the proposed development of an integrated, state-wide mental health information system to ensure easy access to forensic patient information across health service districts. It is also considered necessary to ensure that summaries of key information relating to each forensic patient, including their offence history, will be readily accessible in hard copy and electronic health records, including the Mental Health Act Information System.

Community awareness

Community awareness and understanding of mental illness and its impact on people and their families has increased over the past decade as a result of a number of national, state and territory developments.[4] Despite these efforts, ongoing misconceptions about mental illness contribute to a lack of understanding of how and why the criminal justice system treats people with a mental illness differently from others. Increasing understanding of mental illness in the community is essential for promoting an understanding of the forensic mental health system.

While most people with a mental illness do not commit offences, when they do it may affirm inaccurate community perceptions that mentally ill people are dangerous and unpredictable. This stigma has the effect of further excluding people with mental illness from the community. Research has shown that social inclusion promotes mental health and that discrimination and social exclusion is itself a mental health risk factor.[5]

The Review acknowledges that a great deal of work is being undertaken by non-government organisations, volunteers, family members and friends, to support and educate the community about mental health.

Queensland does not currently have a comprehensive, strategic platform to drive mental health promotion, prevention and early intervention. The Review considers that a more strategic, sustained approach to developing community education strategies will help achieve improved community awareness and understanding of mental health law and the forensic mental health care system in Queensland. This is a necessary step towards relieving the distress and misunderstandings that have characterised the experiences of victims, and adversely impacted the treatment and rehabilitation of patients in the past. The development of resource materials about the Queensland forensic mental health system for use by media professionals is also recommended.

A need has been identified for incorporating Indigenous perspectives when educational and promotional material is prepared and for developing culturally appropriate material about mental illness for use in Indigenous communities.

The Review is keenly aware of the need for victims of serious, violent crimes to receive accurate, timely information. With this in mind, the Review proposes that police involved in investigating serious violent offences receive training about the forensic mental health system. Value can also be added by utilising the recently established police Mental Health Coordinator positions as a point of contact for arresting officers seeking guidance and information about the Mental Health Court processes and services for victims in matters referred to that Court.

4 Commonwealth of Australia, *Evaluation of the Second National Mental Health Plan* (2003) 16-19.

5 Mental Health Foundation of New Zealand, *Respect Costs Nothing: A survey of discrimination by people with experiences of mental illness in Aotearoa New Zealand* (2004).

RECOMMENDATIONS

Chapter 3

Victims' Rights, Needs and Interests

3.1 That the provision stating how the purpose of the *Mental Health Act 2000* is to be achieved be amended to provide that community protection and the needs of victims be taken into account in decisions relating to forensic patients.

Information and support for victims prior to the Mental Health Court

3.2 That Queensland Health establish a victim register to facilitate the provision of information to victims in cases where the defendant is a classified patient detained in an authorised mental health service awaiting determination of a charge for an indictable offence.

3.3 That the following persons may apply to be registered to receive classified patient information:

- the actual victim of the offence
- a member of the immediate family of a deceased victim (including siblings)
- the parent or guardian of a victim under the age of 18 or of a victim who has a legal incapacity.

3.4 That the following information may be released to registered persons by Queensland Health:

- the defendant is detained in an authorised mental health service, but the name and address of any place where the defendant is living is not to be released
- whether the defendant is granted limited community treatment (other than escorted leave on the grounds of the hospital), the conditions of limited community treatment relevant to the victim's need to feel safe, and any revocation of limited community treatment by the Director of Mental Health
- where the defendant is absent without permission from the authorised mental health service
- the defendant has been returned to a correctional facility or to court.

3.5 That the *Mental Health Act 2000* be amended to override the operation of section 62A of the *Health Services Act 1991* to enable the disclosure of information to victims in the abovementioned circumstances.

3.6 That the Director of Mental Health decide applications by victims to be registered to receive information about a classified patient who is on remand.

3.7 That the Director of Mental Health may grant an application for registration he or she reasonably considers appropriate but must refuse an application if he or she reasonably believes that the disclosure of the information is likely to:

- cause serious harm to the health of the patient, or
- endanger in a serious way the safety of the patient or another person.

3.8 That the applicant may nominate a person or entity to receive information about a classified patient on their behalf.

3.9 That a victim seeking the release of information about a patient and the victim's nominee sign a declaration undertaking that he or she will not disclose, for public dissemination, any patient information disclosed to the victim. A breach of this undertaking may be cause for refusal to further disclose patient information to the victim or his or her nominee.

3.10 That Queensland Health enable victims who wish to complain about the decision of the Director of Mental Health to have access to an internal review mechanism

3.11 That the Queensland Health Victim Support Service maintain the Victim Register and provide information to registered victims both personally and in writing, together with other information to assist victims to understand the context and implications of the information.

3.12 That where a classified patient charged with a serious sexual or other violent offence is detained in an authorised mental health service the Queensland Health Victim Support Service make all reasonable efforts to identify and contact the victim to offer early support and information.

Queensland Health Victim Support Service

3.13 That Queensland Health, building on the current position and role of the Victim Support Coordinator, establish a state-wide Victim Support Service to:

- provide information and support to victims of crime in relation to classified patients, persons referred to the Mental Health Court and forensic patients in accordance with the proposed scheme
- assist victims with negotiating the processes and understanding the outcomes of Mental Health Court and the Mental Health Review Tribunal proceedings
- raise awareness and understanding of the needs of victims with staff of authorised mental health services and the Mental Health Review Tribunal
- collaborate with Indigenous health organisations and workers in the provision of information and support to Aboriginal and Torres Strait Islander victims
- promote coordination of the provision of services to victims of crime where the perpetrator has been diverted to the forensic mental health system.

3.14 That the Victim Support Service be staffed by professional officers with experience working in forensic mental health and by sufficient administrative staff to support the professional officers. The Service should be physically located in Brisbane and in either Townsville or Cairns. The north Queensland service should have a strong focus on Aboriginal and Torres Strait Islander victims of crime and be provided in a culturally appropriate way. The Service should work in collaboration with Indigenous organisations, Indigenous mental health workers and the Victim Counselling and Support Service of Relationships Australia. Sufficient resources should be available to provide training to health workers in victim support in rural and remote communities and to assist with transport costs for victims.

3.15 That Queensland Health, the Office of the Director of Public Prosecutions and the Queensland Police Service, develop protocols for the identification and early referral of victims by police or the Office of the Director of Public Prosecutions to the Queensland Health Victim Support Service where the defendant is detained in an authorised mental health service for assessment of the defendant's mental state in relation to the offence or is referred to the Mental Health Court.

3.16 That Queensland Health and Queensland Police Service investigate the possibility of establishing a 'fax back' system for the referral of victims to the Victim Support Service, similar to the process currently in place between the Homicide Investigation Squad and the Queensland Homicide Victims' Support Group.

3.17 That the Office of the Director of Public Prosecutions include in its template letters sent to victims in Mental Health Court matters and in Mental Health Court fact sheets the contact details for the Queensland Health Victim Support Coordinator and, once it is established, the Queensland Health Victims' Support Service.

Victim Statements in the Mental Health Court

3.18 That the *Mental Health Act 2000* be amended to delete reference to the term 'non-party' and instead refer to a statement by a victim or interested person, in recognition of the particular position of victims of crime.

3.19 That section 284 of the *Mental Health Act 2000* be amended to provide that a victim or an interested person may make a statement to the Mental Health Court for the purpose of assisting the Court in making a decision on a reference, including a decision:

- whether or not the person was of unsound mind or is unfit for trial
- whether or not to make a forensic order
- whether to order, approve or revoke limited community treatment
- as to any conditions the Court may impose on an order for limited community treatment.

3.20 That the *Mental Health Act 2000* be amended to provide that a statement by a victim or an interested person contain the views of the victim or interested person on:

- the conduct of the person the subject of the proceeding and the impact of that conduct on the victim or the interested person
- the risk the victim or interested person believes the person the subject of the proceeding represents to the victim or the interested person or another person
- any matters relevant to the decisions the Court may make.

The Court should give the statement such weight as it considers appropriate.

3.21 That the *Mental Health Act 2000* provide that a statement by a victim or interested person be sworn and submitted to the Court through a party to the proceeding.

3.22 That section 285 of the *Mental Health Act 2000* be amended to require the Mental Health Court, in its decision on a reference, to give reasons for:

- taking into account a victim statement or an interested person statement and how the statement was taken into account, or
- refusing to take into account a victim statement or an interested person statement.

3.23 That the *Mental Health Act 2000* be amended to enable the Mental Health Court registry to provide a copy of any victim or interested person statement to the authorised mental health service and to the Mental Health Review Tribunal, unless the Court orders to the contrary.

3.24 That, with the consent of the victim, the Queensland Health Victim Support Service, prior to the Mental Health Court hearing, facilitate the provision to the treating team of

written information from the victim about the circumstances of the offence, the impact of the offence on the victim and the victim's views on conditions for limited community treatment.

Support for victims in Mental Health Court proceedings

3.25 That, in consultation with the Queensland Health Victim Support Coordinator, the Office of the Director of Public Prosecutions review the template letters to victims involved in Mental Health Court matters to ensure the information contained in those letters is accurate, understandable and sensitive to victims' needs.

3.26 That Queensland Health, the Office of the Director of Public Prosecutions, the Mental Health Court and the Mental Health Review Tribunal review the Mental Health Court fact sheets with a view to developing a comprehensive kit for victims containing a step by step explanation in plain English of the process through the criminal courts, the Mental Health Court and the Mental Health Review Tribunal, contact details for counselling and support agencies and relevant forms such as the application for registration and templates or guidelines for statements to the Court.

3.27 That the Office of the Director of Public Prosecutions be resourced to allow for the assignment of a Senior Crown Prosecutor to Mental Health Court matters sufficiently early to enable greater engagement of the Queensland Police Service and the victim in the preparation for the hearing.

3.28 That, in references involving serious sexual or other violent offences, the Office of the Director of Public Prosecutions and the defendant's legal representative be encouraged to prepare at an early time an agreed statement of facts for use by court appointed examining psychiatrists and in the Mental Health Court hearing.

3.29 That prosecutors be available to meet with victims of serious sexual or other violent offences prior to and after the Mental Health Court hearing to explain the jurisdiction and processes of the Court, to obtain information about the circumstances of the offence and relevant information about the defendant, to check the agreed statement of facts with the victim and to explain the implications of possible outcomes and the actual outcome.

3.30 That the Office of the Director of Public Prosecutions, in consultation with the Queensland Health Victim Support Service, assist victims to prepare victim statements for the Mental Health Court, ensure that these statements are produced to the Court and ensure that the attention of the Court is drawn to the requirements of section 285 of the *Mental Health Act 2000*.

3.31 That the Office of the Director of Public Prosecutions, on request, provide a copy of the Mental Health Court decision to the victim and, where transcripts are ordered by the Court, make a copy available to the victim.

3.32 That the Queensland Health Victim Support Service, through liaison with the Office of the Director of Public Prosecutions, provide court support services to victims who request such support.

Information and support for victims after a forensic order is made

3.33 That a register to facilitate the provision to victims and other eligible persons of information about patients on forensic orders, be established by Queensland Health and maintained by the Queensland Health Victim Support Service.

3.34 That the following persons may apply to be registered to receive information about a forensic patient:

- the actual victim of the offence with which the forensic patient was charged
- if the victim is deceased, an immediate family member of the deceased victim
- if the victim is under 18 years or has a legal disability, the victim's parent or guardian
- another person who satisfies the Tribunal that the person has a sufficient personal interest in being informed.

3.35 That the following information about a forensic patient may be released by Queensland Health to registered persons:

- when a review for the patient is to be carried out
- an order for or approving limited community treatment for the patient (other than escorted leave on the grounds of the hospital), the conditions of the limited community treatment relevant to the victim's need to feel safe, and an order revoking an order or approval for limited community treatment
- the patient is absent without permission from the authorised mental health service and the subsequent return of the patient
- an order that the patient be transferred from one authorised mental health service to another
- an order approving that the patient move to another State or an approval that the patient transfer, under an interstate agreement, to another State
- the death of the patient, but not the cause of death
- the revocation of the forensic order.

The name and address of any place where the patient is living must not be released.

3.36 That section 221 of the *Mental Health Act 2000* be amended to provide that the Mental Health Review Tribunal may decide applications for registration by victims or persons with a sufficient personal interest.

The following persons do not have to establish a sufficient personal interest:

- the actual victim of the offence with which the forensic patient was charged
- if the victim is deceased, an immediate family member of the deceased victim
- if the victim is under 18 years or has a legal disability, the victim's parent or guardian.

In determining whether other persons have a sufficient personal interest, the Tribunal must have regard to the following matters:

- the nature, seriousness and circumstances of the offence that led to the patient becoming a forensic patient
- the impact the refusal to grant the order is likely to have on the health, safety and welfare of the applicant

- whether the making of the order is likely to have a significant adverse affect on the patient's treatment or rehabilitation
- any other matters the Tribunal considers appropriate.

Examples of people who may have a sufficient personal interest are:

- a person who was with the victim when the offence was committed
- a personal attorney or personal guardian of the patient
- a family member, or dependant, of the victim
- a family member, carer or dependant of the patient.

The Tribunal must refuse an application for registration if it reasonably believes the release of that patient information to the applicant is likely to:

- cause serious harm to the health of the patient, or
- endanger in a serious way the safety of the patient or another person.

The Tribunal must refuse an application if it is satisfied the application is frivolous or vexatious.

The Tribunal may refuse an application for registration or revoke registration if the Tribunal:

- reasonably suspects the applicant, or the applicant's nominee, has disclosed, for public dissemination, any patient information released under the Act, after providing the applicant with an opportunity to show cause why the registration should be made or should not be revoked
- is unable, after making reasonable efforts, to contact the applicant.

3.37 That the applicant may nominate a person or entity to receive information about a forensic patient on their behalf.

3.38 That the applicant and his or her nominee sign a declaration undertaking that he or she will not disclose, for public dissemination, any patient information disclosed to the victim. A breach of this undertaking may be cause for refusal to further disclose patient information to the applicant or his or her nominee.

3.39 That the Queensland Health Victim Support Service provide patient information both personally and in writing to the registered person or the nominee, together with other information to assist victims to understand the context and implications of the information.

3.40 That, if required, legislative amendments be made to ensure the information to be released under an order to release patient information is provided to the Queensland Health Victim Support Service by the Mental Health Review Tribunal and the Director of Mental Health.

Victim statements in the Mental Health Review Tribunal

3.41 That, in relation to Mental Health Review Tribunal proceedings, the *Mental Health Act 2000* be amended to delete reference to the term 'non-party' and instead refer to a statement by a victim or interested person, in recognition of the particular position of victims of crime.

3.42 That section 464 of the *Mental Health Act 2000* be amended to provide that a victim of crime or other interested person may make a statement to the Mental Health Review Tribunal for the purpose of assisting the Tribunal in making a decision on a review for a forensic patient, including a decision:

- whether to revoke a forensic order
- whether to order, approve or revoke limited community treatment
- as to any conditions the Tribunal may impose on an order for limited community treatment.

3.43 That the *Mental Health Act 2000* be amended to provide that a statement by the victim or other interested person is to contain the views of the victim or interested person on:

- the conduct of the person the subject of the proceeding and the impact of that conduct on the victim or interested person
- the risk the victim or interested person believes the person subject to the proceeding represents to the victim or interested person or another person
- any matters relevant to the decisions that the Mental Health Review Tribunal may make.

The Tribunal should give the statement such weight as it considers appropriate.

3.44 That the statement provided to the Mental Health Review Tribunal by the victim or other interested person be sworn.

3.45 That the *Mental Health Act 2000* be amended to provide that where a victim or interested person has made a fresh statement to the Mental Health Review Tribunal on a review, the Tribunal be required to provide to the victim or interested person, as a matter of course, a statement of reasons for:

- taking into account a victim statement or an interested person statement and how the statement was taken into account, or
- refusing to take into account a victim statement or an interested person statement.

Support for victims for Mental Health Review Tribunal matters

3.46 That the Queensland Health Victim Support Service provide assistance to victims in preparing applications for registration to receive information about a forensic patient.

3.47 That the Queensland Health Victim Support Service, in consultation with the Attorney-General's representative, assist victims in the preparation of a victim statement for a Mental Health Review Tribunal review.

3.48 That the Queensland Health Victim Support Service, with the consent of the victim, facilitate the provision to the Attorney-General's representative at an early time of a copy of any victim statement for a review.

3.49 That the Queensland Health Victim Support Service facilitate pre-hearing contact between the victim and the Attorney-General's representative if requested by the victim.

3.50 That the Act be amended to enable a confidentiality order to be made in respect of an application for registration to receive information if the Mental Health Review Tribunal is satisfied that disclosing the identity of the applicant and the grounds of the application

to the patient is likely to have an adverse effect on the physical or mental health of the applicant, or the patient, or place the safety of the applicant, the patient or another person at risk.

3.51 That the Department of Communities review the service it funds to provide counselling and support to victims of crime to ensure that future arrangements incorporate a specialist position focussing on victims in cases where the offender is diverted to the mental health system. This position will act as a reference point for counsellors in the service and for contact with the Queensland Health Victim Support Service.

3.52 That the Queensland Health Victim Support Service and the Victim Counselling and Support Service in Relationships Australia develop training or information packages for counsellors and staff of the helpline to ensure they have an understanding of the forensic mental health system and the implications for victims where a defendant has been referred to the Mental Health Court and are able to refer victims appropriately.

3.53 That the Queensland Police Service, the Office of the Director of Public Prosecutions, the Queensland Health Victim Support Service and services funded by the Department of Communities to provide counselling to victims of crime, develop protocols for the referral of victims to counselling services as early as possible.

3.54 That the Queensland Health Victim Support Service explore options for the appropriate provision of voluntary conferencing between victims and forensic patients.

Chapter 4

The Forensic Mental Health Legal Process

Delays up until the Mental Health Court hearing

4.1 That Queensland Health establish a process to ensure accountability of administration for compliance with the requirements of the *Mental Health Act 2000* in relation to the provision of section 238 reports within statutory time frames.

4.2 That the Director of Mental Health:

- ensures administrators of authorised mental health services are promptly informed of delays in the provision of section 238 reports
- provide audit outcomes on the timeliness of these reports to administrators and to the Director-General, Queensland Health.

4.3 That priority be given to legislative amendments to facilitate the release of information, including witness statements and patients' criminal histories, by the Queensland Police Service to relevant people within Queensland Health for the purpose of preparing section 238 reports.

4.4 That the Office of the Director of Public Prosecutions and the Queensland Police Service provide information promptly to the Director of Mental Health and the authorised mental health service regarding the facts and information obtained about the alleged offence including the nature and seriousness of the offence and whether there are victims involved.

4.5 That standard processes for transferring information from the Queensland Police Service to Queensland Health are introduced and included in relevant policy and procedures manuals for both departments.

4.6 That the *Mental Health Act 2000* be amended to substitute the Director of Public Prosecutions for the Attorney-General as the person to whom the Director of Mental Health may refer the matter of the mental condition of the patient under section 240 and the person who is the decision maker under section 247.

4.7 That in referring the matter, the Director of Mental Health be required to provide an assessment of the matter to the Director of Public Prosecutions (DPP) including any recommendation to assist the DPP in making a decision under section 247 of the *Mental Health Act 2000*.

4.8 That the *Mental Health Act 2000* be amended to enable the Director of Mental Health to extend for an additional two month period the deferment period of a person not fit for trial at the end of the first two month deferment period if the Director of Mental Health reasonably believes that the person will be fit for trial within another two month period.

4.9 That the *Mental Health Act 2000* be amended to allow the Director of Mental Health, notwithstanding section 240(4), to refer a matter to the Director of Public Prosecutions rather than to the Mental Health Court where he or she reasonably believes that the person is fit for trial and was not of unsound mind at the time of the offence.

4.10 That the *Mental Health Act 2000* be amended to allow the Director of Mental Health to obtain a further psychiatrist's report where he or she considers the report is necessary for the making of a decision on a reference by the Director of Public Prosecutions under section 247.

4.11 That consideration be given to the allocation of additional Court time for the Mental Health Court as a matter of urgency.

4.12 That additional resources be provided to allow areas whose workload is directly related to the hearing of matters before the Mental Health Court to respond to an increase in Court sitting time.

4.13 That the remuneration of assisting psychiatrists in the Mental Health Court be reviewed with a view to making the position more attractive to suitably qualified applicants.

Proceedings in the Mental Health Review Tribunal

4.14 That the Attorney-General's representative, take a more assertive and proactive role in representing the interests of the community, including victims, in Mental Health Review Tribunal hearings.

4.15 That the Mental Health Review Tribunal give consideration to the publication of de-identified reports of proceedings in matters in which publication is in the public interest, such as when matters of principle or precedent are raised.

4.16 That early and sufficient provision of material to parties before Mental Health Review Tribunal hearings be facilitated by a practice direction under section 480 of the Mental Health Act 2000 setting appropriate guidelines for the provision of documents.

4.17 That the Director of Mental Health and administrators of authorised mental health services implement a system for improving and monitoring the timeliness of provision of documentation to the Mental Health Review Tribunal.

4.18 That the recruitment of Mental Health Review Tribunal members draw on a broader range of community backgrounds, particularly persons who have experience with or awareness of victims issues, and that less reliance be placed on the use of Queensland Health employees.

4.19 That the current endeavour to increase the number of Indigenous Mental Health Review Tribunal members be continued with special attention to increasing the number of Indigenous members in north Queensland.

4.20 That, where possible the Mental Health Review Tribunal constitute special panels in significant forensic matters with emphasis on the inclusion of members with specialist forensic expertise and broader community backgrounds and that use be made of enlarged panels and dedicated listing to facilitate this objective.

4.21 That a review of the remuneration of psychiatrist members of the Mental Health Review Tribunal be undertaken.

4.22 That the *Mental Health Act 2000* be amended to provide that the role of the Attorney-General in the Mental Health Review Tribunal is to represent the public interest.

4.23 To enable the Attorney-General to exercise his or her role in a considered manner and thereby enhance his or her ability to adequately represent the public interest, the important role of the Attorney-General's representative in Tribunal proceedings should be recognised through the provision of adequate funding to enable proper preparation for a review and the appearance of experienced advocates in the proceedings.

4.24 That material held on the Office of the Director of Public Prosecutions' Mental Health Court file in relation to a forensic patient be incorporated into the Attorney-General's Tribunal file for the patient.

Chapter 5

Intellectual Disability and the Forensic Process

5.1 That a review of the provisions of the *Mental Health Act 2000* affecting people with an intellectual disability be conducted as part of any reform to provide secure care for people with an intellectual or cognitive disability who exhibit severely challenging behaviour.

Chapter 6

Managing Risk

Strengthening policy and practice

6.1 That the *Mental Health Act 2000* be amended to require the Director of Mental Health to provide policies and practice guidelines for the treatment and care of forensic patients, including Persons of Special Notification.

6.2 That the *Mental Health Act 2000* be amended to require the authorised doctor to have regard to the Director of Mental Health's policies and guidelines for forensic patients, including Persons of Special Notification in preparing the patient's treatment plan, which must include a risk management plan.

6.3 That the *Mental Health Act 2000* be amended to require the administrator of the authorised mental health service to ensure the Director of Mental Health's policies and practice guidelines for forensic patients, including those relating to Persons of Special Notification, are given effect.

6.4 That the *Mental Health Act 2000* be amended to provide that the Director of Mental Health monitor and audit compliance with the requirements of the Act so far as they relate to the treatment and care of forensic patients, including Persons of Special Notification.

6.5 That the *Mental Health Act 2000* be amended to provide that the Persons of Special Notification category be defined in legislation in terms of the present offence types.

6.6 That the Person of Special Notification (PSN) Policy and relevant administrative forms are amended to require consideration of the safety of vulnerable individuals, including children, who may live in the same house as a PSN on limited community treatment (LCT), and where risk is indicated, the treating team is to ensure a risk management plan is in place and appropriate LCT conditions are sought from the Mental Health Court or Mental Health Review Tribunal.

6.7 That the *Mental Health Act 2000* be amended to require the Tribunal to obtain an independent examination and report from a psychiatrist other than the psychiatrist responsible for the patient's treatment when making a decision about revocation of a forensic order for a Person of Special Notification.

6.8 That treatment plans for forensic patients, including Person of Special Notification, routinely and explicitly incorporate information provided by carers, support persons and service providers, including that relating to their capacity to support limited community treatment.

6.9 That Queensland Health expand the number of Indigenous mental health worker positions available to provide culturally appropriate services for Indigneous forensic patients.

6.10 That the policies relating to forensic patients, including Person of Special Notification, require that reports given to the Mental Health Court and Mental Health Review Tribunal provide advice as to whether the necessary treatment and support required by the patient for limited community treatment is available.

Limited community treatment

6.11 That state-wide guidelines be developed on monitoring and responding to non-compliance by Person of Special Notification, and include a requirement that where a PSN has not complied with limited community treatment (LCT) conditions in a significant way or symptoms re-emerge, the patient must undergo a full mental health assessment before LCT is allowed to continue.

6.12 That Queensland Health amend the 'Treatment Plan – limited community treatment' form to include a field relating to verification of limited community treatment in order to

ensure consistent state-wide implementation of this process of external verification of limited community treatment orders and approvals.

6.13 That Limited Community Treatment Review Committees continue to focus on reviewing the content and quality of documentation relating to forensic order reviews prior to Mental Health Review Tribunal hearings in line with existing policy guidelines.

6.14 That the Limited Community Treatment Review Committee provide feedback to the treating team prior to the Mental Health Review Tribunal hearing for incorporation into the final 'Clinical report – forensic order review' report to be sent to the Tribunal.

6.15 That the Director of Mental Health develop standardised structures and processes relating to limited community treatment decision-making and the operation of the Limited Community Treatment Review Committees across the State.

Risk management systems

6.16 That a structured program of risk management for forensic patients be adopted state-wide that includes strategies for reducing or removing risk factors, (for example, substance misuse), managing symptoms, and interventions to address psychological and social issues.

6.17 That Queensland Health continue implementation of the Sentinel Events Review recommendation relating to core state-wide standardised processes for mental health assessment, risk assessment and treatment, and in addition include specific reference to forensic mental health issues and information.

6.18 That high priority is given to the development of the proposed state-wide mental health information system to ensure easy access to forensic patient information in emergency departments and across health service districts, as recommended in the Sentinel Events Report (key recommendation 2).

6.19 That information relating to forensic patients, including diagnosis, *Mental Health Act 2000* status, limited community treatment conditions, offence history and other critical information is readily accessible in a forensic summary form in the front of all clinical and administrative files, as well as on the Mental Health Act Information System.

Chapter 7

Community Awareness

7.1 That a more strategic, sustained approach be taken to developing community education strategies which support improved community awareness and understanding of the forensic mental health care system in Queensland.

7.2 That the mental health sector, in conjunction with any state-wide mental health promotion, prevention and early intervention centre that is established, develop local initiatives for increasing community understanding of mental illnesses and their treatment and the mental health services provided in local areas.

7.3 That the plan for the Queensland Centre for Mental Health Learning to improve mental health sector workers' knowledge and skills in forensic mental health be progressed

as a matter of priority. The Centre's proposed extension of this training to the broader health and community sector should also be implemented as soon as possible.

7.4 That police involved in investigating serious violent offences are provided with training about the Mental Health Court and the forensic mental health system.

7.5 That the police Mental Health Coordinators become a point of contact for arresting officers seeking guidance and information about the Mental Health Court processes and services for victims in matters referred to that Court.

7.6 That Queensland Health develop culturally appropriate material about mental illness for Indigenous communities that explains the forensic mental health process including information about what families can expect if a person returns to the community.

7.7 That Queensland Health ensure Indigenous perspectives are represented appropriately in the development of mental health resources and educational and promotional material.

7.8 That, in implementing the mental health promotion, prevention and early intervention key area for action in the Draft Queensland Mental Health Plan 2007-2011, consideration be given to developing resource materials for media professionals about the Queensland forensic mental health system.

CHAPTER 1 – INTRODUCTION

Background of the Review

On Tuesday 23 May 2006, the Honourable Stephen Robertson MP, Minister for Health, stated that the Government would conduct a review of the *Mental Health Act 2000*. On 14 June 2006, the Government announced the appointment of Brendan Butler AM SC to conduct the Review, which commenced on 3 July 2006.

Establishment of the Review was prompted by concerns raised earlier this year about the merit of allowing persons charged with serious criminal offences and found to be of unsound mind or unfit for trial due to mental illness or intellectual disability, to return to the community on limited community treatment (a form of leave). Concern was also expressed about the level of consultation and information afforded victims and their families when decisions about the approval of limited community treatment for forensic patients are made.

The purpose of the Review was outlined in the Terms of Reference as involving two important aspects. The Review was charged with examining the efficacy of current legislative provisions and administrative arrangements that take account of the interests of victims and their families and whether these provisions need to be amended to further enable victims and their families to be involved in the decision making process.

The Review was also required to consider whether the *Mental Health Act 2000* and associated arrangements achieve an appropriate balance between the responsibility of the State to strengthen the safety and protection of the community with the provision of rehabilitation opportunities for patients under a forensic order.

Terms of Reference for the Review

The Terms of Reference established by the Minister for Health acknowledged the framework set out in the *Mental Health Act 2000*, the *National Mental Health Strategy* and the obligations under the *United Nations Principles for the Protection of Rights of People with Mental Illness and for the Improvement of Mental Health Care.*

The Terms of Reference required the Review to:

- assess the efficacy in protecting the interests of victims and their families of provisions in the *Mental Health Act 2000* about the Mental Health Court and the Mental Health Review Tribunal and current administrative arrangements to support the Court and the Tribunal
- assess the adequacy of legislative provisions and administrative arrangements relating to limited community treatment
- assess the efficacy of current legislative provisions and administrative arrangements for the referral of certain matters by the Director of Mental Health to the Attorney-General
- consider whether criteria should be developed to permit appropriate, interested members of the public to represent their concerns to the Mental Health Court and the Mental Health Review Tribunal before limited community treatment is ordered or approved
- consider whether and in what circumstances victims and their families should be informed about a decision to order or approve limited community treatment
- assess the ongoing relevance of recommendations from previous reviews of the *Mental Health Act 2000* in relation to the interests of victims of crime and their families

- assess the implementation of the recommendations in the Mullen Chettleburgh *Review of Queensland Forensic Mental Health Services* as they relate to victims and their families, breaches of conditions of limited community treatment and the provision of information by third parties to the Mental Health Court and the Mental Health Review Tribunal.

The full Terms of Reference are attached as Appendix A.

The Terms of Reference do not provide for a comprehensive review of the legislative framework in the *Mental Health Act 2000*. For example, the Terms of Reference did not permit the continued existence of the Mental Health Court or the Mental Health Review Tribunal to be questioned. Their emphasis was upon the interests of victims and their families.

The Review took into account the principles of justice for victims of crime outlined in the *Criminal Offence Victims Act 1995*. However, its role did not allow it to investigate or report on individual cases.

The Review Team

The Review was headed by Brendan Butler AM SC. The team supporting the Reviewer comprised the following officers:

- Queensland Health - three officers
- Department of Justice and Attorney-General - one officer.

The Team provided support to the Review by:

- conducting analysis of material at direction of and with approval of the Reviewer when scoping the issues
- providing support to the Reviewer as chair of the Independent Expert Reference Group
- participating in the consultation process with relevant stakeholders under direction from the Reviewer, in particular providing advice on the process and completing analyses of consultation outcomes at all stages of the Review
- preparing consultation materials and drafting interim and final reports with direction from the Reviewer.

Steering Committee

The Reviewer provided regular reports on the Review's progress to the Review Steering Committee and met with the Steering Committee on a number of occasions.

The Steering Committee comprised representatives from the Department of Premier and Cabinet, Treasury, Department of Justice and Attorney-General, Queensland Health, the Department of Communities, Seniors and Youth, Disability Services Queensland and the Queensland Police Service. The role of the Steering Committee was to ensure that time goals were met and there was adherence to the Terms of Reference.

Consultation process

The Review consulted extensively with all relevant agencies and concerned members of the public. The Reviewer met with more than 60 individuals and groups, including victims and their families, clinicians, patients and government and non-government organisations across the State. He visited inpatient facilities in Brisbane, the Gold Coast, Toowoomba, Townsville and Cairns as well as meeting with stakeholders in those areas.

On 28 July and 12 September 2006, the Team consulted with patients from the High Security Unit and staff at The Park – Centre for Mental Health.

Between 23 and 25 August 2006, the Reviewer and a team member visited Townsville and met with the following stakeholders:

- Townsville Adult Mental Health Service staff
- Aboriginal and Torres Strait Islander mental health staff
- Aboriginal and Torres Strait Islander Legal Service
- non-government organisations
- Victim Liaison Officer, Office of the Director of Public Prosecutions
- Consumer Advocacy Group for Mental Health
- Forensic Mental Health Consumer Consultant.

During a visit to Cairns on 30 and 31 August 2006, the Reviewer and a team member held meetings with the following people:

- Cairns Mental Health Service staff and other health staff
- Aboriginal and Islander mental health and remote health service staff
- Queensland Health/Queensland Police Service liaison staff
- Consumer Advisory Group
- Indigenous community representatives.

The consultation process also included the public release of a *Call for Submissions Paper* and a *Discussion Paper.* The *Call for Submissions Paper* was released in July 2006 inviting submissions to inform the development of the *Discussion Paper*. In addition to mailing both papers to stakeholders, the papers were posted on the Review website at www.reviewmha.com.au, the Consult Queensland website www.getinvolved.qld.gov.au and advertised in the Courier Mail and a selection of other Queensland regional newspapers.

The Review received in excess of 40 formal written submissions in response to the *Call for Submissions Paper.*

The *Discussion Paper* was publicly released on 29 September 2006, calling for further submissions to be provided by 27 October 2006. Over 40 formal submissions to the *Discussion Paper* were received. This figure includes six submissions posted on the Consult Queensland website. The Review also received approximately 70 other enquiries and related correspondence.

Independent Expert Reference Group

An independent expert reference group assisted the Reviewer. The Reference Group membership included representatives from the following areas:

- Victims of crime - individuals and support services including the Queensland Homicide Victims' Support Group and Relationships Australia Queensland
- Mental health consumers
- Carers - Association of Relatives and Friends of the Mentally Ill (ARAFMI)
- Queensland Health psychiatrists and private psychiatrists
- Queensland Police Service

- Office of the Director of Public Prosecutions
- Legal Aid Queensland
- Queensland Alliance (mental health peak body)
- Indigenous health – Queensland Health and Queensland Aboriginal and Islander Health Council
- Transcultural Mental Health Centre
- Disability Services Queensland Accommodation Support and Respite Services
- Disability Council of Queensland
- Public Housing Tenants' Association.

The role of the Reference Group was to provide the Reviewer with information and advice on issues, assist with identifying stakeholders who should be consulted and provide feedback on options and proposed recommendations. The Group met on three occasions - 27 July, 7 September and 27 October 2006.

Mental health policy context

The focus of the Review was on the forensic mental health system with particular attention placed on cases heard in the Mental Health Court involving those charged with indictable offences. However, when examining proposals for reform falling within its Terms of Reference, the Review had to be aware of the broader mental health landscape.

Mental health policy and service development in Queensland is guided by a number of international, national and state developments. These include:

- *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*
- *National Mental Health Strategy*
- *National Statement of Principles for Forensic Mental Health* (2006)
- *Queensland Health Strategic Plan 2005-2010*
- *Queensland Mental Health Strategic Plan 2003-2008*
- *Queensland Health Action Plan 2005*
- *Queensland Forensic Mental Health Policy.*

The Review's Terms of Reference required the formulation of recommendations within the framework established by these broader mental health initiatives. High levels of public concern about mental health services in all Australian states and territories have been acknowledged by the Senate Select Committee on Mental Health[6] and the Mental Health Council of Australia,[7] and the recent prioritisation of mental health by the Council of Australian Governments.

6 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community* (2006).
7 Mental Health Council of Australia, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia* (2005).

The Queensland Government has committed to providing substantial additional funds to expand mental health services over the next five years. Some of this funding is to increase capacity in community mental health services, as well as specialist forensic mental health services, including court liaison and prison mental health care. The non-government sector has been allocated additional funding to support people during recovery and reintegration into the community.

The Review in preparing this Final Report has had regard to current responses to mental health service needs by both the Australian and Queensland governments.

CHAPTER 2 – ISSUES AND CONCEPTS

Scope of Review

The Terms of Reference limit the scope of the Review to issues affecting victims of offences committed by people with a mental illness who have been placed on a forensic order. These are people with a mental illness or intellectual disability who, after being charged with indictable offences, have been diverted to the Mental Health Court for a determination as to their mental state in relation to the alleged offending.

Under the Terms of Reference, the Review is charged with examining the efficacy of current legislative provisions and administrative arrangements that take account of the interests of victims and their families and whether these provisions need to be amended to further enable victims and their families to be involved in the decision making process.

The Review must also consider whether the *Mental Health Act 2000* and associated arrangements achieve an appropriate balance between the responsibility of the State to strengthen the safety and protection of the community with the provision of rehabilitation opportunities for patients under a forensic order.

Needs of victims

After extensive consultations with a broad range of stakeholders, the Review has formed the view that further reform is required to serve the legitimate needs of victims of crime and to enhance public confidence in the system dealing with forensic patients.

The Review considers that reform in the interest of victims can be achieved while preserving the rights of forensic patients. It is essential that both victims and patients be treated fairly. Fair and compassionate treatment of forensic patients need not limit the capacity to protect the public from harm and provide victims of crime with the support they need.

Victims of crime in cases where the offender is mentally ill have needs at least equivalent to those of victims in cases dealt with through the normal criminal justice courts. The *United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power* sets the standard for governments in this area.[8] The definition of 'victim' in the Declaration is sufficiently broad to encompass persons harmed by people with a mental illness. The principles provide for victims to be treated with compassion and respect for their dignity and to be provided compensation, restitution and assistance. The Declaration incorporates the following principle:

> The responsiveness of judicial and administrative processes to the needs of victims should be facilitated by:
>
> (a) informing victims of their role and the scope, timing and progress of the proceedings and of the disposition of their cases, especially where serious crimes are involved and where they have requested such information;
>
> (b) allowing the views and concerns of victims to be presented and considered at appropriate stages of the proceedings where their personal interests are affected, without prejudice to the accused and consistent with the relevant national criminal justice system;

8 United Nations, *United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power,* GA 40/34, annex, 40 UN GAOR Supp (No. 53) at 214, UN Doc A/40/53 (1985).

(c) providing proper assistance to victims throughout the legal process;

(d) taking measures to minimize inconvenience to victims, protect their privacy, when necessary, and ensure their safety, as well as that of their families and witnesses on their behalf, from intimidation and retaliation;

(e) avoiding unnecessary delay in the disposition of cases and the execution of orders or decrees granting awards to victims.

The principles set out in the United Nations Declaration have been given recognition in Queensland in the *Criminal Offence Victims Act 1996*. Unfortunately that Act focuses on the processes in the criminal courts and fails to meet all the needs of victims in cases where the offenders are found not to be criminally responsible.

Specific provisions in the *Mental Health Act 2000* give victims of crime improved access to information and improved their ability to contribute to the Court and Tribunal processes. Nevertheless, those improvements still fall short of the access available to victims in the criminal courts. The involvement of victims in the mental health system is constrained because of the competing considerations arising where the defendant is a patient receiving medical treatment. While acknowledging a balance must be struck between competing interests, the Review has concluded further reform is both possible and necessary in order to ensure the concerns of victims of crime are heard and the system is responsive to their needs.

