Review of the Mental Health Act 2000

Discussion paper

May 2014
Contents

Introduction ........................................................................................................4
Recommendations ..............................................................................................8
Introduction

Background

Mental health disorders have a significant impact on the health and wellbeing of individuals, their families, carers and the community. These disorders are recognised as serious, and are sometimes debilitating. Families, carers, friends and others who support those with mental health disorders are an important part of a patient’s recovery.

In Australia, one in five people are affected by a mental health disorder. The Australian Bureau of Statistics estimates the annual cost of mental health disorders in Australia at approximately $20 billion\(^1\).

In Queensland, more than 85,000 people receive services through the public mental health system each year.

More than $1.1 billion is invested each year in providing Queenslanders with public mental health services and support, healthcare facilities and treatment. More than 300,000 Queenslanders receive treatment for mental health disorders in the private sector, which is largely funded by Medicare.

Mental health facilities and services are provided across Queensland, with a number specialising in areas such as children and youth services or complex mental healthcare.

Partnerships with government and non-government agencies, service providers, families and carers all contribute to the care and recovery process.

The majority of people with a mental illness receive treatment and care for their illness voluntarily—however, some individuals are unable to give informed consent to treatment.

To improve and maintain the health and well-being of these individuals, effective legislation is required to safeguard their rights and ensure treatment and care is provided to support their recovery.

In a limited number of cases an individual may be of unsound mind at the time of an unlawful act or be unfit for trial, due to a mental illness. In these circumstances, the legislation is designed to divert those affected by a mental illness from the criminal justice system into appropriate treatment and care to protect the individual and wider community. However, the majority of involuntary patients in mental health facilities are not admitted as a result of committing an unlawful act.

\(^1\) ABS, National Survey of Mental Health and Wellbeing, 2007.
Review of the Mental Health Act 2000

The Mental Health Act 2000 replaced the Mental Health Act 1974 to reflect contemporary clinical practices, international, national and state policy directions and broad community expectations.

Key policy issues within the Mental Health Act 2000 can be conceptualised into two broad content areas, namely:

- policy issues relating to the involuntary assessment and treatment of people with a mental illness, and
- policy issues relating to people with a mental illness who are charged with an offence, including the treatment and care of these people.

In June 2013, the Honourable Lawrence Springborg MP, Minister for Health, announced a review of the Mental Health Act 2000 to deliver the best possible mental healthcare for Queenslanders.

The review of the Act is being undertaken as part of a number of key reforms being implemented, including the establishment of the