The mental health framework

The Mental Health Court and the Mental Health Review Tribunal exist within the framework of the *Mental Health Act 2000.* The Explanatory Notes that accompanied the introduction into the Parliament of the Mental Health Bill 2000 acknowledged criticisms of the earlier 1974 Act and outlined the considerable changes in the treatment of the people with a mental illness that had occurred in the intervening period.

The *Mental Health Act 2000* was drafted to conform to the framework endorsed by all Australian Governments in 1992 in the *National Mental Health Strategy* and to implement the statement of patients' rights contained in the *National Mental Health Statement of Rights and Responsibilities*.[9] This national framework implemented the commitment made by the Australian Government in adopting the *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*.[10] Model Mental Health Legislation released in 1995 guided the drafting of the Act.[11]

The *Mental Health Act 2000* provides the legal framework for the involuntary treatment of people with mental illness. About 14% of these people have been charged with a criminal offence and placed on a forensic order that subjects them to a higher level of monitoring than other involuntary patients. It is this group of forensic patients which is the focus of the Review's work.

Balancing competing rights

It is fundamental for all mental health consumers, including forensic patients, to be accorded basic rights and treated with humanity and respect. They should not be discriminated against

9 Australian Health Ministers, *National Mental Health Statement of Rights and Responsibilities* (1991).

10 United Nations, *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,* [Principle 13], GA Res 46/119 (1991).

11 University of Newcastle, *Model Mental Health Legislation: Report to the Australian Health Ministers' Advisory Council, National Working Group on Mental Health* (1994).

on the grounds of mental illness. Where, however, a person has committed a serious criminal act, particularly a violent act, consideration must also be given to the fundamental rights of others to protection and support. It follows that while the thrust of the *Mental Health Act 2000* in protecting the rights of all people with mental illness must be maintained, the needs of victims and the community must also be addressed.

The *United Nations Principles for the Protection of Persons with Mental Illness* affirms the entitlement of all persons with a mental illness to fundamental freedoms and basic rights. Among the rights recognised by the principles are the right of persons with a mental illness to live and be treated, as far as possible, in the community and their right to have the confidentiality of their information respected.

While the United Nations principles affirm the rights of patients, they also acknowledge there are competing public safety considerations. The principles are subject to the following general limitation clause:

> The exercise of the rights set forth in these principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.[12]

The general principles also apply to persons serving sentences of imprisonment or who are detained in the course of criminal proceedings or investigations. But the document qualifies this position by recognising that in those cases such limited modifications and exceptions as are necessary in the circumstances may be made.

In respect of treatment, the principles state as follows:

> Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.[13]

This principle, including the qualification in favour of protecting others' safety, has been adopted in the *Mental Health Act 2000.*[14]

The *National Statement of Principles for Forensic Mental Health*, endorsed by the National Mental Health Working Group, which reports to the Australian Health Ministers' Advisory Council, provides a framework of nationally agreed principles for the delivery of forensic mental health services within Australia. These principles state that they have been developed in the context of, and are underpinned by, international and national policy frameworks including the *United Nations Principles for the Protection of People with a Mental Illness*.[15] They recognise that forensic mental health is a specialised field within mental health. Their focus on forensic patients aligns with the target group identified by the Review's Terms of Reference.

The principles affirm that all persons accessing mental health services are entitled to the protection of their civil and human rights and freedom from abuse consistent with the United Nations principles.

The principles also recognise that public safety considerations arise in forensic matters. They state that treatment decisions must be cognizant of the following:

12 United Nations, *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,* [1], GA Res 46/119 (1991).
13 Ibid.
14 *Mental Health Act 2000* (Qld) s 9(a).
15 National Mental Health Working Group, *National Statement of Principles for Forensic Mental Health* (2006).

- legitimate needs of the community for a reasonable level of protection from dangerous or seriously disruptive behaviour.
- protection of the individual patient from unacceptable risk of serious damage to self or serious deterioration.
- cultural significance and impact of isolating practices on offenders.
- safety needs of the individual, other patients/prisoners and staff.[16]

The interests of victims are also acknowledged. The principles set out considerations that should be addressed in legislation.[17] These include that:

- courts or statutory bodies may consider material from a person who is not a party to a proceeding, for example, a victim, if it is relevant to the determination of the Court
- legislation must permit the notification of next-of-kin, carers and victims about decisions regarding detention, release or transfer.

None of the relevant international and national statements of principle are inconsistent with legislation striking an appropriate balance between the rights of forensic patients and the interests of the community and of victims in particular.

The Mental Health Act 2000

The *Mental Health Act 2000* (the Act) commenced on 28 February 2002 and replaced the *Mental Health Act 1974*, within the context of broader mental health reforms.

The Act is widely regarded by mental health professionals, the legal profession and academics as the most progressive and innovative framework for the delivery of mental health services to involuntary patients in Australia. Many submissions have expressed the view that the Act is a sound legislative framework compared to schemes in other Australian and many international jurisdictions.

Section 8 of the Act reflects and incorporates the *United Nations Principles for the Protection of Rights of People with Mental Illness and for the Improvement of Mental Health Care* as general principles for the administration of the Act.

Section 9 of the Act requires a power or function under the Act to be performed or exercised so that the person's liberty and rights are adversely affected only if there is no less restrictive way to protect the person's health and safety or to protect others and any restriction on the person's liberty and rights is the minimum necessary in the circumstances.

These statements in the Act are an important protection against abuse, neglect and exploitation of mentally ill people who are one of the most vulnerable groups in our community.

Recognising the interests of victims of crime

In 1999, during the development of the *Mental Health Act 2000*, Queensland Health undertook a consultation process specifically focussed on the role and rights of victims. When the new Act was enacted in 2000, provisions to recognise the role of victims of crime where the offender has a mental illness were incorporated. In contrast to the earlier *Mental Health Act 1974*, the *Mental Health Act 2000* contains provisions that give victims of crime and their families opportunities

16 United Nations, *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,* [Principle 2], GA Res 46/119 (1991).

17 United Nations, *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,* [Principle 13], GA Res 46/119 (1991).

to provide information to the Mental Health Court and to the Mental Health Review Tribunal and to be notified of certain information about the patient.

Over four years have passed since the commencement of the *Mental Health Act* in 2002. The commissioning of this current review provides a timely opportunity to gauge the effectiveness of these provisions.

The Review is concerned that the present provisions do not go far enough in meeting the legitimate needs of victims. Later chapters in this Report give detailed consideration to the powers of the Court and Tribunal to receive material from victims and to release information to them and make specific recommendations for amendments to the Act. In addition the Review favours incorporation of a statement of purpose in the Act to ensure decision makers are entitled take account of the interests of victims.

Protection of the community

Another focus of the Review is to find an appropriate balance between the rights of the patient and the safety of the community.

The public outcry that surrounded the cases which gave rise to this Review is indicative of the way in which a few high profile cases involving forensic patients can affect public confidence in the provision of forensic mental health services. Maintenance of public confidence is important to the integrity of the mental health court system and to the peace of mind of victims and patients.

For there to be trust in the system the public need to be assured that their safety is given appropriate priority. Members of the public are entitled to expect that where mentally ill persons have committed criminal offences, particularly serious violent offences, the system will take the necessary steps to ensure treatment of the person has full regard to the need for public safety in managing the risk of re-offending. This means striking the right balance between the individual rights of the patient and those of the community.

The Act addresses the safety of members of the community in provisions which deal specifically with those people charged with an indictable criminal offence and found by a court to be of unsound mind or unfit for trial. That finding can be made either by a Supreme Court judge constituting the Mental Health Court or a jury in a criminal trial. Where that finding is made by the Mental Health Court, the Court may, after having regard to the seriousness of the offence, the person's treatment needs and the protection of the community, place the person on a forensic order. A forensic order provides for the person to be detained in an authorised mental health service for involuntary treatment or care.[18]

Criminal responsibility

Almost two centuries ago, English law accepted insanity as a defence to a criminal charge. It was decided that where, because of mental disease, persons did not know the nature or quality of their criminal act, or did not know what they did was wrong, they were not to be held criminally responsible for that act. This concept was enshrined in the Queensland Criminal Code at the beginning of the last century.

18 See Appendix D, (Key Concepts).

Section 27 of the Criminal Code provides that a person is not criminally responsible for an offence if, at the time of the offence, the person was in such a state of mental disease or natural mental infirmity that they were deprived of the capacity to:

- understand what they were doing; or
- to control their actions; or
- to know that they should not do the act or make the omission constituting the offence.

'Mental disease or natural mental infirmity' does not include a personality disorder or a situation where the mental disorder was caused by rage, jealousy or intoxication.

The Court must determine whether the defendant was of unsound mind at the time of the commission of the offence or is unfit to plead. The Act defines 'unsound mind' as the mental state defined in section 27 in the Criminal Code.

Some submissions have expressed the view that a finding of unsoundness of mind should not relieve an offender of legal responsibility for his or her actions. As already observed, the concept that a person lacking capacity due to mental illness is not criminally responsible for his or her acts is deeply ingrained in our criminal law. The Act has merely adopted the pre-existing Criminal Code 'defence' of insanity in this regard.

The Criminal Code defines criminal responsibility as meaning 'liability to punishment as for an offence'.[19] The scheme of the *Mental Health Act 2000* is consistent with this criminal law concept. People who are found of unsound mind are not subject to punishment for the offence. This is so whether the issues of capacity and fitness are determined by a criminal court or by the Mental Health Court. The Terms of Reference do not permit the Review to consider whether a change should be made to this fundamental principle of our criminal law.

This approach does not ignore the nature and seriousness of the act committed but focuses on treatment of the person's condition and protection of the person and others, rather than on punishment.

Some submissions to the Review have suggested that the Mental Health Court should set a minimum period during which the person on a forensic order cannot be released into the community. It has been argued that the adoption of a minimum period would assist victims by giving them time to comprehend what had happened and to become accustomed to the idea of the person's return to the community.

The setting of a minimum time period in order to meet the needs of victims would amount to a form of punishment and therefore be inconsistent with the absence of criminal responsibility on the part of the patient. The imposition of a minimum period of inpatient detention was an option considered and rejected at the time of the enactment of the Act. It is a concept inconsistent with the deeply entrenched principle in our criminal law that to be liable for punishment a person should be held criminally responsible, and is inconsistent with the scheme of the Act.

Consequences of a forensic order

Although a person found to be of unsound mind or unfit to plead is not subject to punishment, the nature and seriousness of their act is not ignored. Those matters are relevant when decisions are made about the patient's treatment and when ensuring the patient does not pose a risk to others.

19 *Criminal Code Act 1899* (Qld) sch 1 s 1.

A number of provisions in the *Mental Health Act 2000* ensure that the Court and Tribunal give attention to the safety of the public when making important decisions about forensic patients.

Protection of the community is one of three matters the Court must have regard to when deciding whether to make a forensic order.[20] Once the order is made it may not be revoked unless the Tribunal is satisfied the patient does not represent an unacceptable risk to the safety of the patient or others, having regard to the patient's mental illness or intellectual disability.[21] The same test must be applied before the Court or the Tribunal may order or approve limited community treatment (LCT).[22]

The Review considers that these provisions adequately provide for community protection by requiring the Court and Tribunal to give precedence to ensuring the patient does not represent an unacceptable risk to others before the important steps of allowing LCT or revoking the forensic order are taken.

Another consequence of being placed on a forensic order is that the patient is subject to detention in a mental health service for treatment and care. The Act requires that the patient have a treatment plan and be subject to regular assessments by an authorised psychiatrist as required under the plan. These requirements continue throughout the currency of the forensic order.

Public concern has been expressed in some high profile cases about patients who have had LCT approved for community visits or to live in the community. A patient on a forensic order may be allowed to have LCT if the Court or Tribunal is satisfied they do not pose an unacceptable risk. The ability to allow gradual reintroduction of a patient to normal life can form an important part of their treatment. However, use of LCT should be subject to careful assessment of the risk involved and should be conducted in a way that carefully manages for any risks that might arise. It is to be remembered that the patient continues to be subject to the forensic order and under the care of the treating team.

Some of those expressing concern are of the view that the person should be detained because of the crime they have committed. This is a call for punishment which, as was explained above, is contrary to long standing principles of our criminal law. The Terms of Reference of the Review do not allow it to question those principles.

Others are concerned that the patient may pose a risk to the safety of victims or other members of the public. In the case of patients who have previously committed a serious violent offence this can be a legitimate concern. There are examples of forensic patients who have committed serious offences while on LCT, isolated though those cases may be. Queensland Health is already in the process of implementing a number of recommendations from earlier reports addressing these concerns. The Review supports the implementation of these recommendations, but considers that further steps need to be taken to improve the management of risk in regard to forensic patients and to build public confidence in the mental health system

Mental illness and violence prevention

A number of submissions have argued that sound clinical assessment, treatment and rehabilitation play a positive role in promoting public safety, ameliorating risk and reducing offending by people with a mental illness.

20 *Mental Health Act 2000* (Qld) s 288(3). The other two criteria are: the seriousness of the offence and the person's treatment needs.
21 *Mental Health Act 2000* (Qld) s 204(1).
22 *Mental Health Act 2000* (Qld) ss 204(1), 289(4).

The research literature supports the view that effective treatment is the preferred strategy for violence prevention in the case of mentally ill patients. The treatment of active symptoms of mental illness and the management of other vulnerabilities associated with the active illness, such as substance misuse, social dislocation and personality deterioration, provides the best way of ensuring violent behaviour does not recur. The aim of such a treatment program is the recovery of the patient and their eventual, successful return as a productive member of society. It is usual for these goals to be achieved through a treatment regime that includes a structured process of gradual supervised return of the patient to life in the community. Recovery will be achievable for most patients but for some inpatient treatment will be lengthy and a few will require permanent care.

For this recovery-based model of treatment to achieve community support, it is necessary that clinicians keep firmly in mind the goal of minimising violent behaviour by patients. The failure of treatment to adequately manage the behaviour of patients to avoid recurrence of violent offending not only impacts upon the victims of that behaviour and erodes public confidence, but also represents a serious setback to the recovery of the patient. It follows that treatment plans must, in the interests of both the patient and the community include all necessary steps to manage any risk of violent behaviour.

Although there has been a debate among researchers over the relationship of mental illness to violent behaviour, more recent studies have confirmed a correlation between serious mental disorders and offending behaviours.[23] People with serious mental disorders are overrepresented amongst violent offenders. International studies show that 5 – 10 % of those charged with murder have a schizophrenic disorder.[24] A similar correlation exists between non-fatal violent offending and schizophrenia.[25] Those responsible for the treatment of high risk mentally ill persons need to be mindful of the correlation that exists between mental illness and the potential for violence.

It is true that the risk that any given patient will offend is small. It has been estimated that the annual risk that a person with schizophrenia will commit a homicide is in the region of 1:10,000.[26] It is also true that the vast majority of people with mental illness are not at risk of acting violently. For example, it is estimated that of those with a schizophrenic illness less than 10 per cent are at high risk of violence and only a few of those will ever commit serious acts of violence.[27] Statistically, a member of the public has little to fear from being the object of violence perpetrated by a person with mental illness. However, that knowledge provides little comfort to those victims who are violently attacked.

An understanding of the relationship between mental illness and violent behaviour can take on particular importance when applying certain provisions of the *Mental Health Act 2000*. The Tribunal may not revoke a patient's forensic order unless it is satisfied the patient does not represent an unacceptable risk to the safety of the patient or others, having regard to the patient's mental illness or intellectual disability.[28] It follows that in assessing whether there is an unacceptable risk the Tribunal may only have regard to a risk that arises from mental illness

23 P Mullen, *A Review of the Relationship between Mental Disorders and Offending Behaviours and on the Management of Mentally Abnormal Offenders in the Health and Criminal Justice Services* (2001) (Unpublished paper for the Criminology Research Council); P Mullen, 'Schizophrenia and Violence: From Correlations to Preventative Strategies' (2006) 12 *Advances in Psychiatric Treatment* 239-248.

24 P Mullen, 'Schizophrenia and Violence: From Correlations to Preventative Strategies' (2006) 12 *Advances in Psychiatric Treatment* 239-240.

25 Ibid 239.

26 C Wallace, P Mullen and P Burgess, 'Criminal Offending and Schizophrenia over a 25 Year period marked by the Institutionalisation and increasing prevalence of co-morbid substance use disorders' (2004) 161 *American Journal of Psychiatry* 716-727.

27 P Mullen, 'Schizophrenia and Violence: From Correlations to Preventative Strategies' (2006) 12 *Advances in Psychiatric Treatment* 245-246.

28 *Mental Health Act 2000* (Qld) s 204(1).

or intellectual disability and that a person who is no longer mentally ill or intellectually disabled cannot be further detained. This was the conclusion reached by the Mental Health Court on appeal in *Re AKB*, where examining psychiatrists testified that the patient, who had a history of arson offences, continued to pose a risk to the community but that risk did not arise from any mental illness or intellectual disability.[29]

Just as under the criminal law a person may only be punished for the offence he or she committed and ordinarily cannot be further held in preventative detention, so under the *Mental Health Act 2000* a person may be detained for treatment only so long as their mental illness or intellectual disability persists. In either case there is potential for an individual at risk of re-offending to be released once the term of imprisonment or treatment from mental illness is completed.

Those cases like *Re AKB* where a person originally found to be of unsound mind is clearly no longer mentally ill but nevertheless may pose a risk for other reasons are likely to be exceptional. Any continuing risk may be associated with the patient's mental illness in combination with other factors.

The correlation between mental illness and violence is sometimes obscured by the effect of other factors associated with violence such as personality traits and substance misuse. Such factors may contribute to a mental illness or result from it.

For those at risk of violence, it is important that treatment is not solely directed to the active symptoms of the mental illness. Substance misuse, personality vulnerabilities and social factors are highly relevant to the potential for violence and need to be considered as part of the treatment process. Deterioration of personality and misuse of substances will often occur as a result of the active mental illness. Even where those factors pre-date the diagnosis of the mental illness, there will still be a causal association in many cases. For example, patients with schizophrenia may manifest substance misuse problems before the onset of obvious psychotic symptoms resulting in their diagnosis.[30] In such cases, the existence of an 'unacceptable risk' of violent behaviour will be related to the mental illness.

It has been argued that the therapeutic goals of treatment must focus on management of these co-existing vulnerabilities in addition to symptom control.[31]

> The mental health community has to start by accepting that violent and antisocial behaviours are among the potential complications of having a schizophrenic syndrome … as long as the problem of violence is minimised or dismissed as 'non-illness related', there can be no progress in reducing risk.[32]

Reducing violence must be seen to be integral to the goals of treatment. Those at risk of violent offending need to be given an appropriately higher priority for management of their illness. Current risk assessment tools do not allow confident predictions to be made as to individual risk.[33] What clinicians can to do is to identify high-risk groups and suggest appropriate management strategies for individuals falling in those groups. This is not about punishing or stigmatising individuals. It is about ensuring that those with identified vulnerabilities receive

29 *Re AKB* [2005] QMHC 005.

30 P Mullen, 'Schizophrenia and Violence: From Correlations to Preventative Strategies' (2006) 12 *Advances in Psychiatric Treatment* 242.

31 Ibid 245.

32 Ibid 243.

33 S Hart, C Michie and D Cooke, 'The Precision of Actuarial Risk Assessment Instruments: Evaluating the "Margins of Error" of Group Versus Individual Predictions of Violence' (Paper presented at Management and Treatment of Dangerous Offenders Conference, York, 28-30 September 2005); P Mullen, 'Dangerous: and Seriously Personality Disordered: And in Need of Treatment', (2006) *British Journal of Psychiatry* (in press) 7.

the optimal treatment to maximise their chance of recovery and avoid the personal devastation associated with a return to violent behaviour patterns.

Clinicians will be able to identify certain patients as falling into a high-risk category for violence but they will not be able to predict, with any certainty, whether any individual will commit violence. However, for those who have already committed a serious violent act, the mental health system is already on notice as to potential vulnerability. Many of those on a forensic order fall into this group. It is important that legislation and administrative arrangements provide clinicians with clear guidance on prioritising the management of violent risk in this group. The increased treatment attention provided to this group has the potential not only to enhance the safety of the public but also to ensure better outcomes for the individuals concerned.

Inadequacies in risk management systems for forensic patients in Queensland were highlighted in the Review of Queensland Forensic Mental Health Services (the 'Mullen Chettleburgh Report') and the Queensland Review of Fatal Mental Health Sentinel Events. Both reviews made recommendations about strategies for improving risk assessment and management in relation to forensic patients.[34] The Review has examined the progress that has been made with implementing those recommendations and considers that further progress is required.

Chapter 6 will detail recommendations designed to enhance risk management in the interests of community protection and sound treatment outcomes.

34 P Mullen and K Chettleburgh, *Review of Queensland Forensic Mental Health Services* (2003) http://www.health.qld.gov.au/publications/corporate/mullenreview/; Queensland Health, *Report of the Queensland Review of Fatal Mental Health Sentinel Events: Achieving Balance* (2005). http://www.health.qld.gov.au/mental_hlth/publications.asp.

CHAPTER 3 – VICTIMS' RIGHTS, NEEDS AND INTERESTS

The focus of the Review

The Review focused on the needs of victims and family members of victims of serious violent offences committed by persons found of unsound mind at the time of the offence or found unfit for trial.

While the needs of these victims will be, in many respects, similar to those of victims of crime generally, the Terms of Reference for the Review are specific to cases proceeding through the Mental Health Court and do not extend to all victims of crime. However, the general service system for victims in Queensland must first be considered when determining whether the needs of victims of offences committed by people with a mental illness or intellectual disability are being adequately addressed or can be met within existing services.

Who is a victim?

In this report, the term 'victim' is used generally to refer to those harmed by an act that resulted in a person being charged with an indictable offence and referred to the Mental Health Court. The number of victims in this category is comparatively small. For example, of all homicide victims in Queensland over a 17 year period from 1989-90 to 2005-06, only 4% (n=46) were victims of homicides committed by persons who were considered mentally disordered. For this period, the total number of homicide victims in Queensland was 1101. In 2005-06, three of the 61 victims of homicide were victims of homicides committed by persons who were considered mentally disordered.[35] Of course, this data does not include family members of these victims. Data on the mental status of the offender, including the identification of the offender as having a mental disorder immediately before or at the time of the offence, is contained in police offence reports. These reports are not necessarily based on a formal diagnosis.

In the case of serious violent offences, victims and their families will often be dealing with serious physical injury or grieving for deceased loved ones. In mental health cases the majority of victims will be family members, family friends or carers of the alleged offender who have a history of involvement with, and a level of understanding of the alleged offender's illness or disability. While victims not known to the alleged offender will be in the minority, they will often have a greater need for information and explanation.

The *Criminal Offence Victims Act 1995* (COVA) defines a victim for the purpose of the principles of the Act as 'a person who has suffered harm from a violation of the State's criminal laws –

(a) because a crime is committed that involves violence committed against the person in a direct way; or

(b) because the person is a member of the immediate family of, or is a dependant of, a victim mention in paragraph (a); or

(c) because the person has directly suffered the harm in intervening to help the victim mentioned in paragraph (a)'.[36]

The COVA principles are solely directed towards those persons falling in the categories covered by the definition in the Act.

35 Queensland Police Service, email, 10 November 2006, preliminary data for the Australian Institute of Criminology, *National Homicide Monitoring Program (NHMP).*

36 *Criminal Offence Victims Act 1995* (Qld) s 5.

The *Mental Health Act 2000* approaches the matter differently by defining the term 'victim' narrowly as 'the person against whom the alleged offence is alleged to have been committed' but extending entitlements to a broader range of persons than merely the person against whom the offence is alleged to have been committed. [37]

The Act provides for persons who are not a party to the proceedings to submit material to the Mental Health Court or the Mental Health Review Tribunal if certain conditions are met, but the Court or Tribunal must be satisfied that the material is relevant.[38] This provision can, for example, allow a person to submit a statement about the risk they believe a patient poses to them.

The Tribunal may order that any person it considers to have 'a sufficient personal interest' will be notified about the holding of reviews and of their outcomes.[39]

Furthermore, in some cases a person found of unsound mind who is not on a forensic order may be prohibited from contacting others falling in a category limited to the actual victim, a relative of a deceased victim or a person who was with the victim when the offence was committed.[40]

The *Corrective Services Act 2006* provides a scheme for granting access to information for victims of crime about prisoners in custodial institutions. A comparison may be made between that scheme and the notification provisions of the *Mental Health Act 2000*. The *Corrective Services Act 2006* provides for the following categories of persons to be registered for the receipt of information:

- the actual victim of the offence
- a family member of a deceased victim
- the parent or guardian of a young victim
- a person who can satisfy the Chief Executive of a history of violence by the prisoner against them
- a person who can satisfy the Chief Executive their life or physical safety could reasonably be expected to be endangered because of a connection the person may have with the offence.[41]

Research on victims' needs

What does the literature tell us?

There has been very little quantitative research into victims' needs. For example, there have been few surveys of victims to ascertain what proportion of victims require various types of assistance. Most research about the impact of crime on victims, their needs and the appropriateness of services provided to them has been in the area of rape, sexual assault and child sexual abuse. However, the literature on victimisation suggests that victims of crime potentially need a comprehensive array of support services.[42] The literature also acknowledges that the needs of victims vary widely between individuals, due to factors such as the nature

37 *Mental Health Act 2000* (Qld) sch 2.
38 *Mental Health Act 2000* (Qld) ss 284, 468.
39 *Mental Health Act 2000* (Qld) s 223(2).
40 *Mental Health Act 2000* (Qld) ss 228B, 313B.
41 *Corrective Services Act 2006* (Qld) s 320.
42 A Frieberg, 'Working Together to Improve Services for Victims of Crime' (Paper presented at the Victim Support Services Conference, 1999); B Cook, F David and A Grant, *Victims' Needs, Victims' Rights: Policy and Programs for Victims of Crime in Australia* (1999).

of the crime and the personal characteristics and circumstances of the victim, such as their age, socio-economic status and race.[43] The report on findings from the 2002-03 British Crime Survey published by the United Kingdom Home Office shows that most victims, including most victims of violence, claimed to not want any form of support or advice (from police or victim services). However, of those victims who wanted support, the majority indicated they did not receive the help they wanted.[44]

Much of the research indicates that effects of crime on the victim can be long lasting and diverse. These effects include physical injuries, financial loss and psychological and emotional distress and disorders. Long term effects for those victims having difficulty rebuilding after the trauma of an offence can include post traumatic stress disorder, major depression, suicide attempts, substance abuse problems and anxiety disorders. Studies indicate that the rate of post traumatic stress disorder is higher among victims who report crimes and become involved in the criminal justice system than those who do not report.[45] The literature suggests this is because the loss of control experienced by victims as a result of the crime is compounded by the lack of control they have in criminal justice processes.

The literature indicates that provision of basic forms of assistance at an early stage, such as information about support services or money to meet out-of-pocket immediate expenses incurred by the search for temporary shelter, for example, can be significant to many victims in aiding recovery.[46] There is also support in the academic literature for 'early intervention', to identify and respond to any adverse effects on a person's mental health associated with being a crime victim, before these manifest in a more severe problem, with associated social and financial costs.[47]

Research conducted by the Australian Institute of Criminology in 1999 identified the following needs of victims that, if met, would assist their recovery and make their dealings with the criminal justice process less traumatic:

- support from family and friends
- support from victim support agencies
- information and knowledge, including services available, the progress of the police investigation, the role of the Office of the Director of Public Prosecutions (ODPP) and likely timeframes, court processes, explanations of legal requirements, the role of the victim in court processes, possible outcomes – the more information the better
- choices – accurate and timely information assists victims to make choices and to regain some control over their lives
- to have their say – it is important for victims to be able to tell their story and be heard
- immediate help and advice – the sooner victims receive positive support and advice the easier their recovery
- a coordinated and streamlined service system that is easy to access

43 R Janoff-Bulman and I Frieze, 'A theoretical perspective for understanding reactions to victimization' (1983) *Journal of Social Issues* 39.

44 L Ringham and H Salisbury, *Support for victims of crime: findings from the 2002/03 British Crime Survey* (2004).

45 J Freedy et al, 'The psychological adjustment of recent crime victims in the criminal justice system' (1994) 9(4) *Journal of Interpersonal Violence.*

46 T Newburn, *The Long Term Needs of Victims: A review of the literature* (1993); Victorian Community Council Against Violence *Victims of Crime: Inquiry into Services* (1994).

47 R Davis, B Taylor and A Lurigo, 'Adjusting to Criminal Victimisation: the correlates of post crime distress' (1996) 11(1) *Violence and Victims*; G Devilly 'Clinical Intervention, Supportive Counselling and Therapeutic Methods: A Clarification and Direction for Restorative Treatment' (2002) 9(1) *International Review of Victimology*.

- sensitivity and understanding by public officials (including the judiciary), service providers and the media.[48]

The Review could not find any research that specifically considered the needs of victims where the accused person is found to be of unsound mind or unfit for trial.

Indigenous victims

The *Aboriginal and Torres Strait Islander Women's Taskforce on Violence Report*[49] and the *Cape York Justice Study*[50] detailed the often desperate position of victims of violent crime in rural and remote communities. Victimisation within many Indigenous communities is endemic and long-standing. Historical victimisation leading to the current state of social crisis in many communities has resulted in a level of emotional, psychological and spiritual need that is not being met. The needs of victims of crime are closely aligned with the needs of whole communities in relation to emotional and spiritual health. The inadequate or non-existent response by mainstream services to the immediate and long term needs of Indigenous victims of crime has been well documented.

What victims told the Review

The Review received submissions from 14 victims and family members of victims of violent crime where the perpetrator was found to be of unsound mind. Direct consultations were also held with 10 victims and family members and with non-government organisations providing services to victims of crime. Most victims who had contact with the Review were the victims of serious violent offences and their lives have been severely affected, if not devastated, by the offence.

Those who had been harmed more recently were among victims who approached the Review but there were others who were still traumatised by offences that occurred many years ago. Indeed, a number of matters involving victims giving information to the Review were dealt with prior to the commencement of the *Mental Health Act 2000*.

Most victims who gave information to the Review believe their experiences and their views were not acknowledged by the processes in the Mental Health Court and the Mental Health Review Tribunal. Like many victims in the criminal justice process, most believe their rights and needs were devalued and that the rights and needs of the defendant were seen as far more important. Many felt that they were treated with disrespect by public officials in the criminal justice system and in the mental health system:

> I was told by (a senior Queensland Health officer) to 'get over it'.

Most victims had no contact with the prosecutor in their case and had no support during the proceedings:

> I never met the prosecutor. I didn't even know his name.

Some were discouraged from attending the Mental Health Court hearing:

> I was told by (the ODPP Victim Liaison Officer) that it was best I didn't attend the hearing.

48 Australian Institute of Criminology (Cook B, David F and Grant A), Victims' Needs, Victims' Rights: Policy and Programs for Victims of Crime in Australia (1999) 40.

49 Queensland Department of Communities (Robertson B), *Aboriginal and Torres Strait Islander Women's Taskforce on Violence Report* (1999).

50 Queensland Department of Communities (T Fitzgerald), *Cape York Justice Study* (2001) http://www.communities.qld.gov.au/community/publications/capeyork.html.

Others commented on the lack of acknowledgement of victims' situations:

> It (the Mental Health Court hearing) was all about his care and future. His parents had support people with them. I had no one. It's really disgusting.

They felt their central involvement in the offence which resulted in the Mental Health Court hearing was discounted and felt distressed by the depersonalisation of the victim that occurred at the hearing. Family members of people who had been killed felt that there was no opportunity for their family member to be acknowledged as a real person during the proceedings.

Many victims did not understand why the prosecution did not proceed through the criminal courts. Some of these victims thought that the defendant was feigning mental illness and most believed that the determination of the defendant's mental state should be made by a judge and jury.

> It (the Mental Health Court hearing) is an emotionally traumatic and difficult time and it would lessen the stress involved with the process to be informed by the DPP beforehand what to expect. This would assist the development of the feeling that justice may prevail. It would also give the victims and their families a voice prior to the hearing and an opportunity to feel they are being heard.

A number of victims stated that once the defendant was referred to the Mental Health Court or transferred to an authorised mental health service, they no longer received any information about the progress of the matter or the location of the defendant.

> It was illogical that I could get information when (the defendant) was under the control of Corrective Services but not when (the defendant) was under the control of Queensland Health.

While most victims appreciated receiving information from the Mental Health Review Tribunal through the notification order process, those who were refused notification orders did not understand why that occurred.

Victims who were granted notification orders complained that, although they were notified of pending reviews by the Tribunal, they were not informed of the matters to be determined at the review and therefore found it difficult to prepare meaningful submissions to the Tribunal.

> The MHRT (Mental Health Review Tribunal) should be accountable for its decisions to victims as well as patients. If they choose not to take the information into account, victims should be informed of why and given an opportunity to modify their submissions for the next MHRT.

Some victims stated the vacuum of information about what might be considered at the six monthly reviews compelled them to lodge submissions on each occasion. To have to do this every six months was re-traumatising and stressful, particularly when they did not know what was being considered by the Tribunal and whether their submissions would be given any weight.

> Victims also have to make a submission … every six months. Every six months they are re-traumatised. Having participated in the notification process, I found it very distressing that I wasn't treated with the same respect and compassion as the patient even though I had harmed no one. I found it difficult to find the strength to reapply every six months, and to be consistently reminded that I was less important than someone I considered to be a dangerous criminal.

Some victims felt fearful of the patient and believed they should be told each time the patient was in the community on limited community treatment (LCT) and when the patient absconded.

Victims were concerned that they could not implement strategies to avoid accidental or intentional contact with the patient if they do not know when the patient is on LCT.

Most victims did not receive counselling and many were not referred to counselling services.

> I was never informed about the counselling support services available to me at that time so I cannot assess whether they are adequate.

Generally, these victims of very disturbing and violent crimes felt unacknowledged, unsupported, uninformed and unable to meaningfully contribute to the process. A number of victims told the Review that their contact with the Review was the first time a public official had listened to their stories.

> The patient's mental health is the priority, but the mental health of victims is given no consideration at all.
>
> I found the process very distressing, and intimidating and I felt the system was so focused on the rights of the patient that my rights were marginalised and my contribution was dismissed. I became so disheartened by how I was treated, that I would feel anxious every time I had to contact someone in the mental health system.
>
> It's very very hard to get information (about the Mental Health Court process), even just trying to get information from police about court dates. It's extremely daunting. You hit a brick wall all the time.
>
> It would have been good to have an organisation or person I could have talked with in person that is responsible for talking to victims and their families, assessing their needs, making the appropriate referrals to support services/counselling etc and informing them of the processes of the system. This person would be responsible for coordinating the transfer from agency to agency, be a single point of contact within the system to assist the victim with negotiating the system and informing them of the system's processes.[51]

The rights of victims

Growing international recognition of the rights and needs of victims of crime was confirmed in the 1985 *United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power*. During the 1980s and 1990s, all Australian jurisdictions introduced legislation implementing the UN Declaration.

The Queensland legislation is the COVA. The purpose of COVA is to advance the interests of victims of crime by stating some fundamental principles of justice that should be observed in dealing with victims of crime.[52]

COVA also sets out the compensation scheme for victims of crime against the person. The scheme includes a process for ex gratia payments by the State to victims where the alleged offender was found to be of unsound mind or not fit for trial under the *Mental Health Act 2000*.

Generally, the COVA principles recognise the right of victims to be treated with courtesy, compassion and respect, to have their privacy respected, to receive information about the progress of the matter through the criminal justice system, to be protected from violence or intimidation, to have their welfare considered throughout the process and to be given information about compensation and welfare, health and legal services for victims.

51 All quotations in this section are from written or verbal submissions from victims of crime or their families.
52 Criminal Offence Victims Act 1995 (Qld) s 4(2).

While many of the general COVA principles will be applicable to victims in matters where the accused person is found to be of unsound mind or unfit for trial, many specific references in COVA were drafted with the criminal trial and sentencing process in mind and are of no assistance to victims in mental health matters.

The following are examples of COVA principles that relate to criminal prosecutions and do not apply to victims where questions of unsoundness of mind or fitness for trial are raised in a reference to the Mental Health Court:

- The details of the harm caused to a victim are to be provided to the court during sentencing.
- Victims, on request, are to be provided with the reasons for a decision not to proceed with a charge or to accept a plea to a lesser charge.
- The victim of a crime involving personal violence should, on request, be advised of the length of the sentence imposed on the offender, further cumulative sentences imposed on the offender while in custody for the offence, the offender escaping from custody while under sentence and eligibility dates for staged release into the community, parole and final discharge of the sentence.
- The victim should be informed about provisions under the *Corrective Services Act 2000* and the *Penalties and Sentences Act 1992* relating to post-prison community based release and the *Juvenile Justice Act 1992* relating to the release of a child after a period of detention.

COVA makes no specific reference to provisions in the *Mental Health Act 2000* relating to the release of a forensic patient from an authorised mental health service. Because the COVA principles are directed to the criminal process and particularly to the sentencing of offenders they do not apply to matters that proceed through the Mental Health Court. These principles may provide a framework for providing information for victims where the person is found to be unfit for trial or of unsound mind. However, there are special considerations that distinguish mental health matters from matters before the criminal courts.

Persons dealt with under the *Mental Health Act 2000* are not criminally responsible for their acts and therefore not liable to punishment. To the extent that forensic patients' freedom is curtailed, the purpose of that curtailment is for their treatment and the protection of the community, not punishment. It follows that the interests of patients and their treatment needs, as well as the *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, are relevant considerations when decisions are made about releasing information to the victim.

The *Mental Health Act 2000* makes specific provision for victims in cases where the defendant has been referred to the Mental Health Court. While no general principles are stated in the Act about the treatment of victims, specific provisions enable submissions to be made by victims to the Mental Health Court and the Mental Health Review Tribunal and certain information to be provided to victims about decisions relating to forensic patients, including decisions granting patients limited community treatment and revoking forensic orders. Whether the provisions achieve an adequate balance between the rights of forensic patients and the rights of victims was the fundamental matter for consideration by the Review.

The general service system for victims

Victim services in Queensland

Service delivery to victims in Queensland is fragmented and appears to be largely uncoordinated. Despite having responsibility for COVA, the Department of Justice and Attorney-General does

not play a role in coordinating or monitoring the implementation of the rights of victims under that legislation by the multiple agencies that have contact with victims.

Victim services in Queensland are delivered by the Queensland Police Service (QPS), the Office of the Director of Public Prosecutions (ODPP), Legal Aid Queensland (LAQ), Queensland Health, the Mental Health Review Tribunal and the Department of Corrective Services and by a range of community-based agencies, funded mainly by the Department of Communities and Queensland Health.

The QPS does not have a dedicated unit to provide support and information to victims. However, individual investigating officers are responsible for victim support in accordance with the COVA principles.

The ODPP has a Victim Liaison Service (VLS) which employs Victim Liaison Officers (VLO) to provide information to victims of violent crime and to liaise with prosecutors. VLO notify victims of progress of the court proceedings and provide referrals to support and counselling services. The VLS does not provide counselling services and only occasionally provides court support services. Victims who are eligible for compensation are referred to Legal Aid Queensland or private solicitors. There are 12 VLO positions throughout the State. This is a decrease from the 16 officers in 2004-05. VLO can only provide limited services to victims. The caseload for 2004-05 across the 16 positions was approximately 6,300.[53] Most VLO do not have specialist qualifications and many are law students who see the position as a pathway into a legal career.

LAQ assists victims through its Victims of Crime Compensation Unit to apply to the court or to the Attorney-General for compensation for their injuries.

As a response to the recommendations of the Mullen Chettleburgh Report, in 2002 Queensland Health established a state-wide Victim Support Coordinator (QH VSC) position. The QH VSC provides a range of assistance and support services, including court support, to victims and their families in circumstances where a matter has been referred to the Mental Health Court or a forensic order is being reviewed by the Mental Health Review Tribunal.

As stated above, the Mental Health Review Tribunal is responsible for determining applications by victims and other persons for orders that they be notified of certain matters relating to a forensic patient and for providing the notifications. The ODPP refers victims to the Tribunal when it provides written advice to the victim of the decision of the Mental Health Court to place the defendant on a forensic order.

The Department of Corrective Services administers the Eligible Persons Register, formerly the Concerned Persons Register, the purpose of which is to enable the provision of information to victims about prisoners convicted of sexual and other violent offences.

Youth Justice Services in the Department of Communities administers a Victims Register for victims of sexual and other violent crimes committed by juveniles and provides restorative justice services through its youth justice conferencing program.

The Department of Communities provides grants to non-government organisations to provide a range of direct service interventions and community 'capacity-building' initiatives. Funding is provided to Relationships Australia Queensland for the Victims Counselling and Support Service which provides counselling and support to victims of crime and their family members who live in Queensland. The service has three components comprising:

53 Queensland Office of the Director of Public Prosecutions, *Office of the Director of Public Prosecutions Annual Report 2004-2005* (2005).

- a 24 hour 1300 telephone information and referral service
- face-to-face and telephone counselling
- community education and promotion.

Staff are based in Cairns, Townsville, Rockhampton, Sunshine Coast, Gold Coast, Logan, Eight Mile Plains, South Brisbane and Chermside. Brokered counselling is available in Ipswich, Toowoomba, Bundaberg and Mackay. An outreach service is available in Bowen, Airlie Beach, Proserpine and Hervey Bay. Relationships Australia Queensland is not funded to provide support for court hearings but counselling pre and post court proceedings is available.

The Department of Communities also funds the following non-government services:

- the Queensland Homicide Victims' Support Group provides peer support services for families of homicide victims, including regular peer support meetings, 24 hour telephone support, support at court hearings, newsletters and respite accommodation facilities
- the Central Queensland Community Legal Centre provides free generalist legal advice, community legal education and advocacy for victims
- Men affected by Rape and Sexual Abuse offers individual and group support to male victims
- Micah Projects provides counselling, support and advocacy for victims
- W WILD – Sexual Violence Prevention Association provides counselling, support and advocacy for victims.

The Department of Communities funds court assistance services throughout Queensland, which provide court support and information to women accessing magistrate courts for a protection order for domestic or family violence. Two of the court assistance services are specifically for Indigenous women.

Queensland Health funds specialist sexual assault services around the State. These services include a state-wide sexual assault hotline, counselling, support, medical care and referral services.

The Department of Child Safety funds Protect All Children Today (PACT) which provides services state-wide to children aged 3 to 17 years who are victims of, or witnesses to crime, and who are required to testify in court. Court support for child witnesses is provided by trained Court Witness Support Volunteers. PACT has almost 80 volunteers state-wide. Most clients are victims of sexual abuse. The service is also available to their (non-offending) family members. Therapy services are also available.

There is little formal systematic coordination between the various services for victims. Victim services have established an informal network, the Vision network, which meets quarterly to share information and consider ways of better coordinating service provision. The agencies involved include the ODPP, LAQ, QPS, the Department of Communities, the Department of Justice and Attorney-General, the Queensland Health Victim Support Co-ordinator, Relationships Australia Queensland, PACT, the Queensland Homicide Victims' Support Group, Bravehearts and the Department of Corrective Services.

The QPS operate a fax back arrangement with the Queensland Homicide Victims' Support Group to ensure immediate assistance and support is provided to the families of homicide victims. This appears to be operating effectively. However, there is no systematic approach between the police and other victim support services to ensure the timely provision of support to victims of other serious violent offences. Specifically, there is no systematic approach to

ensuring that victims are directed to the victim support services in cases where a criminal matter has been referred to the Mental Health Court.

Victim services in other jurisdictions

Broadly similar services to victims are offered in other Australian states and territories. All jurisdictions provide victim advisory and support services through a combination of government, community-based and volunteer resources.

Several states (New South Wales (NSW), Victoria, Western Australia (WA) and Tasmania) have a specialist victims unit or branch within the respective Justice Departments; for example, the Victim Services Bureau in NSW and the Victim Support Agency in Victoria. South Australia (SA) and the Australian Capital Territory (ACT) have a coordination unit or position. The unit/branch/coordinator supports their Department's central, 'lead agency' role. The Queensland Department of Justice and Attorney-General does not have an equivalent business unit.

The interstate Justice Departments are generally the primary funding body for community-based victim services, and their victims unit/branch provide a wide range of services, either directly or in conjunction with funded, community-based services. The units/coordinators also have service development, service coordination, policy development and ministerial advisory roles.

The functions of the 'Victims' Services' branch or unit in the larger jurisdictions include services provided directly to victims, often in conjunction with community-based service providers, such as:

- assessment and referral, which may comprise early intervention
- case management
- counselling and therapeutic service
- information and advice on legal procedures, services available, victims rights, often via the telephone helpline service
- emotional and other support, including face-to-face, home visits or via the telephone helpline
- court support
- advice and assistance in preparing victim impact statements for court and preparing compensation applications.

Other functions of such units include:

- coordination and integration of victim services provided by other agencies
- monitoring criminal justice agency compliance with victims charters
- administering counselling schemes
- training of service providers
- policy development and policy advice
- administrative support to compensation tribunals and advisory boards
- maintenance of service provider databases
- development and dissemination of information material (e.g. brochures, websites).

In Queensland some of the functions noted above, such as counselling/therapy services and a telephone advice and referral line are provided by Relationships Australia Queensland.

However, there is no lead agency that provides an easily identifiable access point and ensures the coordination of service provision to victims. Victims have reported being unaware of the range of services available to them.

Most jurisdictions (NSW, Victoria, WA, SA and ACT) have witness assistance services, usually located within the ODPP. The Queensland equivalent is the VLS in the ODPP, but the nature and range of services provided is far more limited than, for example, those provided by the NSW Witness Assistance Service to identified priority groups.

Victoria and South Australia have non-government, community-based court support services staffed largely by volunteers. In Queensland, PACT volunteers provide court support, primarily to child witnesses. Other, smaller services assist specific types of victims in court. Beyond the client groups of PACT and the smaller services there are many groups of victims who do not appear to have access to a court support service. These groups include adult victims of sexual assault, victims of serious violence, including victims of serious family violence, and some groups of vulnerable or special needs victims such as people with disabilities, the elderly or infirm, and people from culturally and linguistically diverse backgrounds.

Previous recommendations about services for victims in Queensland

In recent years, several reports have commented on the inadequacies of services for victims of crime in Queensland and have noted the need for improved witness support or victims' advisory services. While none of these reports made specific reference to the particular needs of victims where the accused person was found to be of unsound mind or unfit for trial, the problems identified generally in relation to victim services also impact on these victims.

The Queensland Law Reform Commission report *The receipt of evidence by Queensland courts: The evidence of children* recommended upgrading witness support, specifically suggesting a dedicated child witness support service.[54]

In 2000, the *Report of the Taskforce on Women and the Criminal Code* called for an 'appropriate agency' to take responsibility for court support for victims of violent crime, including state-wide coordination.[55] It also made recommendations that any review of COVA include consideration of amending the Act to place a definite obligation on public officials to inform victims of their rights, rather than waiting for victims to request information, and that a criminal justice agency be made responsible for the provision of this information. It recommended that 'those government agencies with responsibilities under COVA be adequately funded to fulfil those obligations'.[56]

In 2002, the *Cape York Justice Study* noted the ODPP VLS appeared to be significantly under-resourced.[57]

The Crime and Misconduct Commission (CMC) report *Seeking Justice: An Inquiry into how sexual offences are handled by the Queensland criminal justice system* in 2003 noted the realignment of the functions of the ODPP's victim service in 2001 as a result of a change in government funding in the 2000-01 financial year.[58] Previously the Victim Support Service provided support, including court support, information and referral services. The Service was renamed the Victim Liaison Service and no longer provides support services to victims. The

54 Queensland Law Reform Commission, *Receipt of Evidence by Queensland Courts: Evidence of Children*, Report No 55 (2000).

55 Queensland Department of Tourism, Fair Trading and Wine Industry Development, Office for Women, *Report of the Taskforce on Women and the Criminal Code* (1999) http://www.women.qld.gov.au/?id=75.

56 Ibid.

57 Queensland Department of Communities (T Fitzgerald), *Cape York Justice Study* (2001) http://www.communities.qld.gov.au/community/publications/capeyork.html.

58 Crime and Misconduct Commission, *Seeking Justice: An Inquiry into how sexual offences are handled by the Queensland criminal justice system* (2003).

Report recommended that the Department of Justice and Attorney-General formally review the roles and functions of the Victim Liaison Officers with a view to enhancing the response of the ODPP to complainants in sexual offence matters. This recommendation followed submissions to the CMC which criticised the response of the ODPP to victims of crime. In response to the CMC recommendation, the Department conducted an audit, which reported in August 2003, with the primary recommendation being no change to the service provided to victims involved in the prosecution process.

The 2002 *Report of the Coordinating Efforts to Address Violence Against Women Project*, a whole-of-government committee established to address some of the concerns raised by the Taskforce on Women and the Criminal Code, noted that there was still no clear lead agency with the responsibility of providing information to victims about their rights, COVA or the operation of the criminal justice system. The report recommended a working group be established to develop proposals for a coordinated response to victims and to investigate the feasibility of a victims' advisory unit.[59]

The Department of Justice and Attorney-General advises that these matters are being considered as part of the ongoing review of COVA. The review also incorporates consideration of the role of the Victim Liaison Service.

The current fragmented state of services available to victims results in many victims falling through the gaps with consequent costs to them and to society. For victims of crime where the defendant has a mental illness or an intellectual disability, the system is even more complex to negotiate. These victims are even more likely to be unacknowledged and unsupported.

Proposals for reform of the general services available to all victims of crime fall outside the Terms of Reference of this Review. Instead, the Review will focus on the specific needs of victims of crime where the offender has been diverted to the mental health system. However, the Review considers that improvements in coordination of the general service system would have significant benefits for these victims.

Provisions for victims in the Mental Health Act 2000

In 1999, during the development of the *Mental Health Act 2000*, Queensland Health undertook a consultation process specifically focussed on the role and rights of victims. The innovations described below were a result of that consultation.

In contrast to the *Mental Health Act 1974*, the *Mental Health Act 2000* contains provisions that are intended to provide victims of crime and their families with an opportunity to put their views forward and to have these considered by the Mental Health Court and the Mental Health Review Tribunal in a manner roughly equivalent to the opportunities provided to victims to make a victim impact statement at the sentencing of an offender in a criminal court.

A victim of crime can provide information to the Mental Health Court that is relevant to its decision, if it is not already before the Court. This could include information about the mental condition of the alleged offender when the offence was committed or the risk the victim believes the alleged offender represents to the victim or the victim's family.

A victim is also able to submit material to the Mental Health Review Tribunal for consideration in cases where the information is relevant to the decision. Information could be submitted

59 Department of Premier and Cabinet, *Report of the CEAVAW Project - Coordinating Efforts to Address Violence Against Women Project* (2002) http://www.women.qld.gov.au/?id=137.

when the Tribunal is deciding whether to approve limited community treatment (LCT) for the patient.

Only the Mental Health Court or the Mental Health Review Tribunal can approve LCT for forensic patients or revoke a forensic order. The test requires that the patient can only be released if the patient does not represent an unacceptable risk to his or her safety or the safety of others, having regard to the patient's mental illness or intellectual disability.

The Mental Health Court and the Tribunal are also obliged to consider whether as a condition of any approval for LCT, a patient must not have contact with a victim or another specific person. If any condition is breached, LCT can be revoked to ensure the person is immediately returned to the mental health facility. Police have powers to act in these circumstances, and have powers to search and enter premises.

Victims may also apply to the Tribunal for a notification order to inform them of forthcoming forensic order reviews and of the decisions made at these reviews.

The notification order mechanism is roughly parallel to the Eligible Persons Register operated by the Department of Corrective Services in relation to victims of violent or sexual crimes committed by prisoners.

The Explanatory Notes to the Mental Health Bill 2000 disclose that certain provisions were intended to ensure that the new Mental Health Review Tribunal would act as an independent review body taking into account the concerns of the community, including victims of crime.[60] The reforms that were intended to achieve this purpose included introducing community representation on the Tribunal panel for making decisions about the detention of a patient and providing capacity for the panel size to be increased up to five members in cases of greater concern, such as when a person has committed a violent offence or posed a potential danger to the community. The Explanatory Notes expressed the view that the Tribunal would act as a properly constituted independent review body that reflects community expectation more appropriately.

The Review is concerned that the practical implementation of the Act has not responded to the concerns of victims to the extent anticipated by the comments in the Explanatory Notes.

The purpose of the Act is stated in section 4 as follows:

> The purpose of this Act is to provide for the involuntary assessment and treatment, and the protection of persons (whether adults or minors) who have mental illnesses while at the same time safeguarding their rights.

Section 5 of the Act provides for the ways in which the purpose of the Act is to be achieved by:

(a) providing for the detention, examination, admission, assessment and treatment of persons having, or believed to have, a mental illness;

(b) establishing the Mental Health Review Tribunal to, among other things-

  (i) carry out reviews relating to involuntary patients; and

  (ii) hear applications to administer or perform particular treatments;

(c) establishing the Mental Health Court to, among other things, decide the state of mind of persons charged with criminal offences;

(d) providing for the making of arrangements for-

60 Explanatory Notes, Mental Health Bill 2000 (Qld) 9.

(i) the transfer to other States of involuntary patients; and

(ii) the transfer to Queensland of persons who have mental illnesses.

The understanding the Court and Tribunal have of the purpose of the Act may affect the way in which each of those bodies construe specific provisions and exercise their discretion in making orders which impact on the interests of victims.

The Tribunal's most recent Annual Report states its role in this way:

> The Tribunal is an independent statutory authority established under the *Mental Health Act 2000* to safeguard the rights of people receiving involuntary treatment for mental illness (treatment without consent) under the Act.[61]

This focus on safeguarding the rights of patients appropriately represents an important component of the Tribunal's role. However, if an emphasis on the rights of patients were applied to the exclusion of the interests of victims this would not achieve an appropriate balance and would be inconsistent with the intent expressed in the Explanatory Notes that the Tribunal take into account the concerns of the community, including victims of crime.

The Review favours amendment of the Act to incorporate a clear statement providing guidance to the Tribunal in how it should approach its role in regard to community protection and the interests of victims of crime. This can be best accomplished by an amendment to section 5 of the Act to add a further way in which the purpose of the Act might be achieved. An amendment in terms similar to the following is envisioned:

(e) providing for the detention, treatment and care of patients on a forensic order, taking into account the rights of patients, community protection and the needs of victims of crime.

Recommendation 3.1

That the provision stating how the purpose of the Mental Health Act 2000 is to be achieved be amended to provide that community protection and the needs of victims be taken into account in decisions relating to forensic patients.

As with proceedings in the ordinary criminal courts, victims are not parties to proceedings in the Mental Health Court. This means that they have no right to take an official part in the proceedings. Victims are not parties because in our criminal justice system it is the responsibility of the State to prosecute cases against people suspected of committing crimes. This is the same in all other similar jurisdictions. The interests of victims and of the community generally are represented in proceedings by the ODPP.

Submissions have suggested that it would not be appropriate for victims to be parties to these proceedings because the substantive criminal proceedings have not yet been finalised. The Mental Health Court may well order the criminal proceedings to continue and it would be inappropriate for potential witnesses in the subsequent criminal proceedings to be parties to the proceedings in the Mental Health Court.

Mullen Chettleburgh recommendations

In 2002, the Mullen Chettleburgh Report considered the position of victims where the perpetrator is a forensic patient and made five recommendations directly relevant to victims:

61 Mental Health Review Tribunal, *Mental Health Review Tribunal Annual Report 2006* (2006).

1) That the mechanisms available under the provisions of the Mental Health Act (2000) to allow victims to submit appropriate impact reports to the new Mental Health Court are implemented with regular monitoring to ensure that they remain effective. That these reports become part of the patient's record during the period of their compulsory treatment initiated by the court.

Fact sheets for victims about the Mental Health Court have been developed jointly by Queensland Health and the ODPP. The fact sheets are available on the website of the Department of Justice and Attorney-General. However, it is difficult to navigate the website to find these documents. The website does not have a direct link on the front page for victims of crime, other than a link to information about domestic violence. To obtain information, a victim must enter through the ODPP web page.

Clinicians have told the Review that non-party submissions by victims to the Mental Health Court are not forwarded to authorised mental health services to be included in patients' files. This has been confirmed by the Mental Health Court Registry which advised that it forwards these submissions to the Mental Health Review Tribunal, but not to treating teams. Clinicians have indicated that this information may be useful for treating teams in conducting risk assessments and developing risk management plans as well as assisting with the preparation of recommendations to the Tribunal about LCT and conditions. This is discussed further in this chapter.

2) That the equivalent of a Concerned Persons Register be established in respect of offenders deemed of unsound mind to allow victims appropriate information about the patients' placements and eventual discharge. The Notification Order provisions of the Mental Health Act (2000) which will be administered by the MHRT, would meet this recommendation. A review of the implementation and effectiveness of this provision should be undertaken within 12 months.

A review of the effectiveness of the notification order process was undertaken by the Mental Health Review Tribunal and reported on in its 2002-03 Annual Report. Questionnaires were distributed to people in whose favour notification orders had been made, patients the subject of those orders and their doctors. The questionnaire was designed to assess knowledge of the provisions and their individual level of satisfaction with the process. Questionnaires were completed by seven people granted notification orders, seven patients and eight doctors. Participants mainly reported:

> ... feeling dissatisfied with the information they receive … does not meet their needs to feel safe … for the most part feel unsupported … and some notifiees experience the process of notification itself as a re-traumatisation every six months ... [62]

Patients who responded in the main 'felt they were personally unaffected by the notification order'. The evaluation identified a number of matters for improvement but found, overall, that process requirements and timeframes for notification were being met.

3) That the new Mental Health Review Tribunal develop mechanisms to ensure that persons who have made a Notification Order are able to provide information to the Tribunal when considering the nature and scope of leaves.

Victims who have been granted notification orders are also able to make non-party submissions to the Tribunal when LCT for patients under forensic orders is reviewed. The Tribunal aims to provide advance notice of one month prior to the hearing and formal notice 7-10 days prior to the hearing.

62 Mental Health Review Tribunal, *Mental Health Review Tribunal Annual Report 2003* (2003).

4) That a culture be fostered in the forensic mental services which is aware of, and sensitive to, issues for victims. This could be advanced by education, engagement in research and participating in services for victims.

The QH VSC meets regularly with victims' groups/agencies, providing information and support to victims and their families. Training and education for forensic mental health service staff has commenced throughout the State with information sessions completed at Toowoomba, Royal Brisbane and Women's Hospital, The Park Centre for Mental Health, Warwick and the Princess Alexandria Hospital. The Review is not aware of any research on victims of crime in which Queensland Health has been involved.

5) That victims who have registered as concerned persons be promptly informed should the patient, who has harmed them in the past, abscond. This notification should be made by the police, and will be facilitated through the introduction of the Information Form which has recently been developed by Queensland Health and Queensland Police Services.

Queensland Health and the Queensland Police Service have developed protocols for informing victims when a patient is absent without permission. The 'authority to return patient' form completed by authorised mental health services and sent to the QPS when initiating absent without permission procedures includes sections to be completed if there is an assessed risk to others and other persons need to be notified. The police will inform the person that the patient is absent without permission. As discussed later in this chapter, authorised mental health services may not hold the contact details of victims and, consequently, improvements on this process are required. It should be noted that absent without permission information is not a category of information that can be released under a notification order.

Provision of information to victims prior to the Mental Health Court hearing

Access to information by victims

A defendant awaiting a hearing in the Mental Health Court may be released on bail, detained in an authorised mental health service, a prison or youth detention centre. The defendant may be transferred from a prison or youth detention centre to an authorised mental health service. If the defendant is detained in, or transferred to, an authorised mental health service, the defendant becomes a 'classified patient'. Under the Act, the Director of Mental Health may approve limited community treatment (LCT) for a classified patient.[63] These provisions apply to both adults and young people. Decision making about LCT for classified patients is discussed in more detail in chapter 6.

If the defendant is detained in an authorised mental health service, the victim is not told of this fact. The victim is also not told if the defendant is given LCT or absconds. This is because the information Queensland Health employees can provide is restricted under the confidentiality provisions of the *Health Services Act 1991,* which prevent disclosure of information if a person who is receiving a public sector health service could be identified from the information.[64] These provisions prevent disclosure to victims of any information about the defendant, including their status as an inpatient at an authorised mental health service.

The literature on victimology strongly indicates that the early provision of support and accurate information is fundamental to the prevention of re-traumatisation and the promotion of recovery.

63 *Mental Health Act 2000* (Qld) s 129(2)(b).
64 *Health Services Act 1991* (Qld) pt 7.

Because the defendant is a patient, the defendant is entitled to confidentiality in the same way as any other patient. While personal information about the defendant's health and treatment should be protected, the strict confidentiality provisions fail to recognise the needs of victims of crime. A better balance between the rights of patients and those of victims is necessary to protect the health of victims as well as patients.

What information should be provided to victims?

During the period between a person being charged and a determination being made by the Mental Health Court, victims have indicated that they need information about:

- whether the defendant is receiving treatment
- whether the defendant is detained as an inpatient or out in the community
- the Mental Health Court process and the forensic mental health system.

A number of victims have told the Review of the fear they felt during this period because they could not obtain any information about whether the defendant was detained or out in the community. Many victims feel that they should have the same access to information as victims in the criminal justice system who, under COVA, have the right to be told if the defendant is in custody, obtains bail or escapes from custody. The Corrective Services' Eligible Persons Register only applies to the release of information about prisoners convicted of a serious violent or sexual crime. However, a victim of a violent crime is usually told by police whether a defendant awaiting trial is in custody or on bail. Victims can also contact the Department of Corrective Services' 'Prisoner Location' phone line to enquire if a defendant awaiting trial is in custody and where the defendant is currently located.

It is appropriate for timely accurate information to be provided to victims at this early stage. The distress of victims is magnified by the lengthy delays in matters coming on for hearing in the Mental Health Court. Victims of crime committed by people with a mental illness or intellectual disability, like other victims of crime to whom COVA applies, need to know for their own safety and peace of mind whether the defendant is subject to some form of containment or is in the community while awaiting a Mental Health Court hearing.

However, in striking a balance between the legitimate needs of victims for information and the interests of defendants, it is necessary to acknowledge that Queensland Health bears a duty of care towards those defendants who are its patients.

For example, although others will not often threaten the safety of patients, the possibility cannot be excluded. A high level of security applies to persons entering as well as leaving prisons. The safety of a prison inmate need not be of concern when informing others of where the inmate is held. Most mental health facilities do not have equivalent controls on those entering the facility. For this reason, although information that a person is being treated in a mental health service may be safely released, the name of the facility where a patient is living and its address should not be released.

The defendant, like other medical patients, is entitled to expect his or her health information to be treated as confidential. Release of patient information should only occur when there is a compelling competing entitlement. Any information given should be limited to that which will enable a victim to be assured as to the level of the defendant's supervision and should not encompass information about treatment regimes other than information that the defendant has been granted escorted leave in the community or unescorted leave either on the hospital grounds or in the community. Likewise information about the conditions placed on limited community treatment should also be limited to those conditions relevant to the victim's need to

feel safe. This would include conditions relating to non-contact with the victim or their family or restricting the areas where the patient may go. It also may include conditions that the patient not use drugs or alcohol, but would not include conditions that the patient attend certain programs in community at specific times.

The Review has concluded that it is essential to remedy the denial of information to victims that presently occurs during the lengthy period before the Mental Health Court hearing. Because no determination of the case has been made by a court at this point it is appropriate that access to information be limited to the immediate victims; that is, a victim actually harmed and the immediate relatives of a deceased victim. It is proposed that a victims' register be created administratively to facilitate the provision of information. Legislative amendment will be necessary to allow the release of information presently treated as confidential under the *Health Services Act 1991*.

A number of victims have told the Review that, although they want to receive information about defendants, it can be distressing to receive the information as this can take victims back to the events of the offence. Under the *Corrective Services Act 2006*, victims may nominate another person or agency to receive the information on their behalf. This enables a trusted person or a victim support agency to provide the information to the victim in a supported environment or to only provide information if the nominee considers it necessary as instructed beforehand by the victim. This option should be available to victims where the defendant has been detained in an authorised mental health service.

Recommendation 3.2

That Queensland Health establish a victim register to facilitate the provision of information to victims in cases where the defendant is a classified patient detained in an authorised mental health service awaiting determination of a charge for an indictable offence.

Recommendation 3.3

That the following persons may apply to be registered to receive classified patient information:

- *the actual victim of the offence*
- *a member of the immediate family of a deceased victim (including siblings)*
- *the parent or guardian of a victim under the age of 18 or of a victim who has a legal incapacity.*

Recommendation 3.4

That the following information may be released to registered persons by Queensland Health:

- *the defendant is detained in an authorised mental health service, but the name and address of any place where the defendant is living is not to be released*
- *whether the defendant is granted limited community treatment (other than escorted leave on the grounds of the hospital), the conditions of limited community treatment relevant to the victim's need to feel safe, and any revocation of limited community treatment by the Director of Mental Health*
- *where the defendant is absent without permission from the authorised mental health service*
- *the defendant has been returned to a correctional facility or to court.*

Recommendation 3.5

That the Mental Health Act 2000 be amended to override the operation of section 62A of the Health Services Act 1991 to enable the disclosure of information to victims in the abovementioned circumstances.

How should information be released?

Under section 129(2) of the Act, the Director of Mental Health approves limited community treatment for classified patients. The Director also decides, under section 89 of the Act, whether a classified patient should be returned to custody or to court. Authorised mental health services are required under Queensland Health policy to notify the Director if a classified patient is absent without permission.[65] As the Director has access to information about the patient that may be relevant to the decision to be made about the release of information, it is appropriate for the Director of Mental Health to be the decision maker in relation to release of information to the victim.

However, the information should not be disclosed to a victim if the disclosure of the information is likely to cause serious harm to the health of the patient or endanger in a serious way the safety of the patient or another. This test broadly parallels the test that is applied under the *Corrective Services Act 2006* in deciding an application by a victim to be included on the Eligible Persons Register.

Not all classified patients have been charged with serious personal offences. Many charges relate to minor property offences. Some patients are only classified patients for a short period and are returned to custody or to the court. Some discretion should exist to avoid unnecessary disclosure of information in these cases. In considering whether to release information it would be appropriate for the Director of Mental Health to consider the nature and seriousness of the charges. However, it is anticipated that information would be released in all serious violent offence matters unless there is a likelihood of serious harm to the health of the patient or that safety is seriously endangered.

Given that information about a patient normally could not be disclosed under the *Health Services Act 1991*, it would be appropriate for the victim and his or her nominee to sign an undertaking that the victim will not disclose the information for public dissemination. As with the Corrective Services' Eligible Persons Register, if the undertaking is breached this would be cause to cease the release of the information to the victim.

Victims applying for information prior to a Mental Health Court hearing should have access to an internal process for reviewing a decision of the Director of Mental Health.

Recommendation 3.6

That the Director of Mental Health decide applications by victims to be registered to receive information about a classified patient who is on remand.

65 Queensland Health, Mental Health Branch, *MHA2000 - Patients absent without Permission flipchart - Classified* http://qheps.health.qld.gov.au/mhalu/documents/forms/pdf/26745.pdf.

Recommendation 3.7

That the Director of Mental Health may grant an application for registration he or she reasonably considers appropriate but must refuse an application if he or she reasonably believes that the disclosure of the information is likely to:

- *cause serious harm to the health of the patient, or*
- *endanger in a serious way the safety of the patient or another person.*

Recommendation 3.8

That the applicant may nominate a person or entity to receive information about a classified patient on their behalf.

Recommendation 3.9

That a victim seeking the release of information about a patient and the victim's nominee sign a declaration undertaking that he or she will not disclose, for public dissemination, any patient information disclosed to the victim. A breach of this undertaking may be cause for refusal to further disclose patient information to the victim or his or her nominee.

Recommendation 3.10

That Queensland Health enable victims who wish to complain about the decision of the Director of Mental Health to have access to an internal review mechanism.

Who should provide the information to victims?

It is vitally important that information is provided to victims in a way that fully explains the background and implications of the information. The forensic mental health system is a complex system using terminology which is unfamiliar to the general public. It is essential that the provision of information is provided in a manner that makes it understandable to victims. This could be done effectively through personal contact by an officer who has an understanding of the mental health system and a knowledge of and sensitivity to the needs of victims of crime.

The release of information to victims on the register should be in writing in conjunction with a personal explanation by an officer within Queensland Health whose specific function is to provide information and support to victims. This unit should also maintain the Victim Register. These officers would have relevant professional qualifications and experience in mental health as well as an understanding of victims' needs. The QH VSC established in 2002 as a result of the Mullen Chettleburgh Report is in an ideal position to be the conduit for the provision of this information. This process will also facilitate information back from the victim to the Director of Mental Health about any factors relating to the victim that the Director should consider when approving limited community treatment. Victims, particularly those who have a long standing relationship with the patient, may have information about the patient's history relevant to decisions about limited community treatment and the conditions that should be placed on limited community treatment.

During the year from 1 January 2005 to 31 December 2005, there were 118 classified patients who had not yet been sentenced. Of these, 55 patients were returned to court or to custody. As at 31 December 2005, four remained classified patients with no disposition. Of the 118 classified patients, 61 were charged with serious personal offences where there was likely to be a victim. Of these, 42 were classified patients for longer than one month. Victims are unlikely to require information in cases where the patient is only admitted for a brief period, such as less

than a month, to an authorised mental health service prior to their return to the criminal court or custody. In relation to patients charged with serious personal offences who are detained for longer periods, the Queensland Health Victim Support Service and the Director of Mental Health should make all attempts to identify the victims through the Queensland Police Service and the Office of the Director of Public Prosecutions to offer early support and information.

The current Queensland Health Victim Support Coordinator is a single position. Victims in regional areas outside of Brisbane have limited access to this service. The additional role of supporting victims prior to the Mental Health Court hearing and expanded state-wide coverage to enable more personal contact with victims across the State both before and after the Mental Health Court hearing will require an increase in resources. The role of the expanded Victim Support Service in Queensland Health is discussed further below.

Recommendation 3.11

That the Queensland Health Victim Support Service maintain the Victim Register and provide information to registered victims both personally and in writing, together with other information to assist victims to understand the context and implications of the information.

Recommendation 3.12

That where a classified patient charged with a serious sexual or other violent offence is detained in an authorised mental health service the Queensland Health Victim Support Service make all reasonable efforts to identify and contact the victim to offer early support and information.

Support for victims

As discussed earlier in this chapter, there is no coordinated service system in Queensland for ensuring victims of crime are provided with appropriate support at critical times. The main problem for victims of crime where the defendant's mental state is at issue is identifying a service that can assist them to understand and access the process in the Mental Health Court and the Mental Health Review Tribunal. The police usually refer homicide victims promptly to the Queensland Homicide Victims' Support Group. Other victims may or may not be referred by police to Relationships Australia Queensland for victim support and counselling. Both these organisations have indicated to the Review they have insufficient detailed knowledge of the forensic mental health system to adequately support victims through the court and tribunal processes.

In the absence of a central victims of crime service providing support and referral for victims of crime, such as the services in New South Wales and Victoria, having an adequate service within Queensland Health and improved referral pathways to that service is essential.

Queensland Health Victim Support Service

The victim support service currently provided by Queensland Health comprises a single officer, the Victim Support Coordinator (VSC). The VSC has a state-wide function but is physically located in Brisbane. Victims who have contact with the VSC generally report high satisfaction with the service. If victims are referred early in the process, the VSC can provide court support for Mental Health Court hearings. The VSC can also provide assistance with the preparation of applications to the Tribunal for notification orders and 'non-party' submissions. In addition, the VSC plays an important role in providing information about mental illness and the forensic mental health system and referral to counselling.

However, not all victims are referred to the VSC. The Review has spoken with a number of victims of serious violent offences who had not been told of the existence of the service at all or who had been involved in the Tribunal process for a lengthy period and had many contacts with Queensland Health personnel before they were referred to the VSC. By this time, victims are often angry, frustrated and distressed as they have been unable to get the information they need. The role of the QPS and the ODPP and referral pathways from these agencies is discussed further below.

The VSC, as a single officer, has limited capacity to provide services to victims living outside south east Queensland. Victims living in north Queensland, if they are referred to the VSC, can only receive services over the telephone or electronically. This may be sufficient for some people, but others will need personal contact.

Indigenous victims are particularly under-serviced. Aboriginal people and Torres Strait Islanders are overrepresented within the forensic patient population and the majority of victims of offences committed by these patients are Indigenous. The complexities of family and clan relationships, the shame associated with mental illness and the lack of culturally appropriate and physically accessible support services means that Indigenous victims are frequently unsupported outside of their families and friends.[66] Where family supports break down, there is often nowhere for victims to obtain professional help.

Consultations with mental health services and Indigenous services in north Queensland indicated that Indigenous patients, their families and victims have little knowledge and understanding of the forensic mental health system. None of the victims who have had notification orders made in their favour are Indigenous. It appears that Indigenous victims do not access the existing mechanisms for victim participation in Mental Health Court or Tribunal processes. A project conducted by Lynore Geia for Relationships Australia's Victim Counselling and Support Service in north Queensland in 2005 identified the following barriers to accessing victim support services:

- lack of knowledge of support services
- confidentiality and privacy issues in relation to Indigenous services
- fear of engaging with non-Indigenous organisations and non-Indigenous staff
- lack of transport to services
- lack of referral pathways between service providers
- lack of Indigenous staff in services
- victims' perceptions of what constituted 'crime' – i.e. the normalisation of criminal acts against family members.[67]

The report recommended the establishment of an Indigenous victims support service under the auspices of Relationships Australia. The Review has been advised that the Department of Communities has not acted on this recommendation.

Indigenous mental health worker positions have been established by Queensland Health in services across the State to support Indigenous consumers and their families and to liaise with the community. While there has been difficulty filling these positions, where workers have been employed, they may provide support to family members of the patient who are victims. It would be essential for a QH Victim Support Service to work with Indigenous mental health workers in providing information to family victims about mental illness, the forensic

66 Relationships Australia (L Geia), *Victims Counselling and Support Services: Indigenous Project Report* (2005) 9.
67 Ibid.

mental health system and their rights. It is also essential for the Service to collaborate closely with Indigenous organisations to develop training, resource materials and referral pathways to ensure appropriate supports and information are provided to Aboriginal and Torres Strait Islander victims.

The Review proposes that the role of the QH VSC be expanded to:

- manage the proposed scheme for the provision of information by Queensland Health to victims prior to a Mental Health Court hearing
- provide ongoing support and information to victims once a forensic order is made
- to provide greater geographic coverage of the service.

Currently, the QH VSC has a caseload of 20 to 30 clients. Work with individual clients increases in the periods before Mental Health Court sittings and Mental Health Review Tribunal hearings. It is anticipated that with earlier and improved referral processes, client caseloads will increase significantly. Accordingly it will be necessary to increase the number of professional and administrative staff providing the service. The service should have a physical presence in north Queensland. Officers with relevant professional qualifications who have experience working in forensic mental health should staff the Service.

The role of this service will be to:

- provide information to victims of crime in relation to classified patients, persons referred to the Mental Health Court and forensic patients in accordance with the proposed statutory scheme
- liaise with the Office of the Director of Mental Health to identify cases where there may be a victim of serious personal offences
- liaise with investigating police officers and the ODPP to identify victims of serious personal offences
- assist victims to prepare applications to the Director of Mental Health for information about defendants who are being detained as classified patients
- with victims' consent, provide information to the Director of Mental Health and treating teams about the circumstances of the offences and the impact of the offences on the victims and victims' views on conditions for limited community treatment
- provide support, in consultation with the ODPP, to victims prior to and during Mental Health Court hearings. This may include assistance with the preparation of a 'victim statement' and attendance at the hearing to support the victim
- provide information to victims about mental illness and the forensic mental health system
- assist victims with understanding the processes and outcomes of Mental Health Court and Mental Health Review Tribunal hearings
- assist victims to apply to the Mental Health Review Tribunal for information about forensic patients
- in consultation with the Attorney-General's representative, assist victims to prepare victim statements for reviews by the Mental Health Review Tribunal
- facilitate the provision of information between the victim and the Attorney-General's representative for the purpose of reviews
- facilitate the provision of counselling or treatment for victims

- collaborate closely with Elders, Indigenous health organisations and Indigenous mental health workers, particularly in north Queensland, to provide information and support to Aboriginal and Torres Strait Islander victims
- promote the service to agencies, such as QPS, ODPP, LAQ, Relationships Australia Queensland, the Queensland Homicide Victims' Support Group, the Department of Corrective Services, the Department of Communities, the Department of Child Safety and other agencies that may come into contact with victims to ensure early referral of victims to the QH VSS.

Recommendation 3.13

That Queensland Health, building on the current position and role of the Victim Support Coordinator, establish a state-wide Victim Support Service to:

- *provide information and support to victims of crime in relation to classified patients, persons referred to the Mental Health Court and forensic patients in accordance with the proposed scheme*
- *assist victims with negotiating the processes and understanding the outcomes of Mental Health Court and the Mental Health Review Tribunal proceedings*
- *raise awareness and understanding of the needs of victims with staff of authorised mental health services and the Mental Health Review Tribunal*
- *collaborate with Indigenous health organisations and workers in the provision of information and support to Aboriginal and Torres Strait Islander victims*
- *promote coordination of the provision of services to victims of crime where the perpetrator has been diverted to the forensic mental health system.*

Recommendation 3.14

That the Victim Support Service be staffed by professional officers with experience working in forensic mental health and by sufficient administrative staff to support the professional officers. The Service should be physically located in Brisbane and in either Townsville or Cairns. The north Queensland service should have a strong focus on Aboriginal and Torres Strait Islander victims of crime and be provided in a culturally appropriate way. The Service should work in collaboration with Indigenous organisations, Indigenous mental health workers and the Victim Counselling and Support Service of Relationships Australia. Sufficient resources should be available to provide training to health workers in victim support in rural and remote communities and to assist with transport costs for victims.

Referral pathways

The key agencies for referral of victims to the QH Victim Support Service (QH VSS) would be the QPS and the ODPP. Currently, most referrals are made to the QH VSC by the ODPP after a matter has been referred to the Mental Health Court.

However, there are a number of problems with this process. First, there are often lengthy delays before a formal reference is made. As discussed above, victims may need to be referred to the QH VSS prior to a reference being made where the defendant is detained in an authorised mental health service. The reasons for delays and recommendations for addressing this issue are set out in chapter 4. Secondly, the ODPP Victim Liaison Service often has difficulties in

identifying the victim from the material provided by police. Unless the victim is also a witness, the identity of the victim may not be clear from the material.[68]

Recommendation 3.15

That Queensland Health, the Office of the Director of Public Prosecutions and the Queensland Police Service, develop protocols for the identification and early referral of victims by police or the Office of the Director of Public Prosecutions to the Queensland Health Victim Support Service where the defendant is detained in an authorised mental health service for assessment of the defendant's mental state in relation to the offence or is referred to the Mental Health Court.

Recommendation 3.16

That Queensland Health and Queensland Police Service investigate the possibility of establishing a 'fax back' system for the referral of victims to the Victim Support Service similar to the process currently in place between the Homicide Investigation Squad and the Queensland Homicide Victims' Support Group.

Recommendation 3.17

That the Office of the Director of Public Prosecutions include in its template letters sent to victims in Mental Health Court matters and in Mental Health Court fact sheets the contact details for the Queensland Health Victim Support Coordinator and, once it is established, the Queensland Health Victims' Support Service.

Provision of information by victims to the Mental Health Court

Many victims have a fundamental need for their own recovery to tell their story and for the impact of the offence on them to be acknowledged and affirmed. The introduction of Victim Impact Statements in the criminal courts and the victim provisions in the *Mental Health Act 2000* are an attempt to meet this need in the criminal justice system and the forensic mental health system.

Under the Act,[69] people who are not parties to the proceedings, including victims and their families, may make submissions to the Mental Health Court when it is making decisions on references. This could include information about the mental condition of the alleged offender at the time of the offence or the risk the victim believes the alleged offender poses to the victim and his or her family. The material may be accepted into evidence if the Court decides the material is relevant to its decision and the information is not already before the Court. The ability for persons who are not parties to a hearing to make submissions to the Court is an innovation in the *Mental Health Act 2000* which was not available under the previous legislation.

The *Mental Health Act 2000*, refers to material submitted by 'non-parties'. This has resulted in the common use of the expression 'non-party submission'. It has been suggested by a number of stakeholders that use of the term 'non-party' makes victims feel marginalised in the proceedings and that their experiences and interests are peripheral.

Submissions to the Review have suggested that the name of a non-party submission be changed to 'Victim Impact Statement' similar to ordinary criminal proceedings. The word 'non-

68 Queensland Office of the Director of Public Prosecutions, *Preliminary submission to the Review of the Mental Health Act 2000* (2006).

69 *Mental Health Act 2000* (Qld) s 284.

party', however, is used to describe these submissions because the category of people able to make submissions is not limited to victims. Any person who is not already a party to the proceeding may make a submission to the Court and the submission may be accepted into evidence by the Court, if the Court decides the material is relevant to its decision and the information is not already before it. Carers or relatives of the person appearing before the Mental Health Court are the other category of people who may have relevant information for the Court about the person's behaviour. It should be noted that in the majority of cases before the Court involving a serious violent offence, a carer, relative or other person known to the defendant will also be the victim of the offence.

Legislation in Victoria, the Northern Territory, Tasmania and South Australia contain similar provisions enabling victims and the defendant's next-of-kin to provide reports to the court in relation to the type of forensic order or the conditions that should be placed on an order. There are no specific provisions in legislation in New South Wales, Western Australia or New Zealand.

The Review proposes that use of the term 'non-party' be discontinued and the particular position of victims be recognised in the legislation but that this recognition not restrict the categories of persons able to make submissions to the Mental Health Court.

Recommendation 3.18

That the Mental Health Act 2000 be amended to delete reference to the term 'non-party' and instead refer to a statement by a victim or interested person, in recognition of the particular position of victims of crime.

Unlike legislation in other States,[70] the *Mental Health Act 2000* does not state the purpose of 'non-party' submissions. Material submitted by a person who is not a party to the proceeding may be relevant to one or more of the following matters the Court may be required to determine:

- whether there is reasonable doubt the defendant committed the acts forming the basis of the offence
- whether a fact that is substantially material to the opinion of an expert witness is in dispute
- whether the defendant was of unsound of mind
- whether the defendant charged with murder was of diminished responsibility
- whether the defendant is fit for trial
- whether a forensic order should be made for a defendant found to be of unsound mind or permanently unfit for trial
- whether limited community treatment should be ordered, approved or revoked for a person placed on a forensic order
- what conditions should be placed on an order for limited community treatment
- whether a non-contact order should be made if the Court decides not to place the defendant on a forensic order.

The Review considers it would be helpful both to the Court and the victim or interested person for the Act to contain more guidance on the purpose of the statement and on what matters the statement should include. The views of the victim or interested person on matters relevant to the decisions of the Court should be the focus of the statement. The 'views' of a victim or

70 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 42; *Criminal Law Consolidation Act 1935* (SA) s 269R; *Criminal Code Act* (NT) s 42ZL; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 33.

interested person will incorporate both information and representations which the victim or interested person may wish to provide or make.

The amendment of section 284 to outline the purpose of a statement and what it may contain will remove the need to include an explicit test of relevance. In addition the new provision should not prohibit the inclusion of information already before the Court.

Recommendation 3.19

That section 284 of the Mental Health Act 2000 be amended to provide that a victim or an interested person may make a statement to the Mental Health Court for the purpose of assisting the Court in making a decision on a reference, including a decision:

- *whether or not the person was of unsound mind or is unfit for trial*
- *whether or not to make a forensic order*
- *whether to order*
- *approve or revoke limited community treatment*
- *as to any conditions the Court may impose on an order for limited community treatment.*

Recommendation 3.20

That the Mental Health Act 2000 be amended to provide that a statement by a victim or an interested person contain the views of the victim or interested person on:

- *the conduct of the person the subject of the proceeding and the impact of that conduct on the victim or the interested person*
- *the risk the victim or interested person believes the person the subject of the proceeding represents to the victim or the interested person or another person*
- *any matters relevant to the decisions the Court may make.*

The Court should give the statement such weight as it considers appropriate.

Recommendation 3.21

That the Mental Health Act 2000 provide that a statement by a victim or interested person be sworn and submitted to the Court through a party to the proceeding.

Section 285 of the *Mental Health Act 2000* requires the Mental Health Court, in its decision on a reference, to give reasons for receiving in evidence, or refusing to receive in evidence, material submitted by persons who are not party to the proceedings. This is an important provision for victims – it is a formal way for their views as well as the harm that was done to them to be acknowledged, particularly as the main focus of proceedings in the Court is on the mental state of the defendant rather than the facts of the case, which have already been agreed upon by the parties. As the recommendations above remove the requirements in relation to a decision of the Court as to whether to receive the statement in evidence or not, section 285 should also be amended.

Recommendation 3.22

That section 285 of the Mental Health Act 2000 be amended to require the Mental Health Court, in its decision on a reference, to give reasons for:

- *taking into account a victim statement or an interested person statement and how the statement was taken into account, or*
- *refusing to take into account a victim statement or an interested person statement.*

Provision of information by victims to the treating team

In compiling the section 238 report or their report for the Mental Health Review Tribunal, the treating team do not receive information about the victim's concerns or needs.

Often, the treating team will have limited access to information placed before the Mental Health Court and may not have sufficient information about the details of the original offence.

The Mullen Chettleburgh Report recommended that victim statements provided to the Mental Health Court should become part of the patient's record. There does not appear to be any process in place to ensure this occurs. The Mental Health Court registry has confirmed that it does forward any victim statements to the Mental Health Review Tribunal but not to treating teams. However, there is no explicit power in the Act to enable the registry to provide victim statements to either the Tribunal or the treating teams.[71]

Clinicians have told the Review that information from the victim could assist the treating team when considering LCT options. If the treating team is aware of specific issues that the victim is concerned about, the treating team will be in a better position to request that appropriate conditions be placed on the patient's LCT. On the other hand, some victims who are concerned about their safety may not feel confident sharing personal information with the patient's treating team.

In chapter 4, the provision of the police brief, including witness statements, to the authorised mental health service is discussed. However, the victim may also wish to provide information to the authorised mental health service prior to the Mental Health Court hearing. The QH VSS could facilitate the flow of this information to the treating team.

Recommendation 3.23

That the Mental Health Act 2000 be amended to enable the Mental Health Court registry to provide a copy of any victim or interested person statement to the authorised mental health service and to the Mental Health Review Tribunal, unless the Court orders to the contrary.

Recommendation 3.24

That, with the consent of the victim, the Queensland Health Victim Support Service, prior to the Mental Health Court hearing, facilitate the provision to the treating team of written information from the victim about the circumstances of the offence, the impact of the offence on the victim and the victim's views on conditions for limited community treatment.

71 Under section 318 of the *Mental Health Act 2000* (Qld), an expert's report received in evidence by the Mental Health Court may be given to an authorised mental health service or the Tribunal.

Support for victims prior to and at the Mental Health Court hearing

Information provided to victims about the Mental Health Court process

Once a matter is referred to the Mental Health Court, carriage of the matter is transferred from the police to the ODPP. On behalf of the community, the ODPP prosecutes people charged with serious criminal offences. The duty of a prosecutor is to act fairly and impartially to assist the court to arrive at the truth.[72] It is not the role of the prosecutor to represent the victim in criminal proceedings in the way that the defence lawyer represents the accused person. The role of the ODPP in Mental Health Court proceedings, as in other criminal proceedings, is to assist the Court in making its determinations.

The ODPP provides information and referral services to victims of violent crime through its Victim Liaison Service (VLS). Victim Liaison Officers (VLO) provide information to victims of crime, notify victims of the progress of court proceedings, provide referrals to support and counselling services and liaise with prosecutors. The VLS does not provide counselling services and only occasionally provides court support services or assistance in preparing submissions to the Mental Health Court.

Letters are sent to victims when the matter is referred to the Mental Health Court providing information about proceedings in the Court, when the matter is listed for hearing, advising the hearing date and when the matter is determined by the Mental Health Court, advising the outcomes of the hearing. The template letters are formal, provide minimal information about the process or about other victim services and do not encourage victims to contact the VLO. The ODPP advised the Review that there is a very low response rate to these letters.[73]

In response to the Mullen Chettleburgh Review, Queensland Health and the ODPP developed a number of fact sheets about the Mental Health Court which, as mentioned above, are available at the ODPP page on the Department of Justice and Attorney-General's website.

Victims have suggested that a comprehensive kit containing information about the process of a reference to the Mental Health Court, its jurisdiction and procedures and the procedures and jurisdiction of the Mental Health Review Tribunal would be useful in assisting victims to understand the process. It is difficult for victims who are traumatised to understand and remember information told to them verbally on one occasion. Victims have said it is important to have written information which they can refer to when needed as well as someone they can contact to get further information and an explanation.

Recommendation 3.25

That, in consultation with the Queensland Health Victim Support Coordinator, the Office of the Director of Public Prosecutions review the template letters to victims involved in Mental Health Court matters to ensure the information contained in those letters is accurate, understandable and sensitive to victims' needs.

72 Department of Justice and Attorney-General, Office of the Director of Public Prosecutions' website http://www.justice.qld.gov.au/odpp/home.htm.

73 Queensland Office of the Director of Public Prosecutions, *Preliminary submission to the Review of the Mental Health Act 2000* (2006).

Recommendation 3.26

That Queensland Health, the Office of the Director of Public Prosecutions, the Mental Health Court and the Mental Health Review Tribunal review the Mental Health Court fact sheets with a view to developing a comprehensive kit for victims containing a step by step explanation in plain English of the process through the criminal courts, the Mental Health Court and the Mental Health Review Tribunal, contact details for counselling and support agencies and relevant forms such as the application for registration and templates or guidelines for statements to the Court.

Preparation for the Mental Health Court hearing

Currently the ODPP VLS does not usually assist victims to prepare material for the Mental Health Court, although the material is submitted to the Court through the ODPP. If the victim has been referred to the QH VSC, that officer may assist the victim to prepare his or her submission.

Submissions that are relevant are much more likely to be accepted and given weight by the Court. People who are not parties to the proceedings are not provided with copies of the other material being submitted to the Court. Given that the prosecutor has all the material, it would make sense for the ODPP through the VLO, in consultation with the Queensland Health VSS, to assist victims in the preparation of their material. In relation to victims in criminal matters, ODPP guidelines provide that it is the responsibility of the case lawyer to ensure that the Victim Impact Statement, where the victim has indicated a wish to provide such a statement, is prepared. This may be delegated to the VLO. There does not appear to be a similar requirement for Mental Health Court matters.[74]

Currently prosecutors do not usually meet with victims in Mental Health Court matters. This is mainly because the victims are not witnesses in these proceedings. Also, prosecutors are usually not assigned to matters until close to the hearing date leaving little time to prioritise information provision to victims. Victims would be much better informed about the case if prosecutors met with them to explain the reasons for the reference, the jurisdiction of the Court and the possible outcomes of the hearing and to provide assistance in the preparation of submissions.

Another difficulty is that it may be problematic from an evidentiary viewpoint for victims who are witnesses in the criminal proceedings to attend Mental Health Court hearings if the matter is returned to the criminal courts for trial as the victim may learn of the evidence of other witnesses. Meeting with the prosecutor prior to the hearing may assist victims in making an informed choice about whether to attend the hearing.

The ODPP has acknowledged the fundamental importance of their role in the Mental Health Court and the Mental Health Review Tribunal:

> … to ensure community confidence in these important institutions, the community must be assured of continued vigilance of the community's interest. This is the ODPP's fundamental role in the MHC (Mental Health Court) and also in the MHRT (as the Attorney-General's representative). This role includes both ensuring the issue of community protection is given proper consideration and to doing what can be done to inform victims of crime regarding references to the MHC.

74 Queensland Office of the Director of Public Prosecutions, *Procedures for Implementing the Fundamental Principles of Justice for Victims of Crime as stated in the Criminal Offence Victims Act 1995 (Qld) & other relevant legislation* (2005).

The ODPP recognises the fundamental importance of its role and also acknowledges that the existing arrangements can be improved.[75]

The Review is of the view that there is a need for increased resources to be assigned to Mental Health Court matters to allow a Senior Crown Prosecutor to be engaged in these proceedings in a more substantial way, including engaging with the victim and with investigating police earlier than is currently the case. This will assist in ensuring that all relevant material, including a proper presentation of the facts of the case, is before the Court. It would be of benefit to victims and to proceedings in the Court for an agreed statement of facts to be prepared with defence counsel in consultation with the victim as early as possible after the reference. Earlier engagement in the case will also enable an increased focus on preparation of submissions in relation to the making of a forensic order and orders for LCT, including appropriate conditions.

Recommendation 3.27

That the Office of the Director of Public Prosecutions be resourced to allow for the assignment of a Senior Crown Prosecutor to Mental Health Court matters sufficiently early to enable greater engagement of the Queensland Police Service and the victim in the preparation for the hearing.

Recommendation 3.28

That, in references involving serious sexual or other violent offences, the Office of the Director of Public Prosecutions and the defendant's legal representative be encouraged to prepare at an early time an agreed statement of facts for use by court appointed examining psychiatrists and in the Mental Health Court hearing.

Recommendation 3.29

That prosecutors be available to meet with victims of serious sexual or other violent offences prior to and after the Mental Health Court hearing to explain the jurisdiction and processes of the Court, to obtain information about the circumstances of the offence and relevant information about the defendant, to check the agreed statement of facts with the victim and to explain the implications of possible outcomes and the actual outcome.

Recommendation 3.30

That the Office of the Director of Public Prosecutions, in consultation with the Queensland Health Victim Support Service, assist victims to prepare victim statements for the Mental Health Court, ensure that these statements are produced to the Court and ensure that the attention of the Court is drawn to the requirements of section 285 of the Mental Health Act 2000.

Recommendation 3.31

That the Office of the Director of Public Prosecutions, on request, provide a copy of the Mental Health Court decision to the victim and, where transcripts are ordered by the Court, make a copy available to the victim.

75 Queensland Office of the Director of Public Prosecutions, *Preliminary submission to the Review of the Mental Health Act 2000* (2006).

Court support

Victims have complained about the lack of support during hearings in the Mental Health Court. While most victims of crime do not receive court support services, victims who are also witnesses in criminal trials will have more contact with the ODPP. Given the relatively small number of these matters and the fact that the QH VSC already provides court support services to some victims, the QH VSS, in consultation with the ODPP, should provide court support to those victims who request this service. Those providing court support should ensure the victim has a safe place to await the commencement of the hearing and that out of court contact between the victim and the defendant is avoided.

Recommendation 3.32

That the Queensland Health Victim Support Service, through liaison with the Office of the Director of Public Prosecutions, provide court support services to victims who request such support.

Physical environment at the court

As noted in the Discussion Paper, a number of victims have told the Review that it is very difficult to hear what is being said in the court rooms where the Mental Health Court sits. The Department of Justice and Attorney-General has advised the Review that the problem with amplification has now been rectified.

Provision of information to victims after a forensic order is made

Access to information by victims

The current arrangements

Once the Mental Health Court places a defendant on a forensic order, the Mental Health Review Tribunal must review the patient's mental condition at least every six months.[76]

In order to receive information about the forensic patient the victim must apply to the Mental Health Review Tribunal for a 'notification order'. A notification order enables one or more of the following types of information to be provided:

- when a review is to be carried out
- a decision made on a review by the Tribunal
- an approval that the patient move out of Queensland
- an order that the patient be transferred from one authorised mental health service to another
- the transfer, under an interstate agreement, of the patient to another State.[77]

Anyone may apply for a notification order. However, for the Tribunal to make the order, it must firstly be satisfied that the applicant has a 'sufficient personal interest'. In deciding whether a person has a 'sufficient personal interest', the Tribunal must consider:

- whether the patient represents a risk to the safety of the person for whom the order is made

76 *Mental Health Act 2000* (Qld) s 200.
77 *Mental Health Act 2000* (Qld) s 221.

- whether it is likely the patient will come into contact with the person
- the nature and seriousness of the offence that led to the patient becoming a forensic patient.[78]

If the Tribunal is satisfied the applicant has a 'sufficient personal interest', it must then consider the following matters in order to determine whether to make a notification order:

- the grounds of the application for the order
- whether as a consequence of the order the patient's treatment or rehabilitation is likely to be adversely affected
- the patient's views
- other matters the Tribunal considers appropriate.[79]

The notification order provisions are rarely used. Since the Tribunal commenced in 2002, there have been:

- twenty-three applications for a notification order, 18 applications were granted, 5 were not granted
- seven notification orders initiated by the Tribunal
- four applications made to vary the order (one order was varied, one order was revoked and two orders remained the same).

The Tribunal is currently administering 23 notification orders. All of the orders have been made in favour of surviving victims or relatives of deceased or surviving victims. Eighteen orders relate to Persons of Special Notification (PSN).[80]

Victims have objected to the 'two tiered process', where the Tribunal determines whether the applicant has a 'sufficient personal interest' and then whether to make a notification order. Victims who are fearful and concerned about release of the patient to the community because of the traumatic experience they endured, question why they should have to justify their entitlement to receive information.

Proposed arrangements

The Review considers that the notification order provisions should be repealed and a new process for providing information to victims be instituted. It is proposed that a Victim Register be maintained by the Queensland Health Victim Support Service and that information should be provided to registered persons by that Service.

The Review considered whether it would be appropriate to remove decision making about the provision of information to victims from the Tribunal and locate it in an administrative unit within Queensland Health in a similar way to the Eligible Persons Register in the Department of Corrective Services. This proposal would have meant that, as with the Corrective Services register, the Director-General would have discretion to decide whether to enter a person on the register and to provide information to that person. Notification orders can currently be made in favour of persons other than the victim, provided they can establish a sufficient personal interest. This may include family members of surviving victims and family members of patients. These people should continue to have the same opportunity to obtain information. The Review does not propose to narrow the current arrangements. Because a range of people are able

78 *Mental Health Act 2000* (Qld) s 223.
79 *Mental Health Act 2000* (Qld) s 224(2).
80 Data obtained from the Mental Health Review Tribunal, October 2006.

to apply for information, it would not be appropriate to give information without examining the reasons for the person wanting the information and the circumstances of the patient.

While victims of crime are victims regardless of whether the perpetrator is convicted and sentenced, the position of forensic patients cannot be equated to that of sentenced prisoners. Although there is agreement that a forensic patient committed the acts for which they were charged, a forensic patient has been found not to be criminally responsible for those acts or has been found unfit to stand trial because of his or her mental impairment. It is a community and government responsibility to provide quality treatment and rehabilitation services for people with mental illness to assist them to recover and rejoin the community safely. As for all health service consumers, mental health patients, including forensic patients, are entitled to expect that details of their illness and treatment will be kept confidential. However, with forensic patients who have committed violent offences, consideration must also be given to the safety and health needs of victims. A careful balancing between the needs and interests of patients and victims must occur. Administrative arrangements may not be the most appropriate way for the balancing of complex and competing interests to occur, particularly where decision making on relevant matters such as LCT resides with an independent tribunal. The Review therefore proposes to retain decision making about the release of information with the Mental Health Review Tribunal.

The Review considers that the appropriate balance between considerations of the needs and interests of victims and patients is not achieved under the current legislation. Actual victims and immediate family members of deceased victims or of child victims should not have to establish a sufficient personal interest. For many of these victims, whether the patient represents an ongoing objective risk to their safety or whether it is likely the patient will come into contact with them as determined by others is irrelevant to their very real need for assurance of their safety. Further, the considerations set out in section 224(2) of the Act are weighted in favour of the interests of the patient.

It is proposed that the Mental Health Review Tribunal determine applications from persons to be placed on the register for the receipt of patient information. The legislation should be amended to grant to actual victims, the relatives of deceased victims and the parents or guardians of victims who are children or are under a legal disability, eligibility as of right to receive information without the need to establish a sufficient personal interest. However, an application should not be granted if the Tribunal reasonably believes the release of the information to the person is likely to cause serious harm to the health of the patient or another person or put the safety of the patient or someone else at serious risk. This provision broadly parallels a similar provision in the *Corrective Services Act 2006*.[81]

Other persons who wish to receive information will need to establish a sufficient personal interest. However, the matters the Tribunal should consider when determining a sufficient personal interest should be altered to include considerations of the health and welfare of the applicant as well as the patient.

Currently, there is no appeal against a decision by the Tribunal on an application for a notification order or a variation of a notification order. The Discussion Paper raised the issue of whether there should be an appeal right. Since commencement of the Act there have been 18 applications granted, seven applications initiated by the Tribunal and five applications refused. Given the limited discretion the Tribunal will have under the proposed reforms in relation to applications for registration by actual victims and family members of deceased victims, the likely consequence is that there will be less refusals and the necessity to provide a commensurate right of appeal to patients. Therefore, the Review considers that, on balance,

81 *Corrective Services Act 2006* (Qld) s 323(2).

it would be preferable to maintain the current position. The Review is also mindful that any appeal would have to be to a Supreme Court judge and would be a legalistic and expensive undertaking.

It is not proposed to significantly alter the categories of information that may be released under a notification order. The primary changes proposed are the addition of the following categories of information:

- the patient is absent without permission and the subsequent return of the patient
- the patient has died.

It is also proposed that escorted limited community treatment on the grounds of the authorised mental health service not be released. Victims are most interested in being advised of when the patient has LCT in the community or unsupervised LCT. It is therefore considered unnecessary to release information about supervised on ground leave.

Some victims indicated to the Review they would like to know each time the patient is on LCT as well as the decision approving LCT and the category of LCT. The Review considered this suggestion but came to the conclusion that it would be impractical. While the Tribunal makes the decision authorising LCT, the specific times the patient has LCT is determined by the patient's psychiatrist often only shortly beforehand. A patient's planned LCT for a specific time may also be cancelled at any time if the psychiatrist is of the view that the patient is not well enough. It should also be noted that victims on the Corrective Services register are not told each time a prisoner has leave.

A number of victims have told the Review that, although they want to receive information about impending reviews and review decisions, it is often distressing to receive the information as this can take victims back to the events of the offence. Under the *Corrective Services Act 2006*, victims may nominate another person or agency to receive the information on their behalf. This enables a trusted person or a victim support agency to provide the information to the victim in a supported environment or to only provide information if the nominee considers it necessary as instructed beforehand by the victim. This option should be available to victims where the defendant has been diverted to the mental health system.

As with the release of information by the Director of Mental Health prior to the making of a forensic order, it is proposed that applicants and nominees sign undertakings not to disclose the information for public dissemination. A breach of this undertaking may be grounds for revocation of the notification order by the Tribunal.

Recommendation 3.33

That a register to facilitate the provision to victims and other eligible persons of information about patients on forensic orders, be established by Queensland Health and maintained by the Queensland Health Victim Support Service.

Recommendation 3.34

That the following persons may apply to be registered to receive information about a forensic patient:

- *the actual victim of the offence with which the forensic patient was charged*
- *if the victim is deceased, an immediate family member of the deceased victim*
- *if the victim is under 18 years or has a legal disability, the victim's parent or guardian*
- *another person who satisfies the Tribunal that the person has a sufficient personal interest in being informed.*

Recommendation 3.35

That the following information about a forensic patient may be released by Queensland Health to registered persons:

- *when a review for the patient is to be carried out*
- *an order for or approving limited community treatment for the patient (other than escorted leave on the grounds of the hospital), the conditions of the limited community treatment relevant to the victim's need to feel safe, and an order revoking an order or approval for limited community treatment*
- *the patient is absent without permission from the authorised mental health service and the subsequent return of the patient*
- *an order that the patient be transferred from one authorised mental health service to another*
- *an order approving that the patient move to another State or an approval that the patient transfer, under an interstate agreement, to another State*
- *the death of the patient, but not the cause of death*
- *the revocation of the forensic order.*

The name and address of any place where the patient is living must not be released.

Recommendation 3.36

That section 221 of the Mental Health Act 2000 be amended to provide that the Mental Health Review Tribunal may decide applications for registration by victims or persons with a sufficient personal interest.

The following persons do not have to establish a sufficient personal interest:

- *the actual victim of the offence with which the forensic patient was charged*
- *if the victim is deceased, an immediate family member of the deceased victim*
- *if the victim is under 18 years or has a legal disability, the victim's parent or guardian.*

In determining whether other persons have a sufficient personal interest, the Tribunal must have regard to the following matters:

- *the nature, seriousness and circumstances of the offence that led to the patient becoming a forensic patient*
- *the impact the refusal to grant the order is likely to have on the health, safety and welfare of the applicant*
- *whether the making of the order is likely to have a significant adverse affect on the patient's treatment or rehabilitation*
- *any other matters the Tribunal considers appropriate.*

Examples of people who may have a sufficient personal interest are:

- *a person who was with the victim when the offence was committed*
- *a personal attorney or personal guardian of the patient*
- *a family member, or dependent, of the victim*
- *a family member, carer or dependant of the patient.*

The Tribunal must refuse an application for registration if it reasonably believes the release of that patient information to the applicant is likely to:

- *cause serious harm to the health of the patient, or*
- *endanger in a serious way the safety of the patient or another person.*

The Tribunal must refuse an application if it is satisfied the application is frivolous or vexatious.

The Tribunal may refuse an application for registration or revoke registration if the Tribunal:

- *reasonably suspects the applicant, or the applicant's nominee, has disclosed, for public dissemination, any patient information released under the Act, after providing the applicant with an opportunity to show cause why the registration should be made or should not be revoked*
- *is unable, after making reasonable efforts, to contact the applicant.*

Recommendation 3.37

That the applicant may nominate a person or entity to receive information about a forensic patient on their behalf.

Recommendation 3.38

That the applicant and his or her nominee sign a declaration undertaking that he or she will not disclose, for public dissemination, any patient information disclosed to the victim. A breach of this undertaking may be cause for refusal to further disclose patient information to the applicant or his or her nominee.

How should the information be provided?

Many victims have told the Review that they considered correspondence advising them of Mental Health Review Tribunal decisions to be officious and insensitive to their concerns. There is a real danger that legalistic written explanations, however correct they may be, may be perceived to be offensive and unhelpful by persons suffering from personal injury or loss. Most people would find many of the facts and concepts involved to be unfamiliar and difficult to comprehend without a personal explanation given in plain English. Relying on this correspondence as the only source of information for victims, may destroy their trust in the legitimacy of the system and increase their fears.

It is therefore proposed that the QH VSS maintain the register and be responsible for the actual provision of the information to persons registered by decision of the Tribunal. This process will enable the information to be provided in a supportive manner and in a way that places the decision or information in context. This process is also appropriate as the source of information that may be released is not always a decision of the Tribunal or within the immediate knowledge of the Tribunal. For example, the Tribunal will not immediately know if a patient is absent without permission, has died or has been transferred, under an interstate agreement, to another State. The Director of Mental Health will hold this information and can provide it to the QH VSS.

Recommendation 3.39

That the Queensland Health Victim Support Service provide patient information both personally and in writing to the registered person or the nominee, together with other information to assist victims to understand the context and implications of the information.

Recommendation 3.40

That, if required, legislative amendments be made to ensure the information to be released under an order to release patient information is provided to the Queensland Health Victim Support Service by the Mental Health Review Tribunal and the Director of Mental Health.

Provision of information by victims to the Mental Health Review Tribunal

As in Mental Health Court proceedings, people who are not parties to the proceedings, including victims and their families, may submit material to the Tribunal for consideration on review of a forensic order. For example, the Tribunal may consider the views of victims and their families when considering what conditions to place on LCT. Because review hearings are not notified publicly, in practice, the only people likely to make submissions are those who have applied for and obtained notification orders.

As with the Court, the Tribunal may not take the material into account if it considers it is not relevant to the decision or the information is already before the Tribunal.[82] Again, as with the Court, the purpose of 'non-party' submissions to the Tribunal is not stated in the Act.

82 *Mental Health Act 2000* (Qld) s 464(1).

In deciding the weight to give the material, the Tribunal must consider the following:

- whether the forensic patient has had sufficient opportunity to examine and reply to the material;
- material previously submitted by the person;
- the circumstances of the offence; and
- any other matters the Tribunal considers relevant.[83]

This explicit requirement for consideration of these matters will not be necessary if the purpose of submissions is clearly stated in the Act. Acordingly, it is proposed that section 464(1) and section 464(3) be replaced by provisions outlining the purpose of a statement and what a statement may contain. This will remove the need for an explicit test of relevance. In addition, the provisions should not prohibit the inclusion of information already before the Court. The requirement for natural justice to be accorded to the patient is sufficient to ensure the patient has had an opportunity to examine and reply to the material.

Recommendation 3.41

That, in relation to Mental Health Review Tribunal proceedings, the Mental Health Act 2000 be amended to delete reference to the term 'non-party' and instead refer to a statement by a victim or interested person, in recognition of the particular position of victims of crime.

Recommendation 3.42

That section 464 of the Mental Health Act 2000 be amended to provide that a victim of crime or other interested person may make a statement to the Mental Health Review Tribunal for the purpose of assisting the Tribunal in making a decision on a review for a forensic patient, including a decision:

- *whether to revoke a forensic order*
- *whether to order, approve or revoke limited community treatment*
- *as to any conditions the Tribunal may impose on an order for limited community treatment.*

Recommendation 3.43

That the Mental Health Act 2000 be amended to provide that a statement by the victim or other interested person is to contain the views of the victim or interested person on:

- *the conduct of the person the subject of the proceeding and the impact of that conduct on the victim or interested person*
- *the risk the victim or interested person believes the person subject to the proceeding represents to the victim or interested person or another person*
- *any matters relevant to the decisions that the Mental Health Review Tribunal may make.*

The Tribunal should give the statement such weight as it considers appropriate.

Unlike the requirements for non-party submissions in the Mental Health Court, there is no requirement for a submission to the Tribunal to be sworn. Patients and their families have expressed concerns that the information put forward by victims is not tested and that they are not told by the Tribunal how much influence the submissions made by victims have on the

83 *Mental Health Act 2000* (Qld) s 464(2).

Tribunal's decisions. Consumer and carer advocates have told the Review that patients are often reluctant to voice their concerns to the Tribunal about 'non-party' submissions because the decisions made by the Tribunal affect their future and they are do not want to jeopardise their chances of being granted LCT.

Victims and their families have also indicated that they are uncertain about whether their submissions are taken into account, or about the weight the Tribunal gives their submissions. After making a decision about whether or not to take into account a 'non-party' submission, the Tribunal is only required to provide reasons for that decision to the person who submitted the material or to a party if asked to do so.[84] It is possible that unsupported victims will not know they have a right to make a request to be advised of the reasons for a decision.

While it may be onerous for the Tribunal to have to supply reasons to all the parties when they may not have a desire or need to receive such reasons, the Review considers that where a statement has been freshly submitted by a victim or an interested person, the victim or other person should be provided with reasons as a matter of course. Otherwise, the Tribunal should continue to provide reasons on request.

Recommendation 3.44

That the statement provided to the Mental Health Review Tribunal by the victim or other interested person be sworn.

Recommendation 3.45

That the Mental Health Act 2000 be amended to provide that where a victim or interested person has made a fresh statement to the Mental Health Review Tribunal on a review, the Tribunal be required to provide to the victim or interested person, as a matter of course, a statement of reasons for:

- *taking into account a victim statement or an interested person statement and how the statement was taken into account, or*
- *refusing to take into account a victim statement or an interested person statement.*

Support for victims

The QH VSC currently provides assistance to victims in preparing applications for notification orders and submissions for Tribunal reviews. The proposed QH VSS should continue this role by assisting victims to make an application to be placed on the register and, in consultation with the ODPP, to prepare a victim statement.

Although a person with a notification order is told of an impending review, he or she is not informed of the matters to be considered at the review. Because of the frequent late lodgement of reports by treating teams, the Tribunal itself may not be aware of the orders being sought until the day of the hearing.[85] Recommendations are made in chapter 4 to promote earlier provision of clinical reports and other material for Tribunal reviews to enable the Attorney-General's representative to properly prepare for the hearing. The QH VSS should consult with the Attorney-General's representative when assisting victims to prepare a statement to ensure the statement addresses the matters to be considered at the hearing. At present, a non-party statement is usually provided to the Attorney-General's representative and the patient at the

84 *Mental Health Act 2000* (Qld) s 465(2).

85 In 2005-2006, over 50% of clinical reports were received by the Tribunal on the day of the hearing or not received at all (Mental Health Review Tribunal, *Mental Health Review Tribunal Annual Report 2006* (2006) 34).

Tribunal hearing. The Attorney-General's representative needs to have earlier access to a copy of any statement by a victim or an interested person to enable him or her to put the views of the victim or interested person to the Tribunal at the hearing where this is appropriate. This can be best achieved through the victim consenting to it being provided at an early to the Attorney-General's representative. This can be facilitated by the QH VSS.

In many cases the victim's earlier statements will have included all the information the victim can usefully provide. However, victims need to feel confident that their earlier statements will be considered as part of the material before the Tribunal on any subsequent hearing. The Tribunal currently advises victims that this is so. Nevertheless, many are fearful that their voice will not be heard if they do not submit a further statement, however distressing that process might be. Victims are likely to be assisted by an opportunity to speak to counsel appearing for the Attorney-General to obtain reassurance that their concerns and earlier statements will be canvassed in a subsequent hearing. The provision by the Tribunal of reasons acknowledging the attention the Tribunal has given the victim's statement would also assist. Victims should be encouraged to include in a statement a request that it be considered in any future reviews and also request that reasons be provided on each occasion. This could be facilitated by the preparation by the Victim Support Service of an appropriate form for completion by victims.

Recommendation 3.46

That the Queensland Health Victim Support Service provide assistance to victims in preparing applications for registration to receive information about a forensic patient.

Recommendation 3.47

That the Queensland Health Victim Support Service, in consultation with the Attorney-General's representative, assist victims in the preparation of a victim statement for a Mental Health Review Tribunal review.

Recommendation 3.48

That the Queensland Health Victim Support Service, with the consent of the victim, facilitate the provision to the Attorney-General's representative at an early time of a copy of any victim statement for a review.

Recommendation 3.49

That the Queensland Health Victim Support Service facilitate pre-hearing contact between the victim and the Attorney-General's representative if requested by the victim.

Victims and their families have also voiced concern that the process of making a submission every six months (or more frequently if the patient makes an earlier application for review) is often traumatic and causes them to relive the offence. Some victims feel the process of constantly rewriting their objections is time consuming and unnecessary because their opinion about the incident and their feelings towards the patient remain unchanged. Many victims feel that they would only have additional things to say if there was a proposed change in the patient's status or leave arrangements.

Consideration has been given to whether the regular review should be extended beyond six months or whether patients' ability to make an application for review outside their scheduled reviews could be restricted. Many submissions have emphasised that to do this may reduce the effectiveness of the supervision provided by the regular independent review of the patient's treatment by the Tribunal or in some cases unfairly impact on patients. The Review is reluctant

to devalue the safeguard provided by independent review. It is considered that the provision of sufficient and appropriate supports to victims through the QH VSS and the Attorney-General's representative should assist in addressing this issue for victims without restricting the existing rights of patients.

Confidentiality orders

Under the present legislation an application for a notification order may be decided by the Mental Health Review Tribunal during a review hearing, at a hearing specifically conducted for the application or by the President on written material without the need to convene a hearing. The Tribunal is required by section 224(2) of the Act to consider the patient's views when deciding whether to make an order.

There is an expectation at common law that a decision-maker such as the Tribunal or the President extend procedural fairness to a person whose rights, interests or legitimate expectations are affected by a decision. Ordinarily, this will require disclosure to an affected person of adverse information that is credible, relevant and significant to the decision.[86] Generally the person must be given an opportunity to respond to adverse information. In the context of an application for a notification order it would usually be necessary for the decision-maker to advise the patient of the application and who the applicant is so the patient has the opportunity to make submissions in respect to the matters that are relevant to the decision of the Tribunal or the President.

The common law requirement of procedural fairness may be excluded by legislation and it is usual in an Act of this type for there to be provision for the making of confidentiality orders. The *Mental Health Act 2000* provides for such an order to be made by the Tribunal under section 458.

In addition to the common law rules in relation to procedural fairness, section 459 of the *Mental Health Act 2000* has a specific statutory provision requiring the Tribunal to observe natural justice at a hearing. However, section 459(5) provides that the making of a confidentiality order may displace this requirement. While an application for a notification order may be heard by way of hearing, in the majority of cases the matter will be determined by the President on the written material without the need for a hearing. In the latter case, it is doubtful that the provisions of section 459 would apply to the application.

There is no specific provision stating that the making of a confidentiality order may displace the requirement in section 224 that the Tribunal consider the patient's views. However, section 458 specifically provides that a confidentiality order may be made in respect to an application for a notification order. The Review has been informed of a case in which the Tribunal has taken the view that a confidentiality order is not able to displace the requirement to consult the patient on an application. The Tribunal concluded that it was not possible to withhold from the patient the identity of an applicant for a notification order. The Tribunal's conclusion would appear to correctly apply the Act as it is presently worded. For a victim who does not want the patient to be advised that they have applied for or received a notification order, the entitlement to apply for a confidentiality order is effectively valueless. The Review recommendations on the amendment of the existing notification order provision have removed the explicit requirement for the patient's views to be taken into account. This should resolve the problem encountered in this particular case by allowing a confidentiality order to override the requirements of natural justice.

86 *GM v Guardianship Tribunal* [2003] NSWADTAP 59.

In general patients have a right to have confidentiality of information about them maintained. This is recognised in section 8(i) of the Act. However, as discussed earlier in the report, it is necessary for there to be a limited imposition upon patients' rights in some situations where victims' legitimate interests are in competition. In order to balance these competing rights, the Review has recommended that limited objective information about the patient should be made available to victims and to other persons who are able to establish a sufficient personal interest.

The further issue arises as to whether or not the patient in all cases should be advised that an application for a notification order has been made or granted and advised of the identity of the applicant.

The current Act allows a confidentiality order to be made prohibiting or restricting the disclosure to the patient of information given before the Tribunal, matters contained in documents filed with or received by it and reasons for decision. It is not clear whether the identity of a person making an application falls within the categories within section 458(1). It would be appropriate to clarify that the identity of such a person does fall within the section.

The section provides that the Tribunal may make a confidentiality order only if it is satisfied that disclosure would either cause serious harm to the health of the person or patient or put the safety of someone else at serious risk. This sets the test at a high level.

The Review has learnt of at least one victim who has declined to proceed with an application for a notification order because to do so would necessitate the patient learning of the application. As discussed earlier, many victims of serious violent offences, including the relatives of deceased victims, are understandably highly fearful of the person who caused the injury. Although sometimes these fears may seem unfounded to an objective observer in full possession of all relevant information, they are nevertheless real and impacting on the person's quality of life. The provision of information reassuring a victim that the patient continues to be monitored and treated by a responsible agency may make an important contribution to allaying their fears. However, for some people the knowledge that their application for information will be communicated to the patient is likely to merely exacerbate their fears. The Review considers that once again this is an area where a fine balance must be struck between the competing interests of the patient and the victim.

The Review considers that, having regard to the limited categories of objective information about the patient it has recommended be released, the balance should be struck in favour of providing a confidentiality order, so long as a proper basis has been laid. It is generally preferable that patients be advised of an application and for that reason applicants should not be encouraged to make unnecessary requests for confidentiality orders. Accordingly, the Review proposes that there should be a test requiring the Tribunal to be satisfied it is likely that disclosure to the patient would have an adverse effect upon the applicant.

Recommendation 3.50

That the Act be amended to enable a confidentiality order to be made in respect of an application for registration to receive information if the Mental Health Review Tribunal is satisfied that disclosing the identity of the applicant and the grounds of the application to the patient is likely to have an adverse effect on the physical or mental health of the applicant, or the patient, or place the safety of the applicant, the patient, or another person at risk.

Counselling for victims

As mentioned earlier in this chapter, the Department of Communities funds Relationships Australia Queensland to provide the Victim Counselling and Support Service. This service includes a 24 hour helpline.

Relationships Australia does not keep data on the number of victims it services where the offender has been referred to the Mental Health Court. During the Review, Relationships Australia conducted a snapshot survey over two months of callers whose enquiries converted into counselling sessions to identify the number of victims where the offence was committed by someone with a diagnosed mental illness or where the matter was referred to the Mental Health Court. Approximately 16% of respondents stated that the offender had a diagnosed mental illness and approximately 8.5% stated that the matter had been referred to the Mental Health Court. This represents a significant proportion of clients. While Relationships Australia acknowledges that victims of crime in circumstances where the defendant is referred to the Mental Health Court face additional distress over and above that of other victims, counsellors employed by Relationships Australia do not have specific training in the forensic mental health system. The effectiveness of the service could be enhanced with this training. Relationships Australia is currently funded on a 12 month basis until June 2007. Any service funded in the future should be funded to enable special attention to be given to victims where the offender is diverted to the forensic mental health system. There should be a specialist position within the service to act as a reference point for counsellors in the service and for contact with Queensland Health Victim Support Service.

Referrals of victims to the Victim Counselling and Support Service of Relationships Australia appear to occur on an ad hoc basis. As the research indicates that early intervention provides the best outcome for victims, there should be standardised referral processes to counselling.

Recommendation 3.51

That the Department of Communities review the service it funds to provide counselling and support to victims of crime to ensure that future arrangements incorporate a specialist position focussing on victims in cases where the offender is diverted to the mental health system. This position will act as a reference point for counsellors in the service and for contact with the Queensland Health Victim Support Service.

Recommendation 3.52

That the Queensland Health Victim Support Service and the Victim Counselling and Support Service in Relationships Australia develop training or information packages for counsellors and staff of the helpline to ensure they have an understanding of the forensic mental health system and the implications for victims where a defendant has been referred to the Mental Health Court and are able to refer victims appropriately.

Recommendation 3.53

That the Queensland Police Service, the Office of the Director of Public Prosecutions, the Queensland Health Victim Support Service and services funded by the Department of Communities to provide counselling to victims of crime, develop protocols for the referral of victims to counselling services as early as possible.

Conferencing

Submissions from some patients, carers and victims have indicated that they are interested in meeting with each other to resolve issues that exist between them. In appropriate circumstances, this process has the potential for achieving significant therapeutic benefits for both the victim and the patient. It can enable victims to play a central role in the process, compared with their participation earlier on in the process where they feel marginalised.

Some patients have indicated that it is important for them to resolve issues relating to the incident. Some patients also feel that they need to explain to the victim or their family what happened and the steps they have taken to recover. This is in keeping with the principles of Queensland Health's *Sharing Responsibility for Recovery* policy document:

> Recovery occurs when people are empowered to take ownership and play an active role in their own recovery process.[87]

A skilled facilitator would be integral to these interactions. It would also be necessary for all parties to be willing participants, for the patient to be sufficiently well and for the victim and the patient to be well supported throughout the process.

The Review considers that conferencing is an option that should be explored. The Victim Support Service should consult with authorised mental health services, forensic patients and consumer consultants, victims and victim support agencies, the Dispute Resolution Branch in the Department of Justice and Attorney-General and Youth Justice in the Department of Communities with a view to implementing a process to facilitate conferencing in suitable cases.

Recommendation 3.54

That the Queensland Health Victim Support Service explore options for the appropriate provision of voluntary conferencing between victims and forensic patients.

87 Queensland Health, *Sharing responsibility for recovery: creating and sustaining recovery oriented systems of care for mental health* (2005) 12.

CHAPTER 4 – THE FORENSIC MENTAL HEALTH LEGAL PROCESS

The Terms of Reference for the Review required that legislative and administrative arrangements be examined in respect to their impact on victims of crime and community protection.

The Review has been alerted to concerns about considerable delays occurring in matters reaching resolution in the Mental Health Court (the Court). These delays can have an adverse impact on both defendants and victims. This period soon after the offence is often the time of greatest stress and anguish for victims who have suffered severe personal injury or have lost a loved one. Victims of crime, defendants and the community all have an interest in matters being resolved expeditiously and in a transparent manner. The Review considers that a variety of factors are contributing to the existence of delays in the period between when a person is charged and when their matter is heard in the Court.

This chapter discusses improvements that can be made to the legislative and administrative processes to reduce delay and enhance proceedings by:

- improving the supply of information to decision makers
- decreasing the number of cases that are unnecessarily referred to the Mental Health Court
- avoiding double handling
- reducing Court backlogs
- clarifying and enhancing the role of the Attorney-General in Mental Health Review Tribunal proceedings
- expanding Mental Health Review Tribunal panel membership to include broad community representation.

The period up until the Mental Health Court hearing

Reducing delays in referrals for certain involuntary patients

The *Mental Health Act 2000* (the Act) provides that if a person charged with a criminal offence is under an involuntary treatment order or a forensic order, the administrator of the treating health service must immediately advise the Director of Mental Health. If the Director agrees, the administrator of the authorised mental health service arranges for the patient to be examined by a psychiatrist.

The psychiatrist is required to provide a report (the section 238 report) on the patient's mental condition which the administrator must give to the Director within 21 days. The psychiatrist must have regard to a number of factors in examining the person including:

- the patient's mental condition
- the relationship, if any, between the patient's mental illness and the alleged offence, and in particular, the patient's mental capacity when the alleged offence was committed
- the likely duration of the patient's mental illness and the likely outcome of the patient's treatment
- the patient's fitness for trial.

The report is used by the Director of Mental Health to assess whether it is appropriate to refer the matter to the Attorney-General (for a less serious matter) or to the Mental Health Court.

If the Director refers the matter to the Attorney-General, the Attorney-General is required to decide whether the matter is continued, discontinued or referred to the Mental Health Court.[88]

In the majority of cases, the 21 day statutory timeframe is not being met. During 2004-05, only 24% of reports were being provided to the Director of Mental Health within the 21 day statutory timeframe.[89] The Director has implemented reporting measures to monitor the delay in the provision of these reports. Despite these measures, during 2005-06 there was a slight decrease in the number of reports being provided within the statutory timeframe to 21%. In part, this slight decrease may be attributable to the increase in the number of reports requested. During 2005-06, 670 reports were requested, compared to 568 reports during 2004-05.

Time taken to provide section 238 reports

Timeframe	2004/2005	2005/2006
Reports provided within statutory timeframes	24%	21%
Average outstanding report (days)	197	161
Maximum outstanding report (days)	363	359
Median outstanding report (days)	205	135
Number of reports requested	568	670

The impact of overdue reports in further contributing to delays in proceedings is concerning and unsatisfactory. More proactive administrative leadership and management are required.

Recommendation 4.1

That Queensland Health establish a process to ensure accountability of administration for compliance with the requirements of the Mental Health Act 2000 in relation to the provision of section 238 reports within statutory time frames.

Recommendation 4.2

That the Director of Mental Health:

- *ensures administrators of authorised mental health services are promptly informed of delays in the provision of section 238 reports; and*
- *provide audit outcomes on the timeliness of these reports to administrators and to the Director-General, Queensland Health.*

Following the receipt of the section 238 report, the Director is then required to refer the patient either to the Attorney-General or to the Mental Health Court within 14 days.[90] However, the statistics from the *Annual Report of the Director of Mental Health 2005* indicate the time taken by the Director to refer these matters has also increased beyond the 14 day statutory timeframe. One of the main reasons for the additional time taken by the Director is the inadequacy of the reports. Recommendations discussed in the sections below will help to address quality and timeliness issues relating to the provision of the section 238 reports.

88 *Mental Health Act 2000* (Qld) s 247.
89 Director of Mental Health, *Annual Report of the Director of Mental Health 2005* (2005) 30.
90 *Mental Health Act 2000* (Qld) s 240(2).

Time taken by the Director to refer matters

Director's Referral to:	2004/2005 Average length (days)	2005/2006 Average length (days)
Attorney-General	15	26
Mental Health Court	25	32
Total (average)	20	29

Time taken by the Attorney-General to make a decision

If the Director of Mental Health refers a matter to the Attorney-General, the Attorney-General is required to decide within 28 days whether to:

- continue proceedings according to law
- discontinue proceedings
- refer the matter of the patient's mental condition to the Mental Health Court.[91]

In the 2005-06 year, the Attorney-General referred four matters to the Mental Health Court.[92]

Reasons for the delays and factors to address them

There can be little doubt that in part the delays are attributable to staff turnover and to work pressure on psychiatrists. The Director's annual report indicates that another problem is delay in receiving information from the Queensland Police Service (QPS) and the Office of the Director of Public Prosecutions (ODPP).[93] The Review has been advised section 238 reports are often prepared in the absence of detailed particulars of the circumstances of the offence from the police, relying solely on the account of events by the patient and possibly the patient's family. It appears there is no systematic process for the provision of the offence particulars to authorised mental health services. The preparation of quality section 238 reports is dependent on prompt access to information held by police including witness statements and criminal histories of patients.

Submissions from the QPS indicate there are legislative barriers which prevent QPS from passing this information to the Director of Mental Health or Queensland Health (QH).[94] A Memorandum of Understanding exists between QH and the QPS but it is focussed on the provision of information by QH to QPS in mental health crisis situations. The Memorandum of Understanding contains an undertaking that parties agree to explore legislative and policy options to enhance information sharing.[95] The QPS has recommended that legislative amendment be made to remove the legislative barriers preventing QPS from providing the relevant information to the treating psychiatrist for the purpose of a section 238 report. This is supported by the Review and needs to be undertaken as a matter of priority.

To enhance information sharing, a standard procedure for transferring information across the State between QH and QPS at the local level is necessary. Consideration needs to be given to ensuring that this procedure is practical and enables information to be provided by QPS

91 *Mental Health Act 2000* (Qld) s 247.
92 Data regarding the time taken by the Attorney-General to make a decision on a reference was received days before the end of the Review and was not able to be analysed.
93 Director of Mental Health, *Annual Report of The Director of Mental Health 2005* (2005) 30.
94 *Police Services Administration Act 1990* (Qld).
95 Queensland Health and Queensland Police Service, *Memorandum of Understanding between The State of Queensland through Queensland Health and The State of Queensland through the Queensland Police Service Mental Health Collaboration* (2005) (signed 03/04/2006) 5.

officers to the authorised mental health service in a timely manner. The Mullen Chettleburgh report recommended that:

> … each District mental health service and police region create liaison positions to provide a single contact point for raising concerns between the services. Regular meetings should be held between the liaison personnel (recommendation 7).[96]

An appropriate position for providing this information may be the QPS Mental Health Intervention District Co-ordinator. QPS has appointed 11 Mental Health Intervention District Co-ordinators to assist with mental health issues. The appointments were made as part of the Mental Health Intervention Project, which commenced in January 2006. These QPS officers have received training in mental health case management and have the rank of Sergeant or Senior Sergeant. They work closely with the Queensland Health Mental Health Co-ordinators and the Queensland Ambulance Service's Mental Health Co-ordinators, to develop intervention strategies for people with a mental illness who have been brought to police attention. Three additional Mental Health Intervention District Co-ordinators will be appointed before July 2007. The Mental Health Intervention Project is also examining whether each police division (station) will require a Mental Health Liaison Officer to support and assist the Mental Health Intervention District Co-ordinator.

During consultation, the Review was advised that the QPS Mental Health Intervention District Co-ordinators have developed positive relationships with authorised mental health services, with positive outcomes for people with a mental illness.

The Review considers that it is appropriate for the Mental Health Intervention District Co-ordinator or a person in a similar role within QPS, to provide relevant information to QH officers for the purposes of compiling section 238 reports or information necessary to prepare for Mental Health Court. It is necessary for this process to be formalised in QPS operating manuals and relevant QH policy documents.

Recommendation 4.3

That priority be given to legislative amendments to facilitate the release of information, including witness statements and patients' criminal histories, by the Queensland Police Service to relevant people within Queensland Health for the purpose of preparing section 238 reports.

Recommendation 4.4

That the Office of the Director of Public Prosecutions and the Queensland Police Service provide information promptly to the Director of Mental Health and the authorised mental health service regarding the facts and information obtained about the alleged offence including the nature and seriousness of the offence and whether there are victims involved.

Recommendation 4.5

That standard processes for transferring information from the Queensland Police Service to Queensland Health are introduced and included in relevant policy and procedures manuals for both departments.

96 P Mullen and K Chettleburgh, *Review of Queensland Forensic Mental Health Services* (2003) 23.

Referral of Involuntary Patients by the Director of Mental Health

Under the Terms of Reference, the Review is required to assess the efficacy of legislative provisions and administrative arrangements that enable the Director of Mental Health to refer certain matters to the Attorney-General.

For patients under a forensic order, or an involuntary treatment order, the Act enables the patient's charges to be referred by the Director to the Attorney-General or the Mental Health Court.[97] This process ensures that 'mental health issues receive appropriate consideration', if a person under a forensic order or a person under an involuntary treatment order is charged with an offence.[98]

The statutory responsibility for determining matters referred by the Director currently rests with the Attorney-General. In practice the Attorney-General always obtains the advice of the Director of Public Prosecutions (DPP) on the matters under consideration. Large volumes of decisions, many of which relate to relatively minor offences, are required to be made each year. It is unusual for a minister to be required to be involved to this extent at this level decision making. The DPP is an independent officer of the Crown who is well qualified to make decisions of this kind. If the DPP were to perform the role that would remove a burden from the Attorney-General, avoid double handling and reduce delay.

Consequently, the Review recommends that the Act be amended to enable the DPP, rather than the Attorney-General, to make decisions about continuing or discontinuing matters referred by the Director of Mental Health. To assist the DPP in making these decisions, it would be helpful if the Act were to require the Director of Mental Health to provide an assessment of the matter, including any recommendations to assist the DPP in making a decision.

Recommendation 4.6

That the Mental Health Act 2000 be amended to substitute the Director of Public Prosecutions for the Attorney-General as the person to whom the Director of Mental Health may refer the matter of the mental condition of the patient under section 240 and the person who is the decision maker under section 247.

Recommendation 4.7

That in referring the matter, the Director of Mental Health be required to provide an assessment of the matter to the Director of Public Prosecutions (DPP) including any recommendation to assist the DPP in making a decision under section 247 of the Mental Health Act 2000.

Deferring reference of a person who is temporarily unfit for trial

Where the Director of Mental Health, after receiving a section 238 report, reasonably believes that the patient is unfit for trial but likely to become fit for trial in less than two months, the reference to the Attorney-General or to the Mental Health Court may be deferred. The Director required to refer the person to the Court or the Attorney-General within the two month period if they continue to be unfit for trial[99].

Where patients may become fit for trial in a period slightly longer than the two month period, the statutory timeframes do not allow the Director to delay the reference to accommodate them.

97 *Mental Health Act 2000* (Qld) s 240.
98 Director of Mental Health, *Annual Report of the Director of Mental Health 2005* (2005) 30.
99 *Mental Health Act 2000* (Qld) s 241.

It is recommended that the Director of Mental Health have the capacity to extend the timeframe for an additional two month period. In selecting an additional two month period, consideration was given to ensuring that any extension of time does not unduly increase the time lost before the matter can be brought to resolution should it go to hearing in the Court.

Recommendation 4.8

That the Mental Health Act 2000 be amended to enable the Director of Mental Health to extend for an additional two month period the deferment period of a person not fit for trial at the end of the first two month deferment period if the Director of Mental Health reasonably believes that the person will be fit for trial within another two month period.

Diverting matters from the Mental Health Court

Currently, the Director of Mental Health may only refer summary offences or minor indictable offences to the Attorney-General. Indictable offences that are of a serious nature must be referred to the Mental Health Court.

The Review has given consideration to the test which requires that matters of a serious nature 'having regard to any damage, injury or loss caused' not be referred to the Attorney-General. The test measures seriousness by focusing upon factual matters relating to the harm caused. The Review considers that the test provides an appropriate general standard for differentiating matters that should automatically proceed to the Mental Health Court.

A key recommendation from the Mullen Chettleburgh Report was to ensure:

> There is appropriate utilisation of processes available through the Mental Health Act 2000 to reduce the number of forensic patients who have committed minor indictable offences (recommendation 11).[100]

The Mullen Chettleburgh Report demonstrated that people were being placed on forensic orders for relatively minor offences, such as wilful damage. The Review notes that efforts have been made by the Director of Mental Health to increase the number of referrals involving minor indictable offences (having regard to any damage, injury or loss caused) to the Attorney-General for discontinuance.

However the attention of the Review has been drawn to those cases involving serious offending where the psychiatric assessment indicates that the person was of sound mind at the time of the offence and is fit for trial. Considerable loss of time is likely to occur in unnecessary Mental Health Court proceedings if the matter ultimately proceeds to trial in the criminal courts. In addition the matters add to the already large backlog of cases before the Mental Health Court.

During 2005-06 financial year, of the 262 matters heard by the Mental Health Court, there were 18 references where the examining psychiatrists' report indicated that the person was not of unsound mind and fit for trial. The person was still required to go to the Mental Health Court, where the average delay was 10 months. Time could be saved if the matter were referred to the Attorney-General (or the DPP if recommendation 4.6 is implemented) for decision rather than the Court.

The contrary view is that referral to the Court is a significant statutory safeguard which allows the defendants access to assessment by Court appointed psychiatrists.

100 P Mullen and K Chettleburgh, *Review of Queensland Forensic Mental Health Services* (2003) 28.

The Review notes that the law officer to whom it is referred will consider whether there is a basis for it being heard in the Mental Health Court. Furthermore, there is ability in the Act for the patient or the patient's legal advisers to refer the matter to the Court if they consider that should happen.

As a further safeguard the Review would support the Director of Mental Health having the ability to obtain a second psychiatric report where he or she considered that necessary for the making of a decision on a referral.

After considering these matters and the need to reduce delay in the Court, the Review favours legislating for the Director of Mental Health to refer serious indictable offences to the DPP,[101] where the Director reasonably believes a person is fit for trial and the person was not of unsound mind at the time of the alleged offence.

Recommendation 4.9

That the Mental Health Act 2000 be amended to allow the Director of Mental Health, notwithstanding section 240(4), to refer a matter to the Director of Public Prosecutions rather than to the Mental Health Court where he or she reasonably believes that the person is fit for trial and was not of unsound mind at the time of the offence.

Recommendation 4.10

That the Mental Health Act 2000 be amended to allow the Director of Mental Health to obtain a further psychiatrist's report where he or she considers the report is necessary for the making of a decision on a reference by the Director of Public Prosecutions under section 247.

The Mental Health Court

Delays in the Mental Health Court

The Terms of Reference required the Review to consider the efficacy of existing administrative and legislative arrangements relating to proceedings before the Mental Health Court. Numerous submissions have identified that delay in the matter being heard and decided in the Mental Health Court is impacting on the parties to the proceedings.

> The Mental Health Court's capacity to hear references in a timely way is an issue of significant concern and adversely impacts on the defendant, the victim and the mental health service sector.[102]

Currently, the average delay in proceedings after a person is referred to the Mental Health Court is estimated to be 10 months. However, the Review has heard that it is not uncommon for some matters to take up to 18 months for resolution.

> It must be accepted that there needs to be some delay from filing of reference to hearing and determination. The Court needs to obtain evidentiary and medical material and it quite often orders assessments by medical practitioners. These assessments can take up to 4 months on average to complete.[103]

101 See recommendation 4.6, which recommends the Director of Public Prosecutions replace the Attorney-General in making decisions as to whether proceedings are continued.
102 Director of Mental Health, *Submission to the Review of the Mental Health Act 2000* (2006).
103 Information provided by the Mental Health Court Registry.

In addition, the Review has been advised that the number of matters awaiting a Mental Health Court decision continues to rise. In 30 June 2002 there were 140 matters pending, compared to 220 at 30 June 2006.[104] At the time of writing, 210 cases were awaiting hearing including:

- ten cases involving charges of murder or manslaughter
- two cases involving charges of attempted murder.[105]

In 2005-06, the Court heard 266 cases (including appeals and applications for inquiries into detention), over 58 sitting days.[106]

It is clear that the time available to the Court is fully utilised. The pressure on the Court to deal with as many cases as possible has resulted in sittings being allocated to the hearing of matters, with no allowance for reading time for judges.[107] In addition to making determinations as to unsoundness of mind and fitness for trial, the Mental Health Court also hears appeals from the Mental Health Review Tribunal and applications for inquiries into detention. Appeals from the Tribunal have increased from 12 in the 2003-04 to 48 in the 2005-06. During 2005-06, there was one application from a patient to inquire into detention and there is currently one matter pending for an application for inquiry into detention.

The Review acknowledges the work undertaken by the Mental Health Court Registry to prioritise matters involving young people. This is an important aspect for the administration of Justice in line with the Juvenile Justice Principles in the *Juvenile Justices Act 1992*.[108]

Allocation of additional resources and court time for the Mental Health Court

It is clear that with the annual increase in workloads and the associated increase in the backlog, there are greater delays in bringing matters to hearing. The Court presently sits for six sittings of two weeks each a year and disposes of approximately forty cases per sittings. Some delay is unavoidable, especially in regard to the obtaining of reports from court appointed examining psychiatrists. Furthermore, the efficient listing of matters to sittings necessitates a ready pool of available matters. For this reason a certain level of backlog is necessary and acceptable. Even with this in mind, the Review has concluded that unnecessary delay could be reduced by the scheduling of more Court time.

To reduce delay, it is necessary that action be taken. Recommendations made previously in this chapter relating to referrals made by the Director of Mental Health will contribute to some minimisation of referrals to the Court. The Review considers a real increase in the court time allocated for the Mental Health Court would further address the backlog and reduce delay.

In addition to reducing the waiting time, this reform would also allow the Court to hear the more serious cases without being under undue pressure. The present impression is that the Court is pressed to finalise as much work as possible in the sittings available.

The availability of judges is important in allocating an increase in sitting days in the Court. While the scheduling of judge time is a matter for the administration of the courts, the Review understands that the allocation of an additional judge to preside from time to time is already under consideration. This will allow more flexibility in the allocation of judges for sittings of the Court.

104 Director of Mental Health, *Submission to the Review of the Mental Health Act 2000* (2006) 32.
105 Information provided by the Mental Health Court Registrar (Brisbane, 22 November 2006).
106 Information provided by the Mental Health Court Registrar (Brisbane, 22 November 2006).
107 The Hon. Justice C Holmes (Mental Health Court), *Mental Health Court Report 1 July 2004 - 30 June 2005* (2005) 1.
108 *Juvenile Justice Act 1992* (Qld) sch 1.

Recommendation 4.11

That consideration be given to the allocation of additional Court time for the Mental Health Court as a matter of urgency.

Clearly, increasing judge time for Mental Health Court matters will have an impact upon overall court workloads and the associated resource implications will need to be considered and adequately funded.

The Mental Health Court Registry which supports the Mental Health Court will need additional resources to manage an increased workload associated with an increase in court sitting time. The Registry is responsible for a range of functions, including:

- scheduling cases for hearing, including ensuring the assisting psychiatrists are available and informing parties of the sittings
- maintaining court records and providing facilities and assistance for the filing of court documents
- arranging appropriate video-conference facilities in cases involving persons detained outside of Brisbane.

The *Mental Health Court Report 1 July 2004 - 30 June 2005* indicates the lack of a proper court management system places enormous strain on the registry staff and there are still problems regarding office space, resources, counter facilities, storage space, security and privacy concerns.[109] Any increase in court sittings would need to address these issues.

Significant resources are expended by all parties involved in Mental Health Court proceedings. For example, the Mental Health Act Liaison Officers in the Mental Health Branch, Queensland Health, undertake the following responsibilities in relation to references:

- prepare information and assist with briefing the Director of Mental Health's Crown Law Counsel
- liaise with the treating team to obtain updated clinical reports
- co-ordinate arrangements with authorised mental health services to determine where the person will be admitted or accommodated if the person is detained under the Act
- assist with briefing Crown Law Counsel
- attend 'all-party meetings'[110] to discuss references and ensure all relevant information is available
- update information on the Mental Health Act Information System (MHAIS).

The workload of the Mental Health Branch will be increased if the proposal to allocate additional Mental Health Court time is implemented. An increase in the number of sittings would also increase demands for Crown Law representation and associated costs for the Director of Mental Health to be represented.

Crown Prosecutors from the ODPP appear on references to the Mental Health Court and are supported by administrative staff. That Office would also require additional resources.

In addition, increasing sitting time would have significant implications for defence counsel. In the 2005-06 year, of the 217 cases referred to the Mental Health Court, Legal Aid Queensland

109 The Hon. Justice C Holmes (Mental Health Court), *Mental Health Court Report 1 July 2004 - 30 June 2005* (2005) 1.
110 All-party meetings include the DMH, legal representative, ODPP, DMH and MHC Registrar.

(LAQ) represented 88% of defendants, 11% were represented by private solicitors and 1% were self-represented.[111]

LAQ is supportive of an increased number of Mental Health Court sittings. However, their submission emphasises that the Mental Health Unit at LAQ is working to capacity and an increase sittings would have 'serious resource implications for Legal Aid Queensland'.[112]

Recommendation 4.12

That additional resources be provided to allow areas whose workload is directly related to the hearing of matters before the Mental Health Court to respond to an increase in Court sitting time.

Appointment of assisting psychiatrists

The allocation of additional Court time will also require an increased time commitment from the assisting psychiatrists. At present, only three senior psychiatrists hold that role with two sitting with the judge at any one time. An extension of Court sitting time may require an increase in the panel of assisting psychiatrists available to sit.

It is envisaged there may be some difficulty in attracting appropriately qualified persons for additional positions having regard to the demands of the Court schedule and the level of remuneration offered. It must be acknowledged these senior professionals are sitting with a Supreme Court Judge in a court with a very important role within both the criminal and mental health systems. At a time of general scarcity of medical practitioners, there is an even greater scarcity of specialist medical practitioners such as psychiatrists, and a dearth of psychiatrists with experience in forensic psychiatry. To ensure the position of assisting psychiatrist in the Mental Health Court continues to be filled, it is necessary to attract people from this limited pool. Given that frequent attendance on scheduled days to meet the Court timetable is likely to have a significant adverse impact on the psychiatrist's professional practice, it is necessary for remuneration to be set at a level equivalent to or approaching what the specialist would obtain if that time were allocated to other professional duties. At present that is not the case.

> It's viewed as charity work.[113]

Adding to the pressure of Queensland's limited pool of psychiatrists with forensic experience has been the increased remuneration for psychiatrists working in Queensland hospitals as well as the rebates available to psychiatrists from the Commonwealth. During 2006, Queensland Health has increased the overall remuneration levels for health sector specialists working in hospitals.[114] This increase includes a $20,000 annual allowance for professional development that is paid directly to the practitioner. As part of the Council of Australian Government's (CoAG) Mental Health initiatives, from 1 November 2006 private psychiatrists have benefited from an increase in the fees and rebates payable through the Medicare Benefits Schedule.[115]

In contrast, the remuneration rate for assisting psychiatrists has not changed in line with these increases.

111 Data obtained from the Mental Health Court Registry.
112 Legal Aid Queensland, *Submission to the Review of the Mental Health Act 2000* (2006).
113 Comment during consultation with psychiatrists.
114 Source: Queensland Health, Human Resources Branch.
115 Queensland Health, *Better access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Scheme* www.health.qld.gov.au.

Recommendation 4.13

That the remuneration of assisting psychiatrists in the Mental Health Court be reviewed with a view to making the position more attractive to suitably qualified applicants.

Opportunity for interested persons to provide information to the Court about limited community treatment

The Review is also asked to consider whether criteria should be developed to enable appropriate interested people to represent their concerns to the Court before limited community treatment (LCT) is ordered or approved.

As discussed in chapter 3, currently any person who is not a party to the proceeding may make a submission to the Court. The Court may receive the submission in evidence if the material is sworn and not otherwise part of the brief of evidence before the Court and it is satisfied the material is relevant to the decision to be made in the proceeding.[116] This permits greater access to the Court than is provided in equivalent jurisdictions in other Australian States.

The recommendations made by the Review in chapter 3 for the receipt of victim and interested person statements do not create any additional restriction on who might make a statement to the Court. No definitional limitation is placed on the category of 'interested person'.

The Review considers that these provisions will enable a broad range of appropriate interested people to provide information and represent their concerns to the Court about LCT for a defendant placed on a forensic order by the Court.

The Mental Health Review Tribunal

Openness and transparency

Open hearings

The Mental Health Review Tribunal is an independent statutory body established under the Act to ensure its provisions are appropriately applied in relation to involuntary patients.[117]

The Tribunal is established to review the following:

- whether or not the treatment criteria apply to patients under involuntary treatment orders
- the detention of young patients in high security units
- the mental condition of forensic patients
- forensic patients' fitness for trial.

The Tribunal also decides:

- applications for notification orders
- treatment applications
- applications for approval for patients to move out of Queensland
- appeals against a decision of the administrator of an authorised mental health service to refuse to allow persons to visit an involuntary patient

116 *Mental Health Act 2000* (Qld) s 284.
117 *Mental Health Act 2000* (Qld) ch 12 pt 1.

- applications for non-contact orders.

Tribunal hearings are usually closed proceedings. The Act provides that a hearing must not be open to the public unless the Tribunal directs that the hearing or part of the hearing be open to the public.[118] Therefore the only people who can attend are:

- the patient
- the patient's lawyer (if applicable)
- the patient's support persons, for example, an allied person
- the patient's psychiatrist
- other members of the treating team.

In addition, subject to the patient's consent and the Tribunal President's approval, observers may attend proceedings if they have a 'genuine reason' for being there. For example, a person who is working in a mental health service is likely to fulfil this criterion. Factors that are taken into account by the President in making a decision about whether to approve an application for a person to observe a hearing include the patient's rights, privacy and dignity.

Questions have been raised about transparency and accountability of Tribunal hearings. It has been suggested that hearings should be open, as are most Mental Health Court proceedings. The Review considered whether existing provisions, which enable information to be submitted to the Tribunal, are sufficient or whether they should be expanded to permit additional people, including victims, to attend hearings.

There is no consistency between the approaches taken by other tribunals. Under section 109 of the *Guardianship and Administration Act 2000*, hearings of the Guardianship and Administration Tribunal are open to the public. However, the Tribunal may, by a confidentiality order, direct a hearing be closed to protect the confidential nature of particular information or matter or for another reason.[119] The Review has been informed a decision as to whether a hearing is closed is made on a case-by-case basis. In contrast, hearings of the Children Services Tribunal are closed and only people involved in the individual matters and tribunal staff are permitted to attend.

The question is whether legislative amendment to permit additional people to attend Mental Health Review Tribunal hearings or to permit open hearings could be justified on the grounds that it would provide a necessary, additional avenue for victims or interested persons to provide information to the Tribunal. Review recommendations have focused on a range of strategies that are required to achieve a careful balancing between the needs and interests of patients and victims. It has already been acknowledged that in certain circumstances the rights of forensic patients, who have committed violent offences, must be considered alongside the safety and health needs of victims. That is, the balance may be shifted in situations where victim or public safety considerations justifiably override patient privacy and confidentiality protections. However, in light of the recommendations for change made by the Review and the role of the Attorney-General's representative in Tribunal proceedings, it is not considered that the inroad into patient confidentiality involved in open hearings can be justified.

As discussed in chapter 3 and later in this chapter, the role of the Attorney-General's representative in Tribunal proceedings includes ensuring the issue of community protection is given proper consideration. The Review considers that legislative amendment to expand participants in these hearings would amount to a duplication of that role. Therefore, rather

118 *Mental Health Act 2000* (Qld) s 460.
119 *Guardianship and Administration Act 2000* (Qld) s 109.

than supporting an expansion of participants, the Review supports the Attorney-General's representative taking a more assertive and proactive role in representing the interests of the community, including victims, in Tribunal hearings.

Recommendation 4.14

That the Attorney-General's representative, take a more assertive and proactive role in representing the interests of the community, including victims, in Mental Health Review Tribunal hearings.

Publication of Tribunal decisions

Under section 525 of the Act, the Tribunal may grant leave to publish a report of a proceeding if it is satisfied publication of the report is in the public interest and the report does not contain information that identifies or is likely to identify the patient, a witness or another person mentioned or otherwise involved in the proceeding. The Tribunal has not published any decisions since its establishment.

To improve transparency and assist public understanding of deliberations undertaken by the Tribunal, the Review supports publication of appropriately de-identified selected reports of proceedings when publication is in the public interest, such as when matters of principle or precedence are raised. Published decisions should be available for public viewing on the internet. This is the approach taken by the Mental Health Court.

Recommendation 4.15

That the Mental Health Review Tribunal give consideration to the publication of de-identified reports of proceedings in matters in which publication is in the public interest, such as when matters of principle or precedent are raised.

Provision of information and documents

The *Mental Health Act 2000* requires that a party to a proceeding must be given a reasonable opportunity to present the party's case, and in particular to inspect a document to which the tribunal proposes to have regard in reaching a decision. Patients and other parties should be afforded natural justice[120] and be provided with documentation in a timely manner to ensure they have time to properly consider it before the review.

The Review has heard that it is common on a review of a forensic order for a party to not receive information relevant to the review until the morning of the hearing or during proceedings.

During consultations, a range of participants indicated that procedural changes are required to enhance the Attorney-General's capacity to adequately represent the public interest at the Tribunal, particularly at reviews for patients originally charged with sexual or other serious violent offences. It has been argued the *Mental Health Act 2000* should be amended to include a requirement that all relevant documents, including clinical reports, be provided to the Attorney-General's representatives at least two weeks before the Tribunal review hearing.

The Review has been told that in order for the Attorney-General to exercise his or her role in a considered manner and adequately represent the public interest, certain changes need to be made to the procedures of the Tribunal, particularly with respect to forensic order reviews for Persons of Special Notification. It has been argued the *Mental Health Act 2000* should be amended to include a requirement that all relevant documents, including clinical reports,

120 *Mental Health Act 2000* (Qld) s 459.

be provided to the Attorney-General's representatives at least two weeks before the Tribunal review hearing.

The Review has been told that often this material is only provided to the Attorney-General's representative several hours beforehand and, in some cases, they are supplied only when the officer walks into the hearing. It seems that it is not uncommon for clinicians to give an undertaking to provide the necessary documents well beforehand, but this promise has not been kept. It has been submitted that the timely provision of these documents can only be assured if the requirement is enshrined in legislation.

Patients and consumer consultants have also expressed dissatisfaction with the lack of timeliness in the provision of documentation. They have told the Review that on occasions they are presented with a victim's submission on the day of the review.

The Tribunal's Annual Report 2006 records that during the past 12 months there has been an improvement from 9.6% to 6.7% in the number of cases in which no clinical report was received.

> The data represents an actual 510 cases over this year in which no written clinical evidence was received by the Tribunal in time for the hearing. In such cases the Tribunal must rely on oral evidence alone, or adjourn the matter to enable written or oral evidence to be provided at a future date.[121]

While the Tribunal reports that it will continue to work on improving performance in this area, it concedes there are still a significant number of reports (44.5%) received on the day of the hearing.[122]

The Review considered establishing minimum statutory timeframes for the provision of documents. However, the evidence suggests that legislating time frames for other processes, for example, the provision of section 238 reports to the Director of Mental Health, has been of limited effectiveness. It has been suggested that it is necessary to look at culture change and motivational strategies such as funding incentives to give services an interest in providing reports to the Tribunal.

With these considerations in mind, the Review considers that it is preferable for the Tribunal President to issue a practice direction under section 480 of the Act to establish appropriate guidelines for the provision of documents to all parties so the documents can be adequately considered prior to the Review hearing.

There should also be additional processes within QH to ensure clinical reports are prepared and lodged with the Tribunal in accordance with the requirements of the practice direction.

Recommendation 4.16

That early and sufficient provision of material to parties before Mental Health Review Tribunal hearings be facilitated by a practice direction under section 480 of the Mental Health Act 2000 setting appropriate guidelines for the provision of documents.

121 Mental Health Review Tribunal, *Mental Health Review Tribunal Annual Report 2006* (2006) 34.
122 Ibid 35.

Recommendation 4.17

That the Director of Mental Health and administrators of authorised mental health services implement a system for improving and monitoring the timeliness of provision of documentation to the Tribunal.

Providing information to the Tribunal about limited community treatment

The Review was also asked to consider whether criteria should be developed to enable appropriate interested people to represent their concerns to the Tribunal before LCT is ordered.

As discussed in chapter 3, currently any person who is not a party to the proceeding may make a submission to the Tribunal. The Tribunal may take the submission into account if the material is not already before the Tribunal and it is satisfied the material is relevant to the decision to be made in the proceeding.[123]

For the same reasons as for the Court, the Review considers that the current provisions and the recommendations in relation to 'victim statements' and 'interested person statements' enable a broad range of appropriate interested people to provide information and represent their concerns to the Tribunal about LCT for a forensic patient.

Broad community representation

As noted in chapter 2, the Explanatory Notes to the Mental Health Bill 2000 indicate that certain provisions were intended to ensure that the Tribunal would act as an independent review body taking into account the concerns of the community, including victims of crime.[124] The legislative reform was intended to introduce community representation onto the Tribunal panel for making decisions about the detention of a patient and provided capacity for the panel size to be increased up to five members in cases of greater concern.

It has been submitted to the Review that the number of QH employees that are Tribunal members adversely affects the independence of the Tribunal.

The Review considers that there are advantages in the Tribunal panels being more broadly representative of community interests. To achieve this, where possible, there should be less reliance on QH employees to fulfil the role of community members on Tribunal panels. It is accepted there is a need for psychiatrists on the panels and the current market availability necessitates that many will need to be drawn from QH. However the majority of current non-psychiatrist 'community members' are from allied mental health professional fields or consumer support backgrounds. The Review considers that in forensic matters Tribunal membership needs to reflect a broader range of community interests. This means that membership should include people from diverse backgrounds, including people with experience in victims' issues and public safety.

In particular, the Review would encourage a process of constituting panels for forensic matters where the clinical members have forensic experience and other members are able to represent broader community understandings.

123 *Mental Health Act 2000* (Qld) s 464.
124 Explanatory Notes, Mental Health Bill 2000 (Qld) 9.

Recommendation 4.18

That the recruitment of Mental Health Review Tribunal members draw on a broader range of community backgrounds, particularly persons who have experience with or awareness of victims issues, and that less reliance be placed on the use of Queensland Health employees.

Indigenous representation on Tribunal

Section 440(5)(c) of the Act promotes the need for membership of the Tribunal to reflect the social and cultural diversity of the general community. In addition, section 484(5) provides that members constituting the Tribunal for a particular hearing must, as far as practicable, include a member who is culturally appropriate to the patient. These provisions provide an additional important safeguard for Indigenous patients who comprise a significant proportion of forensic patients, including PSN. Data indicates that as at 10 October 2006, 17% of patients who were Persons of Special Notification[125] were from an Aboriginal or Torres Strait Islander background (13 patients were Aboriginal, three were Torres Strait Islanders and one patient was of Aboriginal and Torres Strait Islander descent).[126]The concentration of Indigenous forensic patients is particularly high in north Queensland.

Indigenous representatives have confirmed that the presence of an Indigenous community representative on the Tribunal would assist in providing a culturally appropriate service. The Review has been informed the Tribunal has worked on improving its services in this area in line with goals in its *Strategic Plan 2005-2010*.[127] Two Indigenous panel members have been appointed recently and consideration is being given to ways of utilising those resources most effectively. The Tribunal is trialling a program of clustering Indigenous hearings to facilitate an Indigenous panel member, as well as involving an Indigenous mental health worker. A network of contacts has also been set up between the Tribunal and Indigenous Mental Health Workers across Queensland.

It is noted that in 2005-06, the Tribunal constituted over 1100 panels across Queensland and scheduled over 7300 hearings.[128] Therefore it may not always be possible to ensure Indigenous representation on all panels conducting reviews relating to Indigenous people. It was also acknowledged that some Indigenous patients on forensic orders may not want a member of their community to be present, due to perceptions of mental illness and the associated stigma.

Recommendation 4.19

That the current endeavour to increase the number of Indigenous Mental Health Review Tribunal members be continued with special attention to increasing the number of Indigenous members in north Queensland.

Constitution of Tribunal for forensic order reviews

Existing legislative provisions require Tribunal panels to be constituted by between three and five members.[129] As noted above, the intention of the provision is to enable increased expertise and community representation on panels that are required to determine complex cases.

125 See chapter 4 of this Report.
126 Data provided by the Mental Health Branch, Queensland Health.
127 Mental Health Review Tribunal, *Strategic Plan 2005-2010* (2005).
128 Mental Health Review Tribunal, *Mental Health Review Tribunal Annual Report 2006* (2006) 5.
129 *Mental Health Act 2000* (Qld) s 447(2).

It has been submitted that the Tribunal can apply the following safeguards in more significant forensic hearings such as the revocation of a forensic order:

- the panel can be constituted by more than three members
- the Tribunal can seek an independent report
- the treating psychiatrist and the patient can be required to attend the hearing
- the Tribunal President can preside over more serious cases.[130]

The Review has been told that the Tribunal aims to provide consistency and the expertise of panels through determining arrangements administratively, for example, panels presided over by the Tribunal President and constituting panels with additional psychiatrist and/or other members. The Tribunal has developed guidelines for members on forensic order reviews. It has been submitted that the Tribunal provides more support in the way of professional development for its Tribunal members than any other mental health jurisdiction in Australasia.[131]

The Tribunal reports it has undertaken reviews with five member panels in contentious forensic order cases from time to time, but in general it has made limited use of these strategies to date. The reasons are that it considers the practical implications for its overall business and the efficient discharge of its duties do not warrant the routine use of additional member panels.

The Review considers there is merit in using differently constituted panels when determinations are being made in relation to more complex forensic matters including those involving a PSN. This would include ensuring that specialist forensic expertise is included on the panel. At a practical level, difficulties are likely to arise in relation to defining the expertise required as well as the availability of that expertise. The present remuneration levels for psychiatrist members reportedly makes it difficult to recruit from the private sector.[132] This needs to be remedied by consideration being given to increased levels of remuneration for psychiatrists. Greater efforts are required to attract specialists from the private sector as well as the public sector. This will allow recruitment of psychiatrists and other panel members with recent forensic experience.

The development of panels constituted specifically for forensic matters would also have an impact on the way matters are listed for review. PSN reviews may need to be grouped together for hearing.

Recommendation 4.20

That, where possible, the Mental Health Review Tribunal constitute special panels in significant forensic matters with emphasis on the inclusion of members with specialist forensic expertise and broader community backgrounds and that use be made of enlarged panels and dedicated listing to facilitate this objective.

Recommendation 4.21

That a review of the remuneration of psychiatrist members of the Mental Health Review Tribunal be undertaken.

130 Mental Health Review Tribunal, *Response to the Discussion Paper on the Review of the Mental Health Act 2000* (October 2006) 22.
131 Mental Health Review Tribunal, *Submission to the Review of the Mental Health Act 2000* (June 2006) 25.
132 Mental Health Review Tribunal, *Mental Health Review Tribunal Annual Report 2006* (2006) 5.

Role of the Attorney-General's representative in the Tribunal

The Attorney-General has a right to appear at the hearing for a review of a forensic order, for deciding a person's fitness for trial and for an application for a forensic patient to move out of Queensland.[133]

As mentioned in the Discussion Paper, the Act does not specify the role of the Attorney-General in these proceedings. However, the role of the Attorney-General is fundamental and derives from the traditional functions of the Attorney-General at common law. These functions include acting to protect the public interest as a representative of the Crown.[134] In doing so, the Attorney-General must balance a range of competing public interests.[135] In the context of Tribunal proceedings for a review of a forensic order, the Attorney-General must weigh up the public interest in the appropriate treatment and rehabilitation of people with mental illness and the protection of their rights and the public interest in the protection of the community.

For the purpose of clarity, it would be beneficial for the Act to include a brief statement of this traditional role.

Recommendation 4.22

That the Mental Health Act 2000 be amended to provide that the role of the Attorney-General as a party in Mental Health Review Tribunal proceedings is to represent the public interest.

Currently, the Attorney-General is represented in the Tribunal by the ODPP. It is usual for more junior prosecutors to attend at hearings with very little preparation, particularly as clinical reports are frequently provided very close to or on the day of the hearing. Further, the Attorney-General is not represented at all forensic order reviews – attendance is usually limited to reviews relating to patients who were charged with serious sexual or other violent offences. Even with this limitation on the number of appearances, the workload is substantial. In 2004-05, the ODPP appeared on behalf of the Attorney-General at 245 hearings before the Tribunal.[136] With the increasing number of forensic patients, it is likely that the workload will see a proportional increase. The ODPP advised the Review that this additional workload, which arose out the implementation the *Mental Health Act 2000*, was not funded by the Government and was expected to be undertaken within existing resources.

Lack of specific funding by government of the important role of the Attorney-General in Tribunal proceedings has resulted in a less than optimal capacity within the ODPP to adequately represent the public interest.

The Review has given consideration to whether the ODPP, Crown Law or some other unit based within the Department of Justice and Attorney-General is the most appropriate agency to represent the Attorney-General in Tribunal proceedings. It is essential for the Attorney-General's representatives to be experienced advocates with experience in and capacity to represent the public interest, including the protection of the community and the position of victims, where this is not contrary to the public interest. Because the Tribunal sits in regional locations around the State, it is also essential that advocates representing the Attorney-General have state-wide coverage.

133 *Mental Health Act 2000* (Qld) ss 450(1)(c) and 452(1)(c).

134 Under section 5 of the *Attorney-General Act 1999* (Qld), one of the Attorney-General's principal functions is to be the State's chief legal representative. Section 8 of that Act preserves the functions, powers, prerogatives and privileges of the Attorney-General under the common law or equity or by tradition or usage.

135 Australian Law Reform Commission, *Standing in Public Interest Litigation*, Report No 27 (1985) 88.

136 Queensland Office of the Director of Public Prosecutions, *Office of the Director of Public Prosecutions Annual Report 2004-2005* (2005)17.

It is unlikely that a separate unit within the Department of Justice and Attorney-General would have the capacity to meet all these requirements. It would be difficult to recruit and retain sufficient numbers of appropriately qualified advocates for such a specialist area and to provide state-wide coverage.

The ODPP and Crown Law both have experienced advocates who could equally adequately represent the Attorney in Tribunal proceedings, if properly funded, and both can provide state-wide services, although the ODPP, with a number of regional offices is better placed in this regard.

Recommendation 4.23

To enable the Attorney-General to exercise his or her role in a considered manner and thereby enhance his or her ability to adequately represent the public interest, the important role of the Attorney-General's representative in Tribunal proceedings should be recognised through the provision of adequate funding to enable proper preparation for a review and the appearance of experienced advocates in the proceedings.

Another matter impacting on the quality of Attorney-General representation in the Tribunal is the lack of continuity in case management by the ODPP and the Department of Justice and Attorney-General once a forensic order is made and the order becomes subject to review by the Tribunal. The ODPP are briefed to appear in the Tribunal by the Department of Justice and Attorney-General which maintains the Tribunal file and delivers the file or brief to the ODPP. The Mental Health Court file remains separate in most cases. This means that prosecutors, particularly in regional areas, only have access to the Tribunal file and not to the preceding Mental Health Court file and therefore have access to limited information about the matter. This impacts on their ability to prepare submissions incorporating material before the Mental Health Court, including the views of victims and a full account of the facts of the offences.

Recommendation 4.24

That material held on the Office of the Director of Public Prosecutions' Mental Health Court file in relation to a forensic patient be incorporated into the Attorney-General's Tribunal file for the patient.

CHAPTER 5 – INTELLECTUAL DISABILTY AND THE FORENSIC PROCESS

The *Mental Health Act 2000* and people with an intellectual disability

The primary purpose of the Act is to provide for the involuntary assessment and treatment of people with a mental illness, while at the same time safeguarding their rights.[137] The principles for the administration of the Act in sections 8 and 9 only apply to people with a mental illness. The definition of mental illness provides that a person must not be considered to have a mental illness merely because the person has an intellectual disability.[138] However, people with a sole diagnosis of intellectual disability may be caught by the provisions of the Act dealing with criminal charges and forensic patients. This is because a finding of unsoundness of mind under section 27 of the Criminal Code or a finding or unfitness for trial may be made in relation to a person with an intellectual disability. If such a finding is made by the Mental Health Court for a person with an intellectual disability, he or she may be placed on a forensic order by the Court after considering the seriousness of the offence, the person's treatment needs and the protection of the community.[139] The effect of a forensic order is that the person be detained in a stated authorised mental health service for involuntary treatment or care.[140]

Of the 428 patients on forensic orders as at 30 June 2006, 23 patients have a sole diagnosis of intellectual disability and 12 patients have a dual diagnosis. Four of these 35 patients have PSN status.

The requirement for people on forensic orders to be detained in an authorised mental health service is clearly inappropriate for people with a sole diagnosis of intellectual disability. Mental health services exist to provide treatment for people with mental illness and do not usually have the facilities or expertise to provide appropriate care for people with an intellectual disability, some of whom may have extremely challenging behaviours and may need long term intensive support and secure care. Detention in high secure facilities for people with mental illnesses can be highly detrimental for people with an intellectual disability, placing the person, other patients and staff at risk.

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

Appropriate facilities for people with an intellectual disability

Appropriate mechanisms are required to ensure that people with an intellectual disability who are afforded a defence or found to be unfit for trial by the Mental Health Court receive appropriate care and are supported in a way which safeguards both the individual and the community.

Key stakeholders including the Mental Health Court and the Mental Health Review Tribunal have acknowledged the difficulty that arises in relation to persons with an intellectual disability:

137 *Mental Health Act 2000* (Qld) s 4.
138 *Mental Health Act 2000* (Qld) s 12.
139 *Mental Health Act 2000* (Qld) s 288(3).
140 *Mental Health Act 2000* (Qld) s 288(2).

> The question of what order should be made where a finding of unsoundness or unfitness for trial is made in respect of an individual who suffers from intellectual impairment but no psychiatric disorder has provided problematic for the Court and may reflect a hiatus in the Mental Health Act 2000. A forensic order provides for involuntary treatment in a mental health service; that may not be appropriate in the case of a person who suffers no psychiatric disorder, but there exists no alternative means of ensuring supervision of an intellectually impaired person who poses a risk of re-offending. An associated difficulty in structuring orders is the lack of placement options for such individuals.[141]

Access to funded services is governed by the *Disability Services Act 2006*, eligibility policy and a prioritisation process. Frequently, people coming before the Mental Health Court cannot be adequately serviced under existing programs funded by Disability Services Queensland and there is no existing framework for provision in a secure environment of services and support for persons with an intellectual disability.

The Hon. W.J. Carter QC has been commissioned by the Government to review options for the provision of a targeted service response for adults with an intellectual or cognitive disability and who exhibit severely challenging behaviour. While the outcomes of this review are not currently available, it is anticipated that it will provide assistance to the Government in determining the requirements for service system and legislative reform. Detailed recommendations in this area are not within the scope of this review. However, in any implementation of the recommendations made by Mr Carter, a review of the forensic provisions of the *Mental Health Act 2000* will be required.

Recommendation 5.1

That a review of the provisions of the Mental Health Act 2000 affecting people with an intellectual disability be conducted as part of any reform to provide secure care for people with an intellectual or cognitive disability who exhibit severely challenging behaviour.

141 Justice C Holmes (Mental Health Court), *Mental Health Court Report 1 July 2004 – 30 June 2005* (2005).

Making forensic orders

If the Mental Health Court (the Court) decides a person was not of unsound mind at the time of the offence and is fit for trial, then the matter is returned to the criminal court for trial and sentence. In 2004-05, approximately 38% of findings of the Mental Health Court resulted in matters being returned to the criminal courts.[142]

If the Court decides a person was of unsound mind at the time of the offence, or that the person is permanently unfit for trial, the criminal proceedings are discontinued. In these circumstances, the Court may make a forensic order detaining the person in an authorised mental health service for involuntary treatment and care.[143]

Where the Court has found that a person is temporarily unfit for trial, the criminal proceedings are stayed and the Court must make a forensic order for the person, detaining the person in an authorised mental health service for involuntary treatment and care.[144]

In deciding whether to make a forensic order, the Court must consider:

- the seriousness of the offence
- the person's treatment needs
- the protection of the community.[145]

The Court must also apply the principles for exercising powers and performing functions under section 9 of the *Mental Health Act 2000* (the Act):

> A power or function under this Act relating to a person who has a mental illness must be exercised or performed so that –
>
> (a) the person's liberty and rights are adversely affected only if there is no less restrictive way to protect the person's health and safety and to protect others; and
>
> (b) any adverse effect on the person's liberty and rights is the minimum necessary in the circumstances.[146]

The discretionary power of the Court to make a forensic order has to some extent addressed past concerns about the unnecessary application of forensic orders. However, there are still a significant number of patients on forensic orders whose treatment and rehabilitation needs vary markedly. As at 1 December 2006, the total number of patients on a forensic order was 461.

Persons of Special Notification

Implementation of the Act in 2002 coincided with the Mullen Chettleburgh Review, which recommended an amendment to introduce an additional category of forensic order to differentiate patients who are serious violent offenders from patients who have committed non-violent offences. The purpose of the additional category was to ensure more intensive treatment and risk management processes are in place for individuals that have committed serious violent offences. This recommendation was not effected in amendments to the Act.

142 Justice C Holmes, Mental Health Court, *Mental Health Court Report 1 July 2004 - 30 June 2005* (2005) 2.
143 *Mental Health Act 2000* (Qld) s 288(2).
144 *Mental Health Act 2000* (Qld) s 288(4).
145 *Mental Health Act 2000* (Qld) s 288(3).
146 *Mental Health Act 2000* (Qld) s 9.

Instead, in 2002, Queensland Health (QH) established the administrative category of forensic patient known as Persons of Special Notification (PSN).

Definition of PSN

A PSN is a patient on a forensic order who has been found of unsound mind or unfit for trial either temporarily or permanently in relation to one or more of the following serious offences:

- murder
- manslaughter
- attempted murder
- rape or assault with intent to rape
- dangerous driving causing death.

PSN represent a relatively small proportion of the total number of patients that are subject to provisions in the Act. As at 1 December 2006, the total number of patients on involuntary treatment orders was 2,817. Of the 461 patients on forensic orders, 99 were PSN. In 2005-06, eight of the 109 forensic orders made and eight of the 70 forensic orders revoked were in the PSN category.[147]

PSN Policy

The *Policy for management, reviews and notifications for a Person of Special Notification* emphasises the responsibility of mental health services to provide a high level of oversight of PSN. In addition to patient safety considerations, the Policy stipulates that treatment and rehabilitation decisions in relation to PSN must consider past harm caused and public safety. Standards outlined in the Policy relating to the management, review and reporting requirements for the treatment and care of this patient group include:

- A PSN will be directly under the care and treatment of an authorised psychiatrist (appointed under the Act). Those patients on more than overnight limited community treatment (LCT) in the community will be reviewed at least monthly by the authorised doctor, unless there is clinical evidence why this frequency of review should be decreased.
- A PSN will be allocated an experienced mental health care co-ordinator or case manager, with input from the district mental health forensic liaison officer, where available. The patient will be reviewed weekly by the nominated case manager while residing in the community on LCT unless there is clinical evidence supporting a reduction in this frequency of review.
- The treatment plan should include a risk management or action plan that outlines the service's response in the event that a patient fails to comply with any aspects of treatment or any conditions of LCT.
- A quarterly report to the Director of Mental Health is to be completed.[148]

The establishment of the PSN administrative category and state-wide PSN Policy appears to have added value by setting clinical practice guidelines for a group of patients that require closer monitoring. It is apparent from Review consultations that the PSN administrative category has had some effect in shaping the approach taken to these patients' treatment and care. In a number of districts, clinicians and managers were readily able to report the number of PSN for which they have responsibility.

147 Data obtained from Mental Health Branch, Queensland Health.

148 Queensland Health, Mental Health Branch, *Policy for management, reviews and notifications for a Person of Special Notification* (2005).

However, stakeholders also report the PSN Policy is not consistently implemented across the State. This view has been confirmed by the results of a recent evaluation of the Forensic Liaison Officer positions, 16 of which were established across the State following the Mullen Chettleburgh Review. Interviews conducted with directors and managers of district mental health services indicated the PSN Policy has been fully implemented in seven districts. However, in six districts it has not been implemented and directors and managers in three districts were unsure of the extent to which it has been implemented. The draft evaluation report also states there are communication problems when PSN transfer between districts. At times, relevant procedures are not adhered to with respect to these transfers.[149]

PSN category in context

The present administrative category of PSN identifies those forensic patients charged with the serious offences listed above. As serious personal violence involving an attempt to kill is charged as attempted murder, the present categories include the majority of cases with highest impact upon victims, including all cases involving loss of life.

Although it is acknowledged that specifying a broader range of offence categories would encompass some patients who represent a high risk but are not presently included because of the nature of their offence, there are a number of reasons for not adopting this course.

Expansion of the number of patients classified as PSN is likely to devalue the effectiveness of the category as a means of promoting greater clinical oversight. Its value is in drawing to the attention of busy clinicians the significance of the index offence and ensuring management strategies take that into account. The number of PSN is presently about 22% of all forensic patients.[150] Should there be a significant increase in that proportion the ability for treating services to give special attention to patients in the category will decrease.

The category of offence may not always be a good predictor of future risk. Some patients who have committed very serious offences may present a low risk because of their response to treatment, physical health or other factors. At the same time, some very high risk patients with severe mental illness may have not come into contact with the criminal justice system. The broader the category is, the greater the chance of placing an unnecessary burden on treating teams by including low risk patients.

The Review sees the value of the PSN category as providing an additional way of categorising patients that supplements the existing risk assessment carried out for all forensic patients. Prior offending is one of a number of factors that clinicians take into account in assessing risk. It is important that the assessment of the risk factors for all forensic patients continue to have the highest priority. Recommendations in this chapter will seek to enhance the processes for ensuring that treatment plans adequately address risk assessment and risk management for all forensic patients. The requirements surrounding the PSN category should be viewed as supplementing those broader risk management processes, not substituting them.

The PSN category ensures that irrespective of clinical assessment of risk, those patients who have committed the most serious offences will be given appropriate attention. This meets the expectations of victims and members of the community that the treatment of those who have killed or committed very serious offences will give full attention to preventing re-offending.

149 Queensland Health, *3rd Draft Report of the Review and Evaluation of the District Forensic Liaison Officer (DFLO) Positions* (2006) 50-1.

150 Data obtained from Mental Health Branch, Queensland Health.

Incorporating the PSN category in legislation

In 2004, Professor Paul Mullen stated that the PSN administrative category appeared to address concerns raised in the Mullen Chettleburgh Report regarding the management of patients who have committed serious violent offences. However, he acknowledged that ongoing adherence to the administrative PSN protocols may be more difficult to achieve without a legislative mandate. He recommended the administrative scheme be reviewed at some time in future.[151]

The Review *Discussion Paper* indicated that consideration was being given to whether the PSN category should be incorporated in legislation. The majority of submissions to the Review are supportive of this proposal. However a small number of submissions question whether there would be any benefits to be gained from it, and indeed whether the disadvantages would outweigh any advantages. Questions were raised as to whether a legislative PSN category would improve the treatment and monitoring of affected patients and whether it would distract clinicians' attention from 'high risk' patients who are not PSN.

There are strengths in existing legislative and administrative arrangements relating to the treatment of all forensic patients, both PSN and non-PSN. For example, forensic patients are subject to a more rigorous review process by the Tribunal in comparison to other involuntary patients and only the Tribunal can revoke the forensic order. It would be misleading to suggest the PSN category, however defined, could include all 'high risk' patients. In addition, the degree of risk that any individual patient presents is likely to fluctuate over time. Therefore it should be assumed that statutory provisions will never abrogate clinicians' responsibility for continuing to provide sound clinical assessment and treatment tailored to individual patients' circumstances, regardless of their legislative status.

In general, the Review is impressed by the added safeguards incorporated in the current PSN policy and considers it is necessary to ensure that they are implemented throughout all parts of the State. Clinical practice standards and guidelines can play an important part in reducing risk. As the information provided to the Review indicates the existing PSN policy has not been effectively implemented in all districts, there is a need for an alternative approach to ensure a higher level of supervision is consistently provided for PSN across the State.

The establishment of a statutory PSN classification should give the public and victims greater confidence that community safety considerations will be given proper weight in decisions about matters such as LCT.

Options for incorporation in legislation

A number of options for incorporating the PSN category into legislation have been considered by the Review.

An option suggested in a number of submissions was to have the Court declare on a case by case basis which patients would be categorised as PSN following an assessment of risk. The Review does not favour this approach. The Court would need to have recourse to expert psychiatric testimony which would be resource-intensive with the following disadvantages:

- lengthened court proceedings
- increased court costs
- inconsistent application of test over time
- increasing numbers of PSN requiring intensive monitoring by mental health services.

151 Letter from Professor Paul Mullen to Dr Jacinta Powell, Acting Director of Mental Health, Queensland Health, 27 July 2004.

The Review favours reliance on offence categories to identify patients for attention as PSN.

Given the existing administrative PSN scheme has been criticised as being problematic because the offence types exclude patients who may present a higher risk than some PSN, the viability of including additional offence types has been examined. Specifically, the impact of an expanded set of offences, which included serious, violent offences and sexual offences was assessed by analysing 2005-2006 Mental Health Court data. The additional offences included grievous bodily harm (GBH), dangerous operation of a motor vehicle causing GBH, unlawful wounding and sexual offences.

Forensic orders were made in relation to these offences, which were selected on the basis that they are likely to give rise to concerns about risk and public safety. The analysis does not include references which were de-listed, those in which the defendant was found to be fit for trial and proceedings continued according to law, or if the defendant was found permanently unfit for trial and no forensic order made.

In total, the data shows that if a legislative PSN category was in place during 2005-2006, which included the existing PSN offences, GBH, dangerous operation of a motor vehicle causing GBH, unlawful wounding and sexual offences it would have resulted in an additional 14 PSN category patients.

The Review considers that a significant increase in the number of PSN would be likely to devalue the effectiveness of the category in focusing clinical attention on the most concerning offences, including homicides. For this reason it favours retaining the existing offence types.

Strengthening policy and practice

The current legislative scheme provides for a patient placed on a forensic order to be detained in an authorised mental health service until the patient ceases to be a forensic patient.[152] The administrator of an authorised mental health service must ensure the forensic order is given effect.[153] An authorised doctor in an authorised mental health service must ensure a treatment plan is prepared for the patient and the administrator must ensure the patient is treated or cared for as required under the treatment plan.[154]

The Review supports strengthening of the provisions to provide legislative support for implementation of standard state-wide policies and guidelines for forensic patients generally and PSN patients in particular. To this end the Review supports amendment of the *Mental Health Act 2000* to provide that:

- the Director of Mental Health provide policies and practice guidelines for the treatment and care of forensic patients, including PSN
- the authorised doctor have regard to the Director of Mental Health's policies and guidelines for forensic patients, including PSN in preparing the patient's treatment plan, which must include a risk management plan
- the administrator ensure the Director of Mental Health's policies and practice guidelines for forensic patients and PSN are given effect
- the Director monitor and audit compliance with the requirements of the Act so far as they relate to the treatment and care of forensic patients, including PSN
- the PSN category be defined in legislation in terms of the present offence types.

152 *Mental Health Act 2000* (Qld) s 293.
153 *Mental Health Act 2000* (Qld) s 294.
154 *Mental Health Act 2000* (Qld) ss 296, 297.

These proposals do not change the offence types that result in a PSN classification. Nor do they diminish the responsibility that mental health services have for ensuring that all patients who have committed serious violent offences are carefully treated and monitored.

Recommendation 6.1

That the Mental Health Act 2000 be amended to require the Director of Mental Health to provide policies and practice guidelines for the treatment and care of forensic patients, including Persons of Special Notification.

Recommendation 6.2

That the Mental Health Act 2000 be amended to require the authorised doctor to have regard to the Director of Mental Health's policies and guidelines for forensic patients, including Persons of Special Notification in preparing the patient's treatment plan, which must include a risk management plan.

Recommendation 6.3

That the Mental Health Act 2000 be amended to require the administrator of the authorised mental health service to ensure the Director of Mental Health's policies and practice guidelines for forensic patients, including those relating to Persons of Special Notification, are given effect.

Recommendation 6.4

That the Mental Health Act 2000 be amended to provide that the Director of Mental Health monitor and audit compliance with the requirements of the Act so far as they relate to the treatment and care of forensic patients, including Persons of Special Notification.

Recommendation 6.5

That the Mental Health Act 2000 be amended to provide that the Persons of Special Notification category be defined in legislation in terms of the present offence types.

Limited Community Treatment

What is Limited Community Treatment?

The Mental Health Court may order, approve or revoke limited community treatment (LCT) when it makes a forensic order.[155] LCT for a patient means 'undertaking some treatment or rehabilitation in the community other than under the community category of an involuntary treatment order'.[156] The Mental Health Review Tribunal may also order, approve or revoke LCT when it reviews a forensic order.[157] LCT is designed to provide an opportunity for recovering patients to make a supported transition back to the community.

The Court or Tribunal may set conditions under which a patient may access LCT. LCT conditions may specify where the patient can go, where they can live, who should accompany them and when they must return.

155 *Mental Health Act 2000* (Qld) chap 7 part 7.
156 *Mental Health Act 2000* (Qld) sch 2.
157 *Mental Health Act 2000* (Qld) s 203.

LCT usually occurs in a graduated way. Initially, a patient may be allowed escorted leave on the grounds of the authorised mental health service, graduating, with appropriate approval, to unescorted leave outside the grounds and, if appropriate, residence in the community. Due to the nature of their mental illness, some patients' access to the community remains very limited. These decisions are based on a range of factors related to the risk that the patient represents to himself or herself and the wider community.

Victims' concerns about being not informed when patient leave is approved were highlighted in the review of the *Mental Health Act 1974*.[158] While the current Act provides more opportunities for victims and their families to provide and receive information in relation to LCT decisions, concerns remain about inadequacies in current provisions and arrangements. These concerns were discussed in chapter 3.

Reviewing forensic orders and approving LCT

In Queensland, the period for which a person is held under a forensic order depends on a range of factors. The Mental Health Review Tribunal is required to review a forensic patient's mental condition at least every six months.[159] In other jurisdictions, the ongoing review of a forensic or equivalent order is conducted either by a mental health review body (New South Wales, Australian Capital Territory and Western Australia - the body makes recommendations to the Minister) or by the court (Victoria, South Australia, Tasmania and Northern Territory).

In Queensland, on a review, the Tribunal must decide whether to confirm or revoke the forensic order for the patient. If the Tribunal confirms the forensic order, it may order, approve or revoke LCT.[160] The Mental Health Court may also order, approve or revoke LCT when it makes a forensic order.[161] The Court and the Tribunal must comply with the human rights principles underpinning the Act when ordering or approving LCT.[162] These principles include a requirement to provide treatment and care in the least restrictive environment, taking into account the patient's health and safety and the protection of others.[163]

In making decisions about LCT, the Mental Health Court or the Tribunal must have regard to:

- the patient's mental state and psychiatric history
- the offence leading to the making of the forensic order for the patient
- the patient's social circumstances
- the patient's response to treatment and willingness to continue treatment.[164]

Unacceptable risk test

In making decisions about LCT, the Court and the Tribunal must also be satisfied that the patient does not represent an *unacceptable risk* to the safety of the patient or others, having regard to the patient's mental illness or intellectual disability.[165] The provision does not require risks that arise from other factors to be taken into account.

If the forensic patient is found to be temporarily unfit for trial and the criminal proceedings are not discontinued, the Court or the Tribunal must not order or approve LCT if it is satisfied there is an *unacceptable risk* the patient would, if the treatment were undertaken in the community:

158 Queensland Health Mental Health Unit, *Victims of Crime and the Mental Health Act – Discussion Paper* (1999) 33-6.
159 *Mental Health Act 2000* (Qld) s 200.
160 *Mental Health Act 2000* (Qld) ch 6 pt 3.
161 *Mental Health Act 2000* (Qld) ch 7 pt 7.
162 *Mental Health Act 2000* (Qld) s 8.
163 *Mental Health Act 2000* (Qld) s 9.
164 *Mental Health Act 2000* (Qld) ss 203(6), 289(6).
165 *Mental Health Act 2000* (Qld) ss 289(4), 204(1).

- not return to the authorised mental health service when required; or
- commit an offence; or
- endanger the safety or welfare of the patient or others.[166]

The approval of LCT for violent offenders has attracted negative publicity and highlighted community concerns about whether certain forensic patients should have LCT, and if so, when and where it should take place. It may be that greater community confidence would result from LCT determinations being made by the Court. However, the following significant concerns have been raised about this concept:

- Determination of LCT by the Mental Health Court would have a substantial impact on the Court's time and in turn adversely impact on its other functions.
- This level of decision making by the Court would effectively remove the Tribunal's functions in relation to PSNs. In this context, consideration would have to be given to whether all of the Tribunal's functions in relation to PSNs (including 6 monthly reviews) should be assumed by the Court.
- The formality of the Court and the reduced capacity for patients to meaningfully participate in the proceedings is contrary to the general principles and intent of the Act.
- The Court is not sufficiently accessible to conveniently conduct reviews on application and at short notice.

Therefore the Review has considered other ways of introducing greater safeguards in relation to the approval of LCT.

Specific categories of conditions

The Court or Tribunal can approve LCT subject to any conditions they consider appropriate, for example, specifying where the person can stay and with whom they can stay. The order for LCT may also be subject to a condition that the patient must not contact a stated person, for example, the victim or a member of the victim's family.[167] Some stakeholders have asked the Review to consider other categories where a condition could be imposed. For example, a discrete criterion could require the Court or Tribunal to consider the needs and safety of any child residing with the forensic patient, when determining whether the patient represents 'an unacceptable risk to the … safety of others'.[168]

One option would be to introduce more specific legislative provisions requiring the Court or Tribunal to specifically address the safety of vulnerable individuals when making decisions about LCT. Alternatively, a less formal and prescriptive approach would require amendment of the QH PSN Policy as recommended by the Coroner:

> That the risk assessment and management strategies to ensure the safety of the children presently in place for persons of special notification who are pregnant or who have dependent children be extended to cases where children reside with the person receiving treatment, whether full time or part time, particularly where the event resulting in the forensic order involved an injury to a child.[169]

Therefore the Review supports amendment of the Policy to require consideration of the safety of vulnerable individuals including children residing with a PSN on LCT. The Policy should also

166 *Mental Health Act 2000* (Qld) ss 204(4), 289(5).
167 *Mental Health Act 2000* (Qld) ss 203(3), 289(3).
168 *Mental Health Act 2000* (Qld) s 204(1).
169 Coroner A Hennessy, *Inquest into the death of Jye Conrad PERRY (a Child)* (2005)13 http://www.justice.qld.gov.au/courts/coroner/findings/perry1105.pdf.

stipulate that where risk is indicated, the treating team should ensure the risk management plan addresses it and appropriate LCT conditions are sought from the Mental Health Court or Mental Health Review Tribunal. Relevant changes would be required to the *Proposal for Changes to LCT* form, to identify family members and other people with whom the person is living who may be at risk, and how this risk is addressed.

Recommendation 6.6

That the Person of Special Notification (PSN) Policy and relevant administrative forms are amended to require consideration of the safety of vulnerable individuals, including children, who may live in the same house as a PSN on limited community treatment (LCT), and where risk is indicated, the treating team is to ensure a risk management plan is in place and appropriate LCT conditions are sought from the Mental Health Court or Mental Health Review Tribunal.

Independent reports on LCT and revocation

Submissions raised the question of whether a report by an independent examining psychiatrist should be required by the Mental Health Court or Tribunal at key decision points in the treatment of a PSN, when the risk of adverse events is likely to be heightened. The Review has been told these milestones include the commencement of unescorted LCT on hospital grounds, commencement of LCT in the community and when a forensic order is revoked.

While the Court[170] and Tribunal[171] have the power to order an examination and report from a psychiatrist other than the psychiatrist responsible for the patient's treatment, they need not do so. The Review has been told that independent examinations and reports are expensive to obtain. Responses to the concept of a mandatory independent report at the milestones identified above have been mixed. While the number of PSN who commence LCT outside the hospital grounds in any one year is not likely to be significant, concerns may be raised about the resource implications of mandatory independent reports. It is also not clear who would pay for the reports – QH, the Tribunal or the Court.

For this reason, consideration could be given to the possibility of reducing the cost of reports by permitting the provision of an 'independent' report by a QH psychiatrist who is not a member of the treating team. However, it has been submitted that many mental health services would have difficulty meeting any additional demands for psychiatric reports. While it may be difficult to justify mandatory independent reports relating to LCT, the same argument cannot be sustained in relation to revocation of PSN forensic orders.

The material available to the Tribunal during reviews includes a 'forensic dossier' which usually comprises brief information about the offence, Mental Health Court reports, the Mental Health Court decision (if published) and the most recent clinical reports provided to the Tribunal. The Review has been told the Tribunal has obtained independent reports for a very small number of reviews, and where it has done so, most concur with the treating team's views. While that may be the case, there can be a significant difference between the assessment of a patient by an independent examining psychiatrist and an assessment by the treating psychiatrist. This difference could have a critical impact on a revocation decision.

Revocation is a significant milestone, which can have wide-ranging consequences. It may be an important step in a patient's recovery in the community. It may also lead to the patient disengaging in an ongoing treatment regime that is essential to managing or preventing

170 *Mental Health Act 2000* (Qld) s 422.
171 *Mental Health Act 2000* (Qld) s 190.

recurrence of acute symptoms of mental illness and re-offending. Therefore the reasons for requiring the Tribunal to obtain an independent report when revoking a forensic order for a PSN are far more compelling than those relating to LCT approval. The Court imposes forensic orders usually after considering reports and testimony by at least two court-appointed examining psychiatrists. It seems appropriate that in considering the revocation of a forensic order of a PSN that the Tribunal also receive the benefit of independent psychiatric input.

Taking into account the gravity of decisions made at this point, the Review considers the potential benefits that may be obtained from a mandatory 'independent' report far outweigh any costs that may be associated with providing them for the limited number of orders that are revoked for PSN each year.[172] It is considered that regardless of whether the reports are obtained from the private sector or an authorised psychiatrist outside the treating team, it would not impose too onerous a drain on resources.

Recommendation 6.7

That the Mental Health Act 2000 be amended to require the Tribunal to obtain an independent examination and report from a psychiatrist other than the psychiatrist responsible for the patient's treatment when making a decision about revocation of a forensic order for a Person of Special Notification.

Approval of LCT for classified patients

A classified patient can only receive treatment, as an inpatient of an authorised mental health service i.e. there is no community category. If the patient is to have any absence from the ward, they require prior approval for LCT from the Director of Mental Health.[173] For example, approval for LCT would be required to go to the canteen or to the bank.

The Director must not give approval for LCT unless the Director is satisfied there is not an unacceptable risk the patient would, if the treatment were undertaken in the community:

- not return to the authorised mental health service when required, or
- commit an offence while away from the authorised mental health service, or
- endanger the safety or welfare of the patient or others.[174]

Also, in deciding whether to give the approval, the Director must have regard to the following:

- the patient's current mental state and relevant psychiatric history
- the offence/s leading up to the patient becoming a classified patient
- the type and amount of LCT the patient has had to date
- the patient's response to treatment and willingness to continue treatment.[175]

Other matters that the Director takes into account include:

- the progress of any previous LCT, for example, any adverse issues, late return, non-compliance with conditions etc
- intended LCT plan, for example, duration, conditions, escorted or unescorted, consequences of non-compliance, living arrangements and available social supports

172 For example, in 2005-2006, eight forensic orders were revoked for PSN (Data obtained from the Mental Health Branch, Queensland Health).
173 *Mental Health Act 2000* (Qld) s 129(2)(b).
174 *Mental Health Act 2000* (Qld) s 129(3).
175 *Mental Health Act 2000* (Qld) s 129(4).

- the expected rehabilitative goals of the LCT
- current risk assessment.[176]

Classified patients can undertake LCT for continuous periods longer than seven days, in contrast to patients treated under involuntary treatment orders who can only have leave approved for up to seven days.

The Review has been informed the Director of Mental Health's standard practice is to approve on a time-limited basis i.e. usually 2-4 weeks at a time. The provision of information about classified patients' LCT to victims was discussed in chapter 3.

Availability of resources required to support LCT

Concerns have been raised by some stakeholders about the capacity of carers and service providers to appropriately accommodate, monitor and support forensic patients on LCT. The question is whether the Court or Tribunal should be required to have regard to the availability of treatment and support for the person prior to ordering or approving LCT.

The success of LCT is dependent on the support that is in place for the patient in the community. Clinicians report that the treating team usually includes information from the patient's family and carers in the review report for the Tribunal. If the Tribunal believes more information is required to make a decision about LCT, it can adjourn proceedings while awaiting receipt of further information. Carers have told the Review that at times, their needs and capacity to support LCT are not given enough consideration or are not taken into account. Some have suggested it may be necessary to incorporate these aspects in legislation to ensure they are an integral part of the decision-making process.

Other factors that impact on decisions about the appropriate level and type of LCT that is appropriate include mental health service capacity and the availability of supported accommodation or step-down facilities to support patients' transition back into the community. The Review is aware of a number of instances where patients remain in inpatient facilities for lengthy periods because of the lack of community based mental health care and rehabilitation options. This situation does not promote the patient's recovery, or relieve pressure on inpatient facilities, which are already operating at full capacity. LCT may not be approved if there are insufficient resources to provide adequate treatment and care for the patient in the community.

The lack of 'step-down' facilities and housing supports that can be 'wrapped around' the person to decrease risk is a concern across the State. For example, patients do not have access to step-down rehabilitation options from The Park – High Security Unit. Funding for community residential services was identified as an issue in the 2005 Final Report of the Queensland Health Systems Review.

> … there is need for improved housing and support for people with mental illnesses, including step down facilities for patients released from acute care. In the absence of a community residential sector, people with mental illnesses are living inappropriate settings such as private boarding houses.[177]

Establishment of additional forensic mental health rehabilitation beds and enhanced capability of other treatment and support services for forensic patients are areas for action in the *Draft Queensland Mental Health Plan 2007-2011*.[178]

176 Queensland Health, Mental Health Unit, *Mental Health Act 2000 Resource Guide* (2002) Chapter 9, 5-6.
177 Queensland Health (P Forster), *Queensland Health Systems Review - Final Report* (2005) 146.
178 Queensland Health, *Draft Queensland Mental Health Plan 2007-2011* (2006) 27-8.

Recommendation 6.8

That treatment plans for forensic patients, including Persons of Special Notification, routinely and explicitly incorporate information provided by carers, support persons and service providers, including that relating to their capacity to support limited community treatment.

Consultations also highlighted that some areas, including Indigenous communities in north Queensland, face particular challenges created by geographical isolation and cultural considerations. The Review has been told about instances where unrealistic conditions are placed on LCT plans for Indigenous people. For example, Indigenous patients have LCT approved to reside in overcrowded housing because of a lack of alternative supported accommodation options. Also, conditions requiring a person to stay at the same place and not allowing them to 'go out to country' when they want to, is contrary to cultural practice and makes it difficult for people to comply with LCT conditions. Stakeholders reported there is widespread acceptance amongst clinicians and treating teams that Indigenous people on forensic orders living in the community, are likely to be moving between locations, contrary to their LCT conditions.

During consultations and site visits, workers highlighted the a lack of adequate support for Indigenous forensic patients who have a 'treatment resistant' mental illness or co-occurring conditions and high support needs. Many Indigenous patients do not have a sole diagnosis of mental illness. More often they have a combination of two or more conditions, which may include a mental health disorder, developmental disability, intellectual disability or substance abuse problems. Their needs usually can only be met with intensive case management and support in the community or in residential, extended care facilities. At present there is a dearth of this type of support and residential services in the north of the State, and there are rarely vacancies in the few facilities that have been established.

> … you need a place of safety and peace for the long term in culturally appropriate settings …[179]

Despite these challenges, the Review was told about some laudable achievements. For example, a north Queensland Indigenous health service has effectively implemented intensive support programs under Project 300 which assists people leaving long term inpatient care, most of whom are forensic patients. Under this Project the service has prevented re-offending by some Indigenous clients, including a forensic patient who has a mental illness and an intellectual disability. In that case, an Indigenous support worker assists the client with activities of daily living, including monitoring his medication regime and preparing simple meals.

These support workers are trained to identify risk factors and to advise services of their concerns. However, concerns were expressed that after identifying some risk behaviour and communicating these concerns to the hospital, hospital staff did not treat the information seriously:

> The hospital should know that when we call on them for assistance, it is serious …[180]

Training of family members and carers in detecting behaviour that indicates risk escalation is necessary. However, stakeholders also reported that in Indigenous communities, there is a tendency for violent behaviour to be tolerated, particularly if it is known the person has a mental illness or has a history of contact with the police. As a consequence, changes in behaviour, while detected, may remain unaddressed, leading to a more serious violent incident.

179 Comment by a member of the Mental Illness Fellowship.
180 Comment by an Indigenous health worker.

Where a serious violent act has been committed, the Indigenous health workers reported that it was often very difficult for the person with a mental illness to return to their community. Following the approval of LCT, the Indigenous health workers and the treating team may need to negotiate and discuss it with the community council before the person is allowed to return to their community.

In some cases, the community council may ban the person from returning, which may leave the person stranded in Cairns or Townsville where rental accommodation is expensive and limited in supply. Community health workers report very high rates of people living on the streets after discharge from hospital. In this environment, participation in high risk behaviour, including substance misuse and re-offending is likely to increase.

Indigenous health workers report they spend a significant amount of time educating and supporting family members. They help family members identify the warning signs and advise them on appropriate actions if the warning signs manifest. In addition, the Review heard that Indigenous health workers spend time reassuring carers and making sure they do not 'burn out'.

> They ring me up all hours of the night. You never really knock off. I'll be at a social thing and someone will tell me that they've had problems with so and so again … and then I'll follow them up and see how they're going.[181]

For Indigenous people with a mental illness, the lack of services in the community is problematic. In rural and remote communities, services are provided by teams that fly in and fly out. For example, the community forensic mental health service visits the Cape to provide a consultation liaison service. However, there is a great need for more practical, day-to-day support for patients on the ground in the community.

In addition, clinicians and allied health workers report problems arise from the lack of understanding of the *Mental Health Act 2000* due to the high turnover of people working in rural communities. In one Indigenous community, stakeholders reported there had been 23 different nurses rotated through one position in the previous two and a half years. It was acknowledged that it is difficult for nurses to stay in the communities as they are often subject to abuse. In addition, the high staff turn-over prevents strong relationships from being established in the community.

The Indigenous health worker acts as a mediator between families who may be seeking 'pay-back' where a person with a mental illness has committed an act of violence. In some communities, the Indigenous health worker also assists clients to comply with their bail conditions, including taking them to report to the police.

Stakeholders repeatedly emphasised to the Review that Indigenous health workers and Indigenous mental health workers play a pivotal role in supporting Indigenous forensic patients. The Review is aware of the need for adequate resources to provide culturally appropriate support to these patients, their carers and their community.

Recommendation 6.9

That Queensland Health expand the number of Indigenous mental health worker positions available to provide culturally appropriate services for Indigneous forensic patients.

As highlighted by the Queensland Review of Fatal Mental Health Sentinel Events, Indigenous people as well as people born overseas and in non-English speaking countries were over

181 Comment by an Indigenous health worker.

represented in the cases reviewed, particularly in the category of those with a serious mental illness that committed homicide. Clearly, it is necessary that cultural and linguistic factors are considered when clinicians are making risk assessment determinations.[182]

In their submission to the Review, the Queensland Transcultural Mental Health Centre emphasised that for people from culturally and linguistically diverse backgrounds, access to bilingual mental health consultants has been important in bridging the gap between the treating team and the consumer.[183] Their submission comments that the inclusion of access to interpreter services will improve the quality of assessment, treatment, care and quality of information being communicated. While the issue of the availability of interpreters for people with a mental illness is beyond the scope of the Terms of Reference, the Review emphasises the important role interpreters play in ensuring clinicians have access to adequate information. This information could be vital when clinicians are conducting a mental state examination, assessing risk and making decisions about LCT.

Court and Tribunal considerations

The Review has considered whether legislation should require the Court and the Tribunal to take into account the availability of appropriate resources in the community in making a decision about LCT. However, the Court and Tribunal have, without the need for legislative direction, demonstrated a preparedness to do this.

The Review considers that the true problem does not arise from any failure of the Court or Tribunal to take these factors into account but from the possibility that the Court and Tribunal may not be provided the necessary information to do so. Accordingly, the Review proposes that the treating team's risk assessment and risk management plan incorporate consideration of whether adequate accommodation and support is available to support LCT. The Review considers it necessary to emphasise the treating team's, and more specifically, the authorised doctor's role in ensuring the Court and Tribunal are fully informed about the capacity of carers and service providers to support the treatment plan, including LCT conditions.

Recommendation 6.10

That the policies relating to forensic patients, including Persons of Special Notification, require that reports given to the Mental Health Court and Mental Health Review Tribunal provide advice as to whether the necessary treatment and support required by the patient for limited community treatment is available.

Non-compliance with LCT conditions

The Review has been told about a number of policy and service system improvements that have been introduced to better manage non-compliance with LCT conditions. Developments that have improved QH and Queensland Police Service's (QPS) capabilities in this area include:

- development of the PSN Policy which includes detailed guidelines for the management of LCT and non-compliance with LCT conditions.
- state-wide standardised processes for patients who are absent without permission (AWOP), including a flipchart and checklists to assist mental health clinicians to appropriately manage AWOP incidents
- weekly reconciliation of QPS and QH mental health data on AWOP patients

182 D Bhugra, 'Severe mental illness across cultures' (2006) 113 *Acta Psychiatrica Scandinavica* 17-23.
183 Queensland Transcultural Mental Health Centre, *Submission to the Review of the Mental Health Act 2000* (2006) 1.

- AWOP module added to the Mental Health Act 2000 Online Training System as a mandatory requirement to be completed by mental health clinicians.

In addition, broader service system initiatives designed to improve interagency coordination and response to a range of mental health crisis situations, including those relating to patients under the *Mental Health Act 2000* include:

- implementation of the Mental Health Intervention Project across the State, which has included updating the Memorandum of Understanding between the QPS and QH;[184] development of QPS/QH *Preventing and Responding to Mental Health Crisis Situations and Information Sharing Guidelines*;[185] identification of Mental Health Intervention Coordinators in QH, QPS and Queensland Ambulance Service; training for staff in these agencies across the State
- establishment of QPS/QH Operational Liaison Committees at the local level
- establishment of 19 community forensic mental health positions in district health services across the State to provide support, advice and education to district mental health clinicians.

The PSN Policy and related district level policies guide the day-to-day management of PSN non-compliance with LCT. The policy requires the treating psychiatrist who authorises LCT to, among other things:

- consider what is to be done if the patient is late returning from LCT or is non-compliant with conditions outlined on the *Treatment plan - limited community treatment*
- consider who has the authority to extend the time of return and under what circumstances
- determine actions to be taken if there is non-compliance with the plan, and who is responsible for initiating the actions
- ensure conditions of LCT are stated clearly so that there is no ambiguity for either staff or patient.

For patients undertaking LCT, the level of clinical monitoring and the action required in the event that the patient fails to comply with conditions of LCT are critical elements of the management plan. The *Clinical report – forensic order review* and *Proposal for changes to LCT or to revoke a forensic order* forms are completed by the treating team for review by the Limited Community Treatment Review Committee and the review by the Tribunal. The *Proposal for changes to LCT or to revoke a forensic order* form requires information to be provided regarding 'action to be taken and consequences if patient does not comply with conditions of LCT'.

In 2002, the Mullen Chettleburgh Report recommended that leave plans and approvals should incorporate prescriptive and precise actions for facilitating leave (recommendation 33).[186] This recommendation has been given effect in the PSN Policy and relevant administrative forms including the *Proposal for changes to LCT or to revoke a forensic order* and *Treatment plan – limited community treatment*.

The need to strengthen practices in this area was subsequently highlighted in the Review of Fatal Mental Health Sentinel Events which recommended that, on a breach of LCT conditions, a full mental health assessment be conducted before allowing LCT to continue (recommendation

184 Queensland Health and Queensland Police Service, *Memorandum of Understanding between The State of Queensland through Queensland Health and The State of Queensland through the Queensland Police Service Mental Health Collaboration* (2005) (signed 03/04/2006).

185 Queensland Health and Queensland Police Service, *Preventing and Responding to Mental Health Crisis Situations and Information Sharing Guidelines* (2006).

186 P Mullen and K Chettleburgh, *Review of Queensland Forensic Mental Health Services* (2003) http://www.health.qld.gov.au/publications/corporate/mullenreview/.

30).[187] While this may be an appropriate policy directive, a legislative approach is likely to be too inflexible to cater to the wide array of situations that can arise. For example, non-compliance can encompass skipping the occasional dose of oral medication or failing to present for an injection, through to becoming absent without permission for lengthy periods. While any level of non-compliance requires prompt remedial action, a full mental health assessment may not be warranted in all circumstances. However, where a full assessment is not conducted that should be justified in the clinical file.

Consultations conducted by QH in 2005 relating to a review of LCT related structures and processes indicated there were continuing concerns about a number of factors which adversely impact on some mental health services' capacity to monitor compliance with LCT conditions. These factors include lack of services to adequately monitor conditions.

The Review has also found that clinicians' responses to non-compliance with LCT conditions vary across the State. This lack of consistency is a particular concern in relation to forensic patients who have committed serious offences. It indicates additional safeguards are required in this area, particularly in relation to PSN and other patients who have committed serious violent offences. While there is general agreement that improvements could be achieved through the systematic use of standards and guidelines for non-compliance, clinicians suggested that it would be difficult to address non-compliance with LCT conditions through legislation.

Recommendation 6.11

That state-wide guidelines are developed on monitoring and responding to non-compliance by Persons of Special Notification (PSN), and include a requirement that where a PSN has not complied with limited community treatment (LCT) conditions in a significant way or symptoms re-emerge, the patient must undergo a full mental health assessment before LCT is allowed to continue.

External verification process

Recommendation 24 of the Mullen Chettleburgh Report required a process be established for external (to the treating team) verification that the leave that is being taken is the leave that has been granted, to minimise errors and provide additional security measures that will protect staff from being compromised by patients or others. This process has not been consistently implemented by mental health services.

A proposal arising out of the LCT Project material suggests the *Treatment plan – limited community treatment* form should be amended to include a field relating to verification of LCT that has been ordered or approved. This verification process should be undertaken by a person external to the treating team, prior to the patient participating in LCT. The proposal also includes a suggested name change of the form for classified and forensic patients – to *Forensic/Classified patient limited community treatment authorisation.*

Recommendation 6.12

That Queensland Health amend the 'Treatment plan – limited community treatment' form to include a field relating to verification of limited community treatment in order to ensure consistent state-wide implementation of this process of external verification of limited community treatment orders and approvals.

187 Queensland Health, *Report of the Queensland Review of Fatal Mental Health Sentinel Events: Achieving Balance* (2005) http://www.health.qld.gov.au/mental_hlth/publications.asp.

Limited Community Treatment Review Committees

QH established Limited Community Treatment Review Committees (LCTRC) in response to the Mullen Chettleburgh Report recommendation that an internal review process be established, which ensures adequate consideration is given to community safety and the proposed leave plan for the patient's rehabilitation (recommendation 20).[188] The Committee comprises senior clinicians and administrators of authorised mental health services.

The QH LCTRC Policy contains terms of reference, membership and guidelines for the Committee's functioning,[189] and states the Committee is to consider the following:

- *all* reports to the Mental Health Review Tribunal concerning PSN regardless of whether changes are proposed or not
- *all* reports to the Mental Health Review Tribunal where there is a *proposed change* to current arrangements for limited community treatment for other *forensic patients*
- applications for limited community treatment for forensic patients
- applications for revocation of forensic orders.

The Policy does not require the patient or the treating team to be present for the LCTRC review.

The LCTRC is not a decision making body. It is a multidisciplinary body, whose role is to provide an additional layer of review before the Mental Health Review Tribunal hearing. It should provide advice and feedback to the Tribunal and the treating team about the content and quality of the documentation, and not duplicate the decision-making role of the Tribunal.

Recent changes to forms will reduce the documentation that is reviewed by the LCTRC. The revised *Clinical report – forensic order review* is the primary document to be reviewed. De-identified information regarding LCTRC outcomes is provided by the Committee to the Mental Health Branch, QH. An LCT Project, which has been established by the Director of Mental Health is reviewing structures and processes relating to LCT for forensic patients, including LCTRC.

Concerns relating to the Committees include:

- lack of rigour in the application of LCTRC processes in each mental health service
- LCTRC do not operate in a consistent way across the State, for example, some services have added a quality assurance aspect to the Committee's role by incorporating a clinical review process
- the quality of information provided by Committees is variable and is often not relevant to the issues the Tribunal has to determine
- it is not clear what the status of the LCTRC report is in a Tribunal proceeding – it comments on the quality of the *Clinical report – forensic order review* from a clinical practice perspective, and may support or oppose a proposal for LCT
- the patient does not have access to the LCTRC report prior to the hearing
- questions have been raised about whether the LCTRC report and the process by which it is provided to the Tribunal offends principles of natural justice and adversely affects the patient's therapeutic relationship with the treating team.

Some submissions have suggested that the LCTRC could be improved by:

188 P Mullen and K Chettleburgh, *Review of Queensland Forensic Mental Health Services* (2003).
189 Queensland Health, Mental Health Unit, *Limited Community Treatment Review Committee Policy* (2002).

- changing the process so the Tribunal may take evidence at the hearing from the treating clinician (representing the treating team's views) regarding the LCTRC recommendations, rather than the Committee sending the recommendations to the Tribunal
- maintaining the Committee as an administrative review body, with the proviso that its role is more clearly defined and current inconsistencies in structures and processes are addressed
- providing training to LCTRC members
- subjecting LCTRC to quality assurance processes
- formally recognising LCTRC in legislation should also support relevant standards and quality processes.

While a limited number of submissions supported incorporation of the LCTRC concept in legislation, it is not clear what benefits would flow from this approach. It is possible that a legislative approach would increase formality and reduce the flexibility required to ensure they operate effectively across all areas of the State. In addition, the Act already provides for a statutory review body in the Tribunal and this begs the question of whether is appropriate to establish an additional statutory review process. A statutory LCTRC would have to apply more stringent standards to processes, for example, those relating to procedural fairness. There would also be resource implications associated with establishing and maintaining the Committee's statutory functions and powers.

The Review supports the present, predominant view of the LCTRC role as simply providing an internal quality assurance measure to improve relevant documentation prior to Mental Health Review Tribunal hearings. In that regard, the process does not raise any issues relating to natural justice because the Committee does not review patients' treatment or interests. Given these considerations, the Review can see advantages in the LCTRC continuing to provide comments and recommendations relating to the draft *Clinical report – forensic order review* report and other relevant documentation prior to Tribunal hearings.

If issues do arise in relation to LCTRC recommendations to the treating team, it would seem preferable for these to be resolved internally within the health service, for example, by giving the treating team opportunity to respond directly to the LCTRC. However, it may also be of benefit to the Tribunal to know whether these processes have taken place and that issues have been appropriately addressed. Therefore the clinical report from the authorised doctor to the Tribunal should incorporate feedback from the LCTRC and advise the Tribunal of any Committee recommendations that have not been adopted with reasons for not complying with the recommendations.

To ensure that there is consistency across the State, in respect to the operation of LCTRC's, standardised processes should be developed by the Director of Mental Health.

Recommendation 6.13

That the Limited Community Treatment Review Committee continues to focus on reviewing the content and quality of documentation relating to forensic order reviews prior to Mental Health Review Tribunal hearings in line with existing policy guidelines.

Recommendation 6.14

That the Limited Community Treatment Review Committee provide feedback to the treating team prior to the Mental Health Review Tribunal hearing for incorporation into the final 'Clinical report – forensic order review' report to be sent to the Tribunal.

Recommendation 6.15

That the Director of Mental Health develop standardised structures and processes relating to limited community treatment decision-making and the operation of the Limited Community Treatment Review Committees across the State.

Risk Assessment and Risk Management

Responsibility for risk management

The mental health system has primary responsibility for risk assessment of forensic patients. Clearly articulated strategies for containing and managing identified risks are an important clinical requirement for all forensic patients and are of particular importance for PSN. Clinicians' access to specialist forensic expertise and relevant clinical history is of critical importance, as are improved systems for monitoring and review to ensure high quality clinical practice. This includes strengthening existing internal service review processes (such as LCTRC) and establishing more systematic external review processes. These strategies should be underpinned by comprehensive and sustainable training to ensure clinical staff are equipped with the necessary knowledge and skills to effectively assess and manage risk.

Actuarial risk assessment

Risk management of forensic patients may comprise an assessment of a range of individual factors utilising actuarial risk assessment tools including the PCL-R, HCR-20 and VRAG, as well as other information that may be gained from clinical records or sources.

Recent critiques indicate there is fundamental statistical error at the heart of psychological tests for predicting violence, commonly referred to as actuarial risk assessment instruments (ARAI). Stephen Hart, a leading international expert in this field and his colleagues recently presented the results of an evaluation of two ARAI - the VRAG and the Static – 99 – and concluded that:

> At best, they suggest that professionals should be extremely cautious when using ARAI to estimate an individual's risk for violence. At worst, they suggest professionals should avoid using ARAI altogether, as the accuracy of these tests is simply too low to support their use when making high-stakes decisions about individuals. The low accuracy not only makes reliance on ARAI ethically problematic, it also means that they may not meet legal standards for the admissibility of expert or scientific evidence.[190]

A recent review of these findings by Professor Paul Mullen adds a further sobering note by asserting that the Hart *et al* critique applies to other ARAI if they are utilised to predict risk. Further, he asserts that they should not be used as a broad predictor of risk if a person's scores fall within a particular range or group, because attributing the worst aspects of that group to a single individual is essentially prejudice. He concludes that 'the margins of error in every actual, or conceivable, risk assessment instrument are so wide at the individual level that their use in sentencing, or any form of detention, is unethical'.[191] Therefore the instruments may at best provide guidance as to whether intervention is warranted, and which risk factors require attention.[192]

190 S Hart, C Michie and D Cooke, 'The Precision of Actuarial Risk Assessment Instruments: Evaluating the "Margins of Error" of Group Versus Individual Predictions of Violence' (Paper presented at Management and Treatment of Dangerous Offenders Conference, York, 28-30 September 2005).

191 P Mullen, 'Dangerous: and Seriously Personality Disordered: And in Need of Treatment', (2006) *British Journal of Psychiatry* (in press) 7.

192 Ibid.

In spite of this disturbing critique, Professor Mullen argues that the risk of persons with a mental illness re-offending can be reduced through a program of risk management which includes reducing or removing risk factors, including substance abuse, managing symptoms, and developing interventions to address psychological and social issues.

> That risk will be reduced by moderating or removing the substance abuse, by improving symptom control, by stable accommodation in a low crime neighbourhood, by structuring his day with meaningful activity, and working on his attitudes and beliefs directed at others. Whether this particular patient would ever have actually committed a crime is moot, what is a reasonable expectation is if your services manage effectively all such patients with these risk factors then the total level of criminal behaviour committed by the patients as a group will fall.[193]

Forensic risk management program

In light of these recent unfavourable analyses of ARIA, the development of a comprehensive program of risk management for patients that have committed serious violent crimes, and of which symptom management is just one component, must be a high priority.[194] In addition to consideration of core clinical and social factors, this program needs to achieve a balance between what is in the interests of the individual patient and what is in the interests of the community. It is recognised that achieving this balance is not a simple or easy task. Decisions about where the patient is best treated and when they should have LCT and transition back into the community are complex, particularly in relation to patients who have committed serious offences.

Clearly, some gains have been made with the introduction of the PSN Policy which provides a broad framework within which risk issues can be considered. It outlines the responsibilities of services in relation to treatment and care and non-compliance with the treatment plan or LCT conditions. It also requires clinicians to record actions that are to be taken if the patient does not comply with the treatment plan, including LCT conditions. In this context, the treating team as well as family and carers play important roles in risk management. The treating team's risk management role involves identification of static factors (things that do not change e.g. gender) and dynamic factors (things that can change e.g. family and carer involvement, police involvement). The team's risk management plan usually indicates how dynamic factors will be addressed. If the plan is not working, clinicians are expected to identify what steps need to be taken to improve it.

While the Act has increased the rigour that applies to decision making in relation to forensic patients, the Review has been told that more needs to be done to improve risk management for forensic patients. System deficiencies in this area were also highlighted in the Queensland Review of Fatal Mental Health Sentinel Events, conducted in 2004, which identified a lack of standardised processes for assessment and treatment as a key area of concern. The Review Committee recommended the development of core state-wide standardised processes for mental health assessment, risk assessment and treatment, with particular focus on addressing non-compliance with treatment, accompanied by appropriate education and training (key recommendation 1).[195]

The current Review also confirmed that more needs to be done in this area. While there appear to be some standardised approaches to risk assessment for all patients under the Act, they are not consistently applied across the State. Some risk assessment training is provided

193 Ibid.

194 P Mullen, 'Schizophrenia and Violence: From Correlations to Preventative Strategies' (2006) 12 *Advances in Psychiatric Treatment* 239-248.

195 Queensland Health, *Report of the Queensland Review of Fatal Mental Health Sentinel Events: Achieving Balance* (2005).

by specialist forensic mental health services within available resources. The Review was also told about a district mental health service which has introduced mandatory annual risk management training for all clinicians. However, it is clear that clinical risk management can be better addressed through implementation of existing standards and guidelines.

Implementation of the Sentinel Events Review key recommendation 1 is being progressed through the Mental Health Sentinel Events Secretariat in the Patient Safety Centre. The Review has been told that a suite of documentation is being developed with expert input provided by a Working Group and will be evaluated through a pilot program. Risk assessment is to be incorporated in various sections of the documentation, rather than being contained in one 'stand alone' form. The documentation will require clinicians to use a structured narrative, thus recording clinical decision-making and compelling the analysis of data and use of clinical judgement. It incorporates the recording of risk and actions required when non-compliance occurs. Further, the development of a 'Clinical History Summary' will enable critical information to be maintained and available for clinicians making it easier to recognise trends in relapse and assessed risks. The Queensland Centre for Mental Health Learning will play a key role in developing and delivering training to clinical staff on this improved assessment and treatment documentation.

The Review is aware that specialist forensic clinicians are providing input into the development of the suite of documents. However, at this stage the extent to which this initiative will incorporate the risk factors that are relevant in forensic mental health is unclear. It is essential that given the patient and public safety issues relating to forensic patients that high priority is given to ensuring the documents specifically address relevant forensic factors.

Recommendation 6.16

That a structured program of risk management for forensic patients be adopted state-wide that includes strategies for reducing or removing risk factors (for example, substance misuse), managing symptoms, and interventions to address psychological and social issues.

Recommendation 6.17

That Queensland Health continue implementation of the Sentinel Events Review recommendation relating to core state-wide standardised processes for mental health assessment, risk assessment and treatment, and in addition include specific reference to forensic mental health issues and information.

Access to clinical and other relevant information

The Mental Health Sentinel Events Review Report recommended each mental health service have a policy on how to respond to a request from another health service for information regarding a patient, with emphasis on the patient's best interests and timeliness of transfer of information. It also stated services should always provide vital information about risk and significant past history of self harm or forensic background even if the client is no longer under involuntary provisions of the *Mental Health Act 2000.* Both community and inpatient settings should be considered when summarising clinical information to be passed on to other mental health services (recommendation 38).

The Review has been advised by clinicians that sometimes information about the offence which gave rise to the imposition of the forensic order is not readily available to them. Sometimes, clinicians only have limited information about the offence(s) with which the person was charged. It is vital that decision-makers have access to these details when decisions are being made in relation to LCT and revocation of a forensic order. This is particularly so when the members of

the treating team have not treated the patient over a long period or have limited knowledge of the circumstances surrounding the offence(s). Clinicians have confirmed that this information is relevant and useful.

Both the history of offending by the patient and details of the seriousness and the circumstances of the offending need to be actively communicated to treating clinicians to be used in assessing risk to the safety of both the patient and the public.

Sound clinical decision making relies on access to relevant information and is of particular significance in the management of forensic patients' including PSN. The magnitude and complexity of information and the variety of circumstances in which clinicians may need to access this information, for example, treating psychiatrist or case manager versus registrar on call or emergency department doctor making determinations on an unexpected presentation are important considerations.

Access to a succinct summary of historical information and current clinical issues is valuable in all contexts. This will form an important component of the standard documentation which was discussed above. Further, for PSN patients, Quarterly Reports provided to the Director of Mental Health highlight significant history as well as current management issues. The requirement for these reports was established without the additional resources needed for the task and, as a consequence, there is significant variability in timeliness and quality. Services require additional resources and expert input, for example, from the Community Forensic Outreach Service to more effectively undertake this work.

Ensuring prompt access to key information in hard copy and/or electronically is equally critical. In the long term, this will be greatly aided in the establishment of a single state-wide mental health information system. In the short term, there is a need to consider how key information, for example, PSN Quarterly Reports can be made more accessible through existing systems such as the Mental Health Act Information System (MHAIS). However, there are significant risks in enabling broader access beyond the treating team if the accuracy and currency of information cannot be guaranteed.

Management of unplanned presentations to another authorised mental health service is also potentially facilitated through electronic access to information. Recent MHAIS enhancements have expanded information which can be accessed by another District. Clinicians are able to conduct an external search to view information about patient status, for example, classified, forensic or PSN, leave status, absence without permission and details of the treating authorised mental health service. The scope of this information is intended to inform the need for contact with the relevant service.

There would be benefits in making a summary of key forensic information readily accessible in the front of all clinical and administrative files for forensic patients, as well as on the MHAIS. Information that would be most useful includes diagnosis, *Mental Health Act 2000* status, limited community treatment conditions and brief offence history.

As already indicated, the volume of information relating to the patient's forensic status may be substantial, for example, Mental Health Court reports, *Police charge sheet* (known as QP9) and witness statements. While it may not be necessary or appropriate for all of this information to be available on a patient's clinical file, standard management processes are needed to ensure clinical staff are able to access more detailed information as they require it. Processes for managing historical information have previously been established, however, more recent indications are that practices currently vary. The extent of these variations is unclear. Nonetheless, review and remedial action is likely to have resource implications for the service sector and the Director of Mental Health's office.

Recommendation 6.18

That high priority is given to the development of the proposed state-wide mental health information system to ensure easy access to forensic patient information in emergency departments and across health service districts, as recommended in the Sentinel Events Report (key recommendation 2).

Recommendation 6.19

That information relating to forensic patients, including diagnosis, Mental Health Act 2000 status, limited community treatment conditions, offence history and other critical information is readily accessible in a forensic summary form in the front of all clinical and administrative files, as well as on the Mental Health Act Information System.

CHAPTER 7 – COMMUNITY AWARENESS

Community perceptions of mental illness

Community awareness and understanding of mental illness and its impact on people and their families has increased over the past decade as a result of a number of national, state and territory developments.[196] Despite these efforts, misunderstanding about mental health issues and systems, stigma and discrimination continue to contribute to negative outcomes for patients, carers and the community.

The research literature indicates misconceptions and negative attitudes towards people with a mental illness have an injurious impact on them as well as on the community. While most people with a mental illness do not commit offences, when they do, it appears to affirm community perceptions that mentally ill people are dangerous and unpredictable. This stigma has the effect of further excluding people with mental illness from the community. Research has shown that social inclusion promotes mental health and that discrimination and social exclusion is itself a mental health risk factor.[197]

The effect of stigma and discrimination on the lives of those affected by mental illness is profound and far-reaching. As well as discouraging help-seeking for mental health problems and disorders generally, stigma has multiple impacts on the quality of consumers' and their families' lives, affecting employment and vocational opportunities, economic participation, community involvement and social connectedness. Physical and mental health status is highly vulnerable to the deleterious effects of stigma, and the feeling of alienation and isolation has been cited as one of the most significant reasons for loss of hope and relapse by those who experience mental illness. Stigma, therefore, has not only a profound individual impact, but also highly significant social and economic consequences.

The findings contained in a recent New Zealand survey confirm the pervasive and harmful nature of stigma and discrimination on the basis of mental illness.[198] However, the research also provides important insights into the form of the discrimination reported in all aspects of respondents' lives from employment and housing, to discrimination from friends and family and the community.

The survey also demonstrates how the fear of discrimination can have just as powerful an effect as discrimination itself. This fear can be paralysing, interfering with all aspects of people's lives with almost half the sample saying they had restricted their activities for fear of discrimination.

Many people had not disclosed their experiences of mental illness, remained isolated or had not drawn attention to themselves to avoid discrimination. People felt they would have recovered more quickly with other people's support but the need to watch out for the negative reactions of other people held them back. People were afraid to use mental health services in case others found out they had experiences of mental illness. This fear included avoiding general health services.

Lack of understanding of mental illness contributes to a lack of understanding of how and why the criminal justice system treats defendants with a mental illness differently to others. Inappropriate media reporting does not assist this situation. Increasing understanding of

196 Commonwealth of Australia, *Evaluation of the Second National Mental Health Plan* (2003) 16-19.
197 Mental Health Foundation of New Zealand, *Respect Costs Nothing: A survey of discrimination by people with experiences of mental illness in Aotearoa New Zealand* (2004).
198 Ibid.

mental illness in the community is essential for promoting an understanding of forensic mental health.

The Review has heard that a great deal of work is being undertaken by non-government organisations, volunteers, family members and friends, to support and educate the community about mental health. This work is integral to the delivery of support and information, particularly where services provided by government fall short.[199]

In Queensland, there is a diversity of individuals and organisations participating in mental health education and support. Organisations have reported some difficulties in attracting volunteers and that the community was sometimes disinterested in finding out more about mental illness.

> In a city of 150,000 people, we couldn't get a single volunteer to help us out with the phones.[200]

A number of national, state and local initiatives have been developed to promote community awareness and mental health well being and reduce stigmatisation and discrimination.

National and State strategies to increase community awareness

The National Mental Health Strategy

The *National Mental Health Strategy* comprises key policy documents and funding agreements endorsed by all Australian Health Ministers.[201] The objectives of the Strategy are:

- to promote the mental health of the Australian community
- to, where possible, prevent the development of mental disorder
- to reduce the impact of mental disorder on individuals, families and the community
- to assure the rights of people with mental disorder.

A key outcome sought under the *National Mental Health Plan 2003-2008*, which is part of the Strategy, is increased levels of mental health literacy in the general community and decreased levels of stigma experienced by people with mental health problems and mental illness. One of the means to achieve this goal is the further promotion of accurate portrayal of mental health problems and mental illness in the media, which is discussed later in this chapter.

National initiatives that contribute to improved outcomes in this area include the Australian Rotary Health Research Fund and school and community-based education programs including *MindMatters*, *CommunityMatters* and *FamilyMatters*.

199 B Dollery and J Wallis, 'Social service delivery and the voluntary sector in contemporary Australia' (2001) 36(3) *Australian Journal of Political Science* 567-575.

200 Comment from a member of a regional Consumer Advisory Group.

201 Australian Health Ministers, *Mental Health Statement of Rights and Responsibilities* (1992); Australian Health Ministers, *National Mental Health Policy* (1992); Australian Health Ministers, *National Mental Health Plan* (1992); Australian Health Ministers, *Second National Mental Health Plan* (1998); Australian Health Ministers, *National Mental Health Plan 2003-2008* (2003); Schedule F1 of the Medicare Agreements supported the First Plan; Schedule B funds from the Australian Health Care Agreements supported the Second Plan.

State initiatives

At the state and territory level, there seems to be a highly variable commitment to mental health promotion. Some jurisdictions, for example Victoria, have historically invested more heavily in health promotion and, more recently, mental health promotion. In May 2006, the VicHealth Centre for the Promotion of Mental Health and Social Wellbeing was established with its defining features including:

- theoretically informed, methodologically rigorous, policy relevant research
- evidence linking community trends, policy interventions and outcomes
- respectful cross disciplinary and cross sectoral partnerships
- engaging communities in research, policy and program development
- knowledge exchange through effective communication of research and practice learning to diverse audiences.

The Centre is supported by and works closely with the Victorian Health Promotion Foundation (VicHealth). Their work is informed by the VicHealth *Plan for the Promotion of Mental Health and Wellbeing*.[202]

Queensland does not currently have a comprehensive, strategic platform to drive mental health promotion, prevention and early intervention. Community awareness raising activities have generally been limited to discrete projects and events such as Mental Health Week. However, a more coherent, holistic approach is proposed with the prioritisation of mental health promotion, prevention and early intervention as one of five key areas for action in the *Draft Queensland Mental Health Plan 2007-2011* (the Draft Plan).[203]

Queensland Centre for Mental Health Promotion, Prevention and Early Intervention

The concept of a Queensland Centre for Mental Health Promotion, Prevention and Early Intervention is a key strategy mooted in the Draft Plan to provide state-wide leadership, conduct research, provide training and facilitate evidence-based approaches.[204] The Centre would work collaboratively across government and non-government sectors to coordinate mental health promotion activities and to actively support generic services in the community to enable those agencies to work with people with mental illness. The Review is supportive of this idea, which would promote a more strategic, sustained approach to raising community awareness and understanding of mental health issues, including those relating to the forensic mental health and justice systems.

> ***Recommendation 7.1***
>
> *That a more strategic, sustained approach be taken to developing community education strategies which support improved community awareness and understanding of the forensic mental health care system in Queensland.*

Local initiatives

Initiatives by mental health services in local communities are also critical to achieving greater community understanding of mental illness and mental health services. The Review has been told about a number of laudable activities supported in the mental health sector in recent years. For example, since 2002, The Park – Centre for Mental Health has implemented a

202 VicHealth Centre for the Promotion of Mental Health and Social Wellbeing website http://www.sph.unimelb.edu.au/vcpmhsw/.
203 Queensland Health, *Draft Queensland Mental Health Plan 2007-2011* (2006).
204 Ibid 16.

range of community awareness and media relations strategies to raise the profile of the service, disseminate positive and accurate information about the service, allay community fears and increase understanding of mental illness by the local media, the community, other government and non-government agencies, mental health service consumers and their carers and the mental health profession. The Park reports these strategies have improved local media relations and raised awareness of the services it provides within the local community and with other agencies such as police.

Recommendation 7.2

That the mental health sector, in conjunction with any state-wide mental health promotion, prevention and early intervention centre that is established, develop local initiatives for increasing community understanding of mental illnesses and their treatment and the mental health services provided in local areas.

Queensland Centre for Mental Health Learning

The Queensland Centre for Mental Health Learning (QCMHL) is a recent Queensland Health initiative which supports the strategic development of the mental health workforce. The Centre is responsible for coordinating, and implementing, where appropriate, the ongoing training and professional development of clinicians and other personnel who support mental health service delivery in Queensland.

Its role is to serve as a state-wide body that will drive and organise a range of education and training programs available to Queensland Health. In addition, it is envisaged the Centre will assist with development of knowledge and skills in the broader health and community sector workforce as that workforce becomes more integrated with the mental health system. That will be achieved through educational partnerships with government departments, non-government organisations and the private sector.[205]

A recently released QCMHL Discussion Paper indicates forensic mental health is one of the specialist workforce areas that will be given immediate, high priority support through targeted training initiatives.[206] This development will be an integral part of a longer term plan for increasing the knowledge and skills of workers across sectors in relation to forensic mental health issues and systems.

Recommendation 7.3

That the plan for the Queensland Centre for Mental Health Learning to improve mental health sector workers' knowledge and skills in forensic mental health be progressed as a matter of priority. The Centre's proposed extension of this training to the broader health and community sector should also be implemented as soon as possible.

Queensland Police Service understanding of forensic mental health

The Review has been advised by members of the Queensland Police Service (QPS) and by victims that most police have limited knowledge of the forensic mental health system. Once a matter is referred to the Mental Health Court it is apparently not uncommon for investigating police to hold the view that the offender is not ill and is 'getting off' or that Mental Health Court is a 'soft option'. These views are often transmitted to victims. As stated in chapter 3, information from police is often the only information victims may be receiving until shortly before the Mental Health Court hearing. Where this information is inaccurate it can cause long term problems

205 Queensland Health, Queensland Centre for Mental Health Learning, *Information Sheet No 1 – August 2006* (2006).
206 Queensland Health, Queensland Centre for Mental Health Learning, *Discussion Paper 4* (2006).

for victims. Under *Criminal Offence Victims Act 1995* (COVA), police have a responsibility to provide accurate information about the progress of the matter through the criminal justice system. This does not appear to be happening in relation to Mental Health Court references.

The QPS has established Mental Health Coordinators in each police district. Part of the role of this position is to manage and monitor training to first response officers under the Mental Health Intervention Project. The training to date has focussed on enhancing tactical communication skills to more effectively respond to incidents involving people with a mental illness. Training should also be focused on providing investigating police, including detectives, with knowledge about the forensic mental health system to ensure that, when dealing with victims where a matter has been referred to the Mental Health Court, they are able to provide accurate information.

The QPS Mental Health Coordinators, who already maintain a close liaison with local mental health services, could act as a point of contact and a resource for arresting officers seeking guidance and information about the Mental Health Court process and victim support contacts.

Recommendation 7.4

That police involved in investigating serious violent offences are provided with training about the Mental Health Court and the forensic mental health system.

Recommendation 7.5

That the police Mental Health Coordinators become a point of contact for arresting officers seeking guidance and information about the Mental Health Court processes and services for victims in matters referred to that Court.

Indigenous representation in the forensic mental health system

Indigenous people are significantly overrepresented in the forensic mental health system, with 18% of people on a forensic order being Aboriginal or Torres Strait Islander origin. However, the percentage of Indigenous people on forensic orders in north Queensland is considerably higher, with approximately 56% of the people on forensic orders in Cairns, Mackay and Townsville being Aboriginal or Torres Strait Islander peoples.[207] Despite this massive overrepresentation in north Queensland, knowledge and understanding about mental illness and particularly the forensic mental health process within Indigenous communities appears to be limited.

Indigenous health workers reported they spent a lot of time talking and explaining issues to family members, but that educating family members was a very slow process.

> I try to explain that it is like having a heart problem or diabetes, but it's in their mind and they need looking after.[208]

The Review heard that terminology, such as 'forensic orders', 'limited community treatment' and the 'mental health review tribunal' were concepts that were foreign to community members. Clinicians and Indigenous health workers also reported that they found it difficult to explain to family members limited community treatment conditions, such as requiring that the person under the forensic order live at a certain address and why they were not allowed to 'go out to country'. These issues were discussed previously in chapter 6.

207 Data from the Mental Health Branch, Queensland Health.
208 Comment by an Indigenous health worker.

The Review heard from Indigenous health workers that the stigma attached to mental illness in Indigenous communities was so great that some people charged with an offence would rather go to jail than go through the Mental Health Court process.

> In jail, at least they know how long they've got till they get out … and they don't have to worry about all the shame if someone finds out they've been in the 'loony bin'.[209]

In a 2005 study of Indigenous young people and their perceptions of mental illness, all participants described their family as, 'pivotal to their emotional, physical and cultural health'.[210] However, the ethnographic study also indicated that traditional supports that had existed previously in communities had diminished, leading to Indigenous people being unable to share traumatic experiences with their kin, resulting in them carrying feelings of shame as individuals.

> This unresolved shame and lack of adequate support to deal with the emotional consequences could potentially lead to situational depression, remorse or even anger.[211]

In north Queensland, community leaders are taking steps to address this breakdown in community sharing and understanding. Indigenous community radio is being used by community leaders to discuss mental health and to promote practical steps that people can take to help someone at risk. The Review also heard that Indigenous men's groups in north Queensland were meeting regularly to support other Indigenous men in talking about spiritual and mental health and restoring relationships to rebuild the community.

> At first, they might just come along, because they've been dragged here. But after a while, they'll have a yarn and really get into it. Now we have some fellows that never miss a meeting.[212]

While it is beyond the scope of the Review to make specific recommendations relating to community organisations, the Review acknowledges and supports the work undertaken by community leaders to facilitate these forums and the positive impact they are having on Indigenous communities.

Recommendation 7.6

That Queensland Health develop culturally appropriate material for Indigenous communities about mental illness that explains the forensic mental health process including information about what families can expect if a person returns to the community.

Representation of Indigenous mental health in the media

The portrayal by the media of Indigenous Australians was the focus of a review undertaken as part of the Mindframe National Media Initiative. The Review investigated the opinions of Aboriginal and Torres Strait Islander peoples across Australia about the media's coverage of mental illness.

The report acknowledged that there were many complexities in reporting mental illness in Indigenous communities:

209 Comment by an Indigenous health worker.
210 A O'Brien, 'Factors shaping Indigenous mental health: An ethnographic account of growing up Koori from a Gubba perspective' (2005) 12(1) *Australian Journal of Nursing* 14.
211 Ibid 16.
212 Comment by an Indigenous community leader.

> … balance needs to be found between reporting factually and being informative without being too specific or too negative. There appears to be a lack of balance between negative and positive stories which can have an effect on Indigenous Australians.[213]

The report also found that Indigenous mental health issues are rarely covered by either mainstream or Indigenous media. This has contributed to the lack of understanding within Indigenous communities towards people with a mental illness.

Recommendation 7.7

That Queensland Health ensure Indigenous perspectives are represented appropriately in the development of mental health resources and educational and promotional material.

Media reporting on mental illness

It is well documented that the way in which the mainstream media report on mental health and mental illness shapes public perceptions. If the reporting is inaccurate, sensationalised or reinforces stereotypes, it can have significant negative effects for people with mental illnesses, including further social exclusion and reluctance to seek out treatment and health.[214]

The media have an important role in a democratic society in informing the public and monitoring the performance of Government. The legal and medical response to offenders with a mental illness is a legitimate subject for public discussion. As this report demonstrates, the needs of victims of crime are an important issue for Government attention. However, it is important for the media when addressing these issues to be mindful of the adverse impact that inaccurate or insensitive reporting can have.

The Review has learnt of patients who found media coverage of mental health matters distressing.

> Regrettably individuals with a mental illness still face substantial stigma and discrimination. They are often the subjects of ridicule, harassment and abuse and have to contend with the negative portrayal of people with a mental illness in the mass media.[215]

> My leave was revoked, but the stuff that got reported had nothing to do with me.[216]

> I feel terrible about what I did. I have nightmares. I'm doing everything I can so I don't get sick again, but they never say that in the paper.[217]

Graphic reporting of mental health cases can also distress victims in those or earlier cases and reactivate their fears and memories.

> Most crime victims have never before dealt with the news media. They can be thrust, often unwillingly, into the limelight solely because of the crimes committed against them. The media can often inflict a "second victimisation" upon crime victims or survivors by enhancing their feelings of violation, disorientation and loss of control.[218]

213 Australian Government (Mindframe Media and Mental Health Project), *Summary Report: News Media and Indigenous Australian Communities* (2004) http://www.mindframe-media.info/cg/atsi/summary.pdf.
214 R Coombes, 'Negative reports of mental health deter people from seeking help' (2006) 332 (7535) *British Medical Journal* 194.
215 Queensland Health, *Sharing responsibility for recovery: Creating and sustaining recovery oriented systems of care for mental health* (2005).
216 Comment by a mental health service consumer.
217 Comment by a mental health service consumer.
218 Australian Institute of Criminology (B Cook, F David and A Grant), *Victims' Needs, Victims' Rights: Policy and Programs for Victims of Crime in Australia* (1999) 73.

As part of a quantitative and qualitative study conducted in 2000-01, the Media Monitoring Project showed that 14.4% of media reports on mental illness reinforced stereotypes that people with mental illnesses are dangerous, violent, unpredictable and unlikely to get better and 29% of mental illness headlines and story contents were found to be unnecessarily dramatic or containing sensational language.[219] The qualitative study found that many of these stories were sourced to police or the courts.[220]

National Mindframe Media Initiative

The approach taken by journalists and editorial teams is integral to the reporting of incidents involving people with a mental illness and helps shape community attitudes and perceptions towards people with a mental illness.

> The media tend to portray mental illness negatively, often stereotyping people with mental illness as being violent and unpredictable, and reporting the transfer of their care from hospital to community settings unfavourably.[221]

Since June 2002, a number of strategies have been implemented to educate media professionals as part of the National Mindframe Media Initiative, funded by the Australian Government's Department of Health and Ageing. The Initiative aims to encourage responsible, accurate and sensitive reporting of issues related to mental illness. These resources also include information to assist people who are responding to media enquiries.

Through a variety of projects, the Initiative aims to influence media coverage and includes:

- *Response Ability*: a package of resources for journalism education and information for high school teachers
- *Media and Mental Health Project*: a resource for media professionals
- *SANE StigmaWatch*: Monitoring of media reporting to fight stigma
- *Mindframe for the Mental Health Sector*: resources for people working in the mental health sector, including how to respond to media enquiries.[222]

Mindframe also delivers face-to-face briefings with a diverse range of media organisations.

However, information specifically relevant to forensic mental health in these resources is limited as the original focus for the Initiative was the reporting of suicide and mental illness. The Review has been advised that Mindframe is reviewing their content with the goal of increasing forensic mental health related information during 2007. This is supported by the Review.

Sensitive media portrayal of forensic mental health issues is particularly important in reducing the stigma for all people with a mental illness. This requires journalists and the editorial teams to have an understanding of mental illness and of the Queensland forensic mental health system, specifically. The prioritisation of mental health promotion, prevention and early intervention as one of five key areas for action in the Draft Plan should provide an opportunity to develop resource materials for media professionals about the Queensland forensic mental

219 J Pirkis et al, *The Media Monitoring Project, A Baseline description of how the Australian media report and portray suicide and mental health and illness* (2002) 65-69 http://www.mindframe-media.info/files/downloads/media_monitoring_project_full.pdf.

220 Ibid 145. The quality ratings used in the study were based on criteria outlined in *Achieving the Balance: A Resource Kit for Australian Media Professionals for the Reporting and Portrayal of Suicide and Mental Illnesses* developed by the Commonwealth Department of Health and Aged Care.

221 Conclusions from study undertaken by C Francis et al, *Mental Health and Illness in the Media: A Review of the Literature* (2001) cited in J Pirkis et al, *The Media Monitoring Project, A Baseline description of how the Australian media report and portray suicide and mental health and illness* (2002) 65-69.

222 Further information is available at www.mindframe-media.info.

health system, in particular the role of the Mental Health Court and the Mental Health Review Tribunal.

Recommendation 7.8

That, in implementing the mental health promotion, prevention and early intervention key area for action in the Draft Queensland Mental Health Plan 2007-2011, consideration be given to developing resource materials for media professionals about the Queensland forensic mental health system.

APPENDICES

Appendix A – Terms of Reference

REVIEW OF THE *Mental Health Act 2000*

The purpose of the *Mental Health Act 2000* is to provide for the involuntary assessment and treatment, and the protection, of persons (whether adults or minors) who have mental illnesses while at the same time safeguarding their rights. In particular, it:

- provides a scheme for the involuntary admission, treatment and protection of people with mental illnesses where this is necessary;
- ensures that the rights of people with mental illness are protected through independent review of their involuntary status;
- provides for the expert determination of criminal responsibility for people with a mental illness or intellectual disability charged with criminal offences;
- facilitates admission and treatment of people with a mental illness serving a sentence of imprisonment or charged with criminal offences.

PURPOSE OF THE REVIEW

On Tuesday 23 May 2006, the Minister for Health, the Honourable Stephen Robertson, announced that Government would conduct a review of the *Mental Health Act 2000*.

Concerns have been raised about the level of consultation that occurs with victims and their families in deciding to grant or approve limited community treatment to patients under a forensic order. The review will examine the efficacy of current arrangements that take account of the interests of victims and their families and whether these arrangements need to be amended to further enable victims and their families to be involved in the decision making process. The review will also consider whether the *Mental Health Act 2000* and associated arrangements achieve an appropriate balance between the responsibility of the state to strengthen the safety and protection of the community with the provision of rehabilitation opportunities for patients under a forensic order.

Within the framework set out in the *Mental Health Act 2000*, the *National Mental Health Strategy* and the obligations under the *United Nations Principles for the Protection of Rights of People with Mental Illness and for the Improvement of Mental Health Care*, the Minister for Health has established the following Terms of Reference for the review of the operation of the *Mental Health Act 2000* and related administrative processes:

LEGISLATIVE PROVISIONS

1. Assess the efficacy in protecting the interests of victims and their families of provisions in the *Mental Health Act 2000* about the Mental Health Court and the Mental Health Review Tribunal, as they relate to:
    a) consideration of the views of victims and their families of offences committed by persons dealt with by the Mental Health Court or Mental Health Review Tribunal;
    b) opportunities for victims or their families to provide information before decisions are made;
    c) notification of victims or their families about decisions made;

d) parties to proceedings before the Mental Health Court or Mental Health Review Tribunal.

2. Assess the adequacy of legislative provisions in the *Mental Health Act 2000* relating to Limited Community Treatment.

3. Assess the efficacy of current legislative provisions that enable the Director of Mental Health to refer certain matters to the Attorney-General.

COMMUNITY CONSULTATION

4. Consider whether criteria should be developed to permit appropriate, interested members of the public to represent their concerns to the Mental Health Court or the Mental Health Review Tribunal before limited community treatment is ordered or approved.

5. Consider whether and in what circumstances victims and their families should be informed about a decision to order or approve limited community treatment.

ADMINISTRATIVE ARRANGEMENTS

6. Assess the efficacy in protecting the interests of victims and their families of current administrative arrangements to support the Mental Health Court and the Mental Health Review Tribunal, as they relate to:
    a) consideration of the views of victims and families of victims of offences committed by persons dealt with by the Mental Health Court or the Mental Health Review Tribunal;
    b) opportunities for victims or their families to provide information before decisions are made;
    c) notification of victims or their families about decisions made.

7. Assess the adequacy of current administrative arrangements relating to Limited Community Treatment.

8. Assess the efficacy of current administrative arrangements which support the referral of certain matters by the Director of Mental Health to the Attorney-General.

IMPLEMENTATION OF PREVIOUS RECOMMENDATIONS

9. Assess the ongoing relevance of recommendations from previous reviews of the *Mental Health Act 2000* in relation to the interests of victims of crime and their families, including but not limited to the *Review of Queensland Forensic Mental Health Services* (the "Mullen/Chettleburgh Report").

10. Assess the implementation of recommendations in the Mullen/Chettleburgh Report, as they relate to:
    a) providing information to victims and their families;
    b) consideration of the views of victims and their families of offences committed by persons dealt with by the Mental Health Court or Mental Health Review Tribunal;
    c) opportunities for victims and their families to provide information before decisions are made;
    d) notification of victims and their families about decisions made;

e) breaches of conditions of limited community treatment;

f) provision of information by third parties to the Mental Health Review Tribunal and the Mental Health Court.

PROCESS FOR REVIEW AND CONSULTATION

The review will be undertaken by an independent and respected individual with the skill to balance the complex range of community safety and health rights issues. The review will report to a Steering Committee headed by the Department of Premier and Cabinet and comprising Queensland Health, the Department of Justice and Attorney-General, Disability Services Queensland, Queensland Treasury and the Queensland Police Service.

The head of the review will be assisted by an independent expert reference group that will include representatives of victims of crime, psychiatrists, consumers, legal and law enforcement figures and a broad cross section of the community. Consultation with the community is to be undertaken with opportunities for written submissions.

The review is to provide an interim report to the Minister for Health before 1 September 2006.

OUTCOMES OF THE REVIEW

The review is to provide a final report to the Minister for Health before 11 December 2006.

The report is to include recommendations arising from the terms of reference relating to –

1. appropriate legislative amendment;

2. measures to improve administrative processes in support of the *Mental Health Act 2000*;

3. action to be taken to further progress recommendations from previous reviews, including the Mullen/Chettleburgh Report;

4. increasing community awareness and understanding about functions, processes and systems relating to the Mental Health Court and Mental Health Review Tribunal.

Appendix B – Consultation meetings with Brendan Butler

Date	Location	Stakeholder
29/06/06	Brisbane	The Hon. W.J. Carter QC and Ms Kelly Weekley - Carter Investigation
04/07/06	Brisbane	Official Solicitor and senior staff, Department of Justice and Attorney-General
04/07/06	Brisbane	Senior police, Queensland Police Service
06/07/06	Brisbane	Queensland Health Victim Support Coordinator
07/07/06	Brisbane	Director of Mental Health, A/Principal Adviser in Psychiatry and Managers, Mental Health Branch, Queensland Health
07/07/06	Brisbane	President and Executive Officer, Mental Health Review Tribunal
07/07/06	Brisbane	Chief Executive Officer, Queensland Homicide Victims' Support Group
07/07/06	Brisbane	The Qld Alliance – President, Executive Director and staff
24/07/06	Brisbane	Prison Mental Health Service staff
24/07/06	Brisbane	Disability Law Project Staff (Toowoomba)
24/07/06	Brisbane	Crown Law counsel for Director of Mental Health
28/07/06	Brisbane	Staff and consumers at The Park – Centre for Mental Health, Brisbane
31/07/06	Brisbane	Professor Ernest Hunter, University of Qld
04/08/06	Brisbane	Chief Magistrate State Coroner
07/8/06	Brisbane	Chief Executive Officer, Queensland Aboriginal and Islander Health Council
07/08/06	Brisbane	Victim's family member
07/08/06	Brisbane	Victim's family member
07/08/06	Brisbane	Patient's family member
07/08/06	Brisbane	Victim
08/08/06	Brisbane	Staff at Youth Justice Services, Department of Communities
08/08/06	Brisbane	Chief Executive Officer and staff, Relationships Australia (Qld)
09/08/06	Brisbane	Public Advocate
09/08/06	Brisbane	Executive Director, Offender Programs and Services, Coordinator, Victims' Register and staff, Department of Corrective Services
09/08/06	Brisbane	Community Forensic Mental Health Service, Queensland Health

Date	Location	Stakeholder
10/08/06	Toowoomba	Toowoomba Mental Health Service Staff, Consumer Advisory Group
11/08/06	Gold Coast	Director of Psychiatry, Executive Officer, Consumer Consultant, Gold Coast Integrated Mental Health Service staff
15/08/06	Tefeconf	Principal Crown Prosecutor, Office of the Deputy Director of Public Prosecutions
21/08/06	Brisbane	The Hon. P de Jersey, Chief Justice, the Hon. Justice C Holmes and the Hon. Justice I Philippedes
21/08/06	Brisbane	Victim's family member
22/08/06	Videoconf	Queensland Health Northern Area Clinical Network Meeting
23-25/08/06	Townsville	• Townsville Adult Mental Health Service staff • Aboriginal and Torres Strait Islander Mental Health staff • Aboriginal and Torres Strait Islander • Legal Service staff • Non-government organisation staff • Office of the Director of Public Prosecutions staff • Consumer Advocacy Group for Mental Health • Forensic Mental Health Consumer Consultant
29/08/06	Brisbane	Aboriginal and Torres Strait Islander Legal Service staff
30-31/08/06	Cairns	• Cairns Mental Health Service staff and other health staff • Aboriginal and Islander mental health and remote health service staff • Queensland Health/Queensland Police Service Liaison staff • Consumer Advisory Group • Indigenous community representatives
06/09/06	Brisbane	Community Safety and Individual Support staff, Department of Communities
12/09/06	Brisbane	Consumers and staff at The Park – Centre for Mental Health
21/09/06	Brisbane	Meeting with Mental Health Review Tribunal members (SE Qld)
27/09/06	Brisbane	Professor Paul Mullen, Forensicare, Victoria
27/09/06	Brisbane	Women's Legal Service
09/10/06	Sunshine Coast	Victim's family member
17/10/06	Brisbane	Deputy Director-General, Higher Courts Administrator and Official Solicitor, Department of Justice and Attorney-General
18/10/06	Brisbane	Sentinel Events Review Implementation Team staff

Date	Location	Stakeholder
18/10/06,	Brisbane	Director of Mental Health, A/Principal Adviser in Psychiatry and Managers, Mental Health Branch, Queensland Health
25/10/06	Brisbane	Principal Crown Prosecutor, Office of the Director of Public Prosecutions
26/10/06	Brisbane	Queensland Police Service senior staff
26/10/06	Brisbane	Director of Mental Health, A/Principal Adviser in Psychiatry and Managers, Mental Health Branch, Queensland Health
30/10/06	T/conf	Patient's family member
31/10/06	Brisbane	Mental Health Court Registrar and staff
06/11/06	T/conf	Victim's family member
06/11/06	Brisbane	Director of Mental Health, A/Principal Adviser in Psychiatry and Managers, Mental Health Branch, Queensland Health
09/11/06	T/conf	Director of Public Prosecutions
14/11/06	T/conf	Victim
20/11/06	Brisbane	Dr Philip Morris, Psychiatrist
22/11/06	Brisbane	President and Executive Officer, Mental Health Review Tribunal

Appendix C – Submissions and responses to Call for Submissions and Discussion Paper

This appendix provides a list of verbal and written submissions received in response to *Call for Submissions* and *Discussion Paper*.

1. Name withheld - mental health professional
2. Name withheld - mental health professional
3. Name withheld - mental health professional
4. False Memory Syndrome Support Group
5. The Advocacy and Support Centre

5A. The Advocacy and Support Centre

6. Name withheld - victim
7. Name withheld - victim
8. Judge MP Irwin, Chief Magistrate
9. The Hon Linda Lavarch, Attorney-General
10. Name withheld - member of the public
11. Mental Health Review Tribunal

11A. Mental Health Review Tribunal

12. Name withheld - relative of victim
13. Name withheld - member of the public
14. Division of Mental Health, Princess Alexandra Hospital

14A. Division of Mental Health, Princess Alexandra Hospital

15. Name withheld - patient
16. Name withheld - member of the public
17. Name withheld - carer
18. Community Forensic Mental Health Service

18A. Community Forensic Mental Health Service

19. Queensland Police Service

19A. Queensland Police Service

20. Queensland Alliance
21. Office of the Public Advocate

21A. Office of the Public Advocate

21B. Office of the Public Advocate

21C. Office of the Public Advocate

21D. Office of the Public Advocate

22. Name withheld - member of the public
23. Australia and New Zealand College of Mental Health Nurses
24. Mental Health Service, West Moreton Health Service District
25. Anonymous
26. Gold Coast Institute of Mental Health

26A. Gold Coast Institute of Mental Health

27. Department of Corrective Services
28. The Royal Australian and New Zealand College of Psychiatrists
29. Queensland Nurses' Union

29A. Queensland Nurses' Union

30. Department of Communities and Disability Services Queensland

30A. Department of Communities and Disability Services Queensland

31. ARAFMI (Queensland) New Farm

31A. ARAFMI (Queensland) New Farm
32. Name withheld - victim and mental health professional
33. Name withheld - relative of victim
34. Department of Child Safety
35. Legal Aid Queensland
35A. Legal Aid Queensland
36. Department of Justice and Attorney-General
36A. Department of Justice and Attorney-General
37. Name withheld - patient
38. Queensland Transcultural Mental Health Centre
39. Name withheld - mental health professional
40. Name withheld - relative of patient
41. Name withheld - patient
42. Name withheld - member of the public
43. Name withheld - relative of victim
44. Name withheld - carer
45. Name withheld - relative of patient with mental illness and carer
46. Department of Housing
47. Anonymous
48. Name withheld - victim
49. Name withheld - member of the public
50. Name withheld - mental health professional
51. Assisting Psychiatrists, Mental Health Court
52. ARAFMI (Queensland) Rockhampton
53. Name withheld - relative of victim
54. Name withheld - mental health professional
55. Name withheld - victim
56. Name withheld - relative of victim
57. State Incorrections Network
58. Carers Queensland
59. Queensland Public Tenants' Association Inc
60. Relationships Australia
61. Name withheld - relative of victim
62. Name withheld - mental health professional
63. Name withheld - victim
64. Name withheld - relative of patient
65. Name withheld - victim
66. Name withheld - consumer and carer
67. Child and Youth Forensic Outreach Service
68. Community Recovery
69. Mental Health Branch, Queensland Health
70. Name withheld - relative of victim
71. Commission for Children and Young People and Child Guardian
72. Department of Child Safety
73. Director of Mental Health, Queensland

Appendix D – Key Concepts

Mental Health Court

Role of Mental Health Court

The Mental Health Court (the Court) is established under the *Mental Health Act 2000* (the Act) to replace the Mental Health Tribunal, with amendments to its jurisdiction and procedures that more closely align it with the broader court system. The Court is required to conduct an inquiry to determine whether the accused person is fit to stand trial or was of unsound mind at the time of the offence or, if the charge is murder, whether the person was of diminished responsibility. The Court also decides appeals against decisions of the Mental Health Review Tribunal and may investigate the detention of patients in authorised mental health services.[223]

The Court is constituted by a Supreme Court judge sitting alone. The judge is assisted by two psychiatrists who advise the Court on medical or psychiatric matters.[224] The Court has inquisitorial powers that enable the judge to examine relevant issues and to accept material that may otherwise be inadmissible in other court proceedings. Hearings are usually open to the public.[225]

The defendant's mental condition may be referred to the Court by the person or their legal representative, the Attorney-General, the Director of Public Prosecutions, the Director of Mental Health (if the person is receiving treatment for mental illness) or the ordinary criminal court.

The Court has the power to order an independent examination and report from a psychiatrist other than the psychiatrist responsible for the patient's treatment. Other material considered by the Court is the brief of evidence including a criminal history provided by the police prosecutor or the Director of Public Prosecutions. The Court may also consider written submissions from the parties to the reference and relevant sworn material from people who are not parties to the proceedings, including victims.[226]

If the Court decides that a person was not of unsound mind at the time of the offence and is fit for trial, then the matter is returned to the criminal court for trial and sentence. In 2004-2005, approximately 38% of findings of the Mental Health Court resulted in matters being returned to the criminal courts.[227]

Making a forensic order

If the Court decides a person was of unsound mind at the time of the offence, or that the person is permanently unfit for trial, the criminal proceedings are discontinued. In these circumstances, the Court may make a forensic order detaining the person in an authorised mental health service for involuntary treatment and care.[228]

If the Court decides a person was of unsound mind at the time of the offence, or that the person is *permanently unfit for trial*, the criminal proceedings are discontinued. In these circumstances,

223 *Mental Health Act 2000* (Qld) s 383.
224 *Mental Health Act 2000* (Qld) s 382.
225 Queensland Courts – Role of the Courts (Mental Health Court) http://www.courts.qld.gov.au/about/role_mhc.asp#constituted.
226 Queensland Courts – Role of the Courts (Mental Health Court) http://www.courts.qld.gov.au/about/role_mhc.asp#constituted.
227 Mental Health Court, *Mental Health Court Report 1 July 2004-30 June2005.*
228 Mental Health Court, *Mental Health Court Report 1 July 2004-30 June2005.*

the Court may make a forensic order detaining the person in an authorised mental health service for involuntary treatment and care.[229]

Where the Court has found that a person is *temporarily unfit for trial*, the criminal proceedings are stayed and the Court must make a forensic order for the person, detaining the person in an authorised mental health service for involuntary treatment and care.[230]

In deciding whether to make a forensic order, the Court must consider:

- the seriousness of the offence
- the person's treatment needs
- the protection of the community.[231]

The Court must also apply the principles for exercising powers and performing functions under section 9 of the Act:

> 'A power or function under this Act relating to a person who has a mental illness must be exercised or performed so that –
>
> (c) the person's liberty and rights are adversely affected only if there is no less restrictive way to protect the person's health and safety and to protect others; and
>
> (d) any adverse effect on the person's liberty and rights is the minimum necessary in the circumstances'.[232]

The discretionary power of the Court to make a forensic order has to some extent addressed past concerns about the unnecessary application of forensic orders. However, there are still a significant number of patients on forensic orders whose treatment and rehabilitation needs vary markedly. As at 1 December 2006, the total number of patients on a forensic order was 461.

Mental Health Review Tribunal

The Mental Health Review Tribunal (the Tribunal) is an independent statutory body established under the Act to ensure the involuntary provisions are appropriately applied in relation to involuntary patients.[233] It is a single, state-wide organisation made up of part-time members and headed by a full-time President.

The role of the Tribunal includes:

- reviewing the application of treatment criteria for patients i.e. determining whether a person should continue to be subject to involuntary treatment and/or detention as provided under an Involuntary Treatment Order
- reviewing the detention of young patients in high security units.
- reviewing the mental condition of forensic patients i.e. determining whether a person should continue to be subject to involuntary treatment and/or detention as provided under a forensic order
- reviewing fitness for trial in relation to person found unfit for trial by a jury or the Mental Health Court, excluding those found permanently unfit
- deciding applications for notification orders i.e. determining whether a person should be advised of certain matters in relation to a patient, such as the date of the Tribunal review or Tribunal decisions

229 *Mental Health Act 2000* (Qld) s 288(2).
230 *Mental Health Act 2000* (Qld) s 288(4).
231 *Mental Health Act 2000* (Qld) s 288(3).
232 *Mental Health Act 2000* (Qld) s 9.
233 *Mental Health Act 2000* (Qld) ch 12 pt 1.

- deciding treatment applications e.g. determining whether ECT is the most appropriate treatment in relation to a patient who is unable to consent
- deciding applications for approval of patients to move out of Queensland
- deciding appeals against decisions to refuse persons to visit an involuntary patient.[234]

Tribunal hearings are usually closed proceedings. The only people who can attend are:

- the patient
- the patient's lawyer (if applicable)
- the patient's support persons, for example, an allied person
- the patient's psychiatrist
- other members of the treating team.

In addition, subject to the patient's consent and the Tribunal President's approval, observers may attend proceedings if they have a 'genuine reason' for being there. For example, a person who is working in a mental health service is likely to fulfil this criterion. Factors that are taken into account by the President in making a decision about whether to approve an application for a person to observe a hearing include the patient's rights, privacy and dignity.[235]

Tribunal panels usually comprise three members – one must be a lawyer (of at least five years' standing), one must be a psychiatrist (or another doctor if a psychiatrist is not readily available) and one must be a person with relevant experience or qualifications. A panel may be increased up to five members in cases which are more complex or contentious. One member panels may be constituted in exceptional circumstances where the President is satisfied it is in the patient's best interests and it is appropriate and expedient to do so or treatment is required urgently. Hearings are convened in health facilities across the State.

Members are appointed by the Governor-in-Council for a term of no longer than three years.[236]

Persons of Special Notification

A Person of Special Notification (PSN) is a patient on a forensic order who has been found of unsound mind or unfit for trial either temporarily or permanently in relation to one or more of the following serious offences:

- murder
- manslaughter
- attempted murder
- rape or assault with intent to rape
- dangerous driving causing death.

Implementation of the *Mental Health Act 2000* (the Act) in 2002 coincided with the Mullen Chettleburgh Review, which recommended amendment of the Mental Health Act 2000 to introduce of an additional category of forensic order to differentiate patients who are serious violent offenders from patients who have committed non-violent offences. The purpose of the additional category was to ensure greater oversight of individuals who have committed serious violent offences. Implementation of this recommendation was not included when amendments

234 Mental Health Review Tribunal http://www.mhrt.qld.gov.au/AboutUsMHRT.htm.
235 Mental Health Review Tribunal, *Observers at Tribunal Hearings* http://www.mhrt.qld.gov.au/Acrobat/OTH.pdf.
236 Mental Health Review Tribunal http://www.mhrt.qld.gov.au/AboutUsMHRT.htm.

were subsequently made to the Act. Instead, in 2002, Queensland Health established the administrative category of PSN.

PSN represent a relatively small proportion of the total number of patients subject to the Act. As at 1 December 2006, the total number of patients on involuntary treatment orders was 2817, and the total number on forensic orders was 461 (including 99 PSN). Mental Health Branch to update figures.

The *Policy for management, reviews and notifications for a Person of Special Notification* emphasises the responsibility of mental health services to provide a high level of oversight of PSN. In addition to patient safety considerations, the Policy stipulates that treatment and rehabilitation decisions in relation to PSN must consider past harm caused and public safety. Standards outlined in the Policy relating to the management, review and reporting requirements for the treatment and care of PSN include:

- A PSN will be directly under the care and treatment of an authorised psychiatrist (under the Act). Those patients on more than overnight limited community treatment (LCT) in the community will be reviewed at least monthly by the treating doctor, unless there is clinical evidence why this frequency of review should be decreased.
- A PSN will be allocated an experienced mental health care co-ordinator or case manager, with input from the district mental health forensic liaison officer, where available. The patient will be reviewed weekly by the nominated case manager while residing in the community on LCT unless there is clinical evidence supporting a reduction in this frequency of review.
- The treatment plan should include a risk management or action plan that outlines the service's response in the event that a patient fails to comply with any aspects of treatment or any conditions of LCT.
- A quarterly report to the Director of Mental Health is to be completed.

Limited community treatment

The Mental Health Court may also order, approve or revoke LCT when it makes a forensic order.[237] LCT for a patient means 'undertaking some treatment or rehabilitation in the community other than under the community category of an involuntary treatment order'.[238] The Mental Health Review Tribunal may also order, approve or revoke LCT when it reviews a forensic order.[239] LCT is designed to provide an opportunity for recovering patients to make a supported transition back to the community.

The Court or Tribunal may set conditions under which a patient may access LCT. LCT conditions may specify where the patient can go, where they can live, who should accompany them and when they must return.

LCT usually occurs in a graduated way. Initially, a patient may be allowed escorted leave on the grounds of the authorised mental health service, graduating, with appropriate approval, to unescorted leave outside the grounds and, if appropriate, residence in the community. Due to the nature of their mental illness, some patients' access to the community remains very limited.

237 *Mental Health Act 2000* (Qld) chap 7 part 7.
238 *Mental Health Act 2000* (Qld) sch 2.
239 *Mental Health Act 2000* (Qld) s 203.

LIST OF ACRONYMS

A

AWOP – Absent without permission

C

COVA – *Criminal Offences Victims Act 1995*

CoAG – Council of Australian Governments

CMC – Crime and Misconduct Commission

D

DCS – Department of Corrective Services

DJAG – Department of Justice and Attorney-General

DMH – Director of Mental Health

DPP – Director of Public Prosecutions

DSQ – Disability Services Queensland

I

ITO – Involuntary Treatment Order

L

LAQ – Legal Aid Queensland

LCT – Limited Community Treatment

LCTRC – Limited Community Treatment Review Committee

M

MHAIS – Mental Health Act Information System

O

ODPP – Office of the Director of Public Prosecutions

P

PSN – Person of Special Notification

Q

QH – Queensland Health

QPS – Queensland Police Service

QAS – Queensland Ambulance Service

QH VSC – Queensland Health Victim Support Coordinator

QH VSG – Queensland Homicide Victims' Support Group

QH VSS – Queensland Health Victim Support Service

QLRC – Queensland Law Reform Commission

V

VLS – Victim Liaison Service (ODPP)

VLO – Victim Liaison Officer (ODPP)

GLOSSARY OF TERMS

Act means the *Mental Health Act 2000*

authorised mental health service generally means a mental health service declared by the Director of Mental Health and may be a high secure unit, an inpatient unit or a community based service.

carer, of a patient, means a person who –

a) provides domestic services and support to the patient; or

b) arranges for the patient to be provided with domestic services and support.

classified patient means a person who, under section 69, *Mental Health Act 2000* is a classified patient.

Court see Mental Health Court

Director of Mental Health means the statutory officer appointed by the Governor-in-Council, responsible on a state-wide basis for ensuring that the assessment and treatment of involuntary patients complies with the *Mental Health Act 2000.*

fit for trial for a person, means fit to plead at the person's trial and to instruct counsel and endure the person's trial, with serious adverse consequences to the person's mental condition unlikely.

forensic order means –

a) a forensic order (Criminal Code); or

b) a forensic order (Mental Health Court); or

c) a forensic order (Minister).

forensic order (Criminal Code) see section 299(b)(i), *Mental Health Act 2000.*

forensic order (Mental Health Court) see section 288(2) and (4), *Mental Health Act 2000.*

forensic order (Minister) see section 302(2), *Mental Health Act 2000.*

forensic patient means a person who is, or is liable to be, detained in an authorised mental health service under a forensic order.

high security unit means a public sector mental health service, or part of a public sector mental health service, declared by the Director of Mental Health to be a high security unit.

index offence is the offence for which a person was charged which led to the person being placed on a forensic order.

indictable offence is a more serious offence that may be tried on indictment (a written charge) before a judge and jury in the higher courts.

i**nvoluntary patient** – means a person –

a) who is , or is liable to be, detained, under chapter 2, part 4 in an authorised mental health service for assessment; or

b) for whom an involuntary treatment order is in force; or

c) who is a classified or forensic patient.

involuntary treatment order an order authorising a patient's involuntary treatment at an authorised mental health service – can be either inpatient or community category.

limited community treatment for a patient, means undertaking some treatment or rehabilitation in the community other than under the community category of an involuntary treatment order.

Mental Health Act means the *Mental Health Act 2000.*

Mental Health Court means the Mental Health Court established under section 381(1) *Mental Health Act 2000*.

Mental Health Review Tribunal means the Mental Health Review Tribunal established under section 436(1), *Mental Health Act 2000.*

Mental Health Tribunal means the tribunal established under the *Mental Health Act 1974* and replaced by the Mental Health Court with the commencement of the *Mental Health Act 2000*.

Person of Special Notification is a patient on a forensic order who has been found of unsound mind or unfit for trial either temporarily or permanently in relation to one of the following serious offences:

- murder
- manslaughter
- attempted murder
- rape or assault with intent to rape and/or
- dangerous driving causing death.

simple offence is a less serious offence that is dealt with by summary trial in the Magistrates Court.

treating team is the team of mental health professionals involved in treating a patient. The treating team may include psychiatrists, nurses, and allied health professionals.

Tribunal see Mental Health Review Tribunal.

unsound mind means the state of mental disease or natural mental infirmity described in the Criminal Code, section 27, but does not include a state of mind resulting, to any extent, from intentional intoxication or stupefaction alone or in combination with some other agent at or about the time of the offence. Section 27 provides:

> A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission the person is in such a state of mental disease or natural mental infirmity as to deprive the person of capacity to control the person's action, or of capacity to know that the person ought not to do the act or make the omission.

victim, for the purpose of this paper, is the term used to refer to those harmed directly or indirectly by an act that resulted in a person being charged with an indictable offence and diverted to the Mental Health Court.

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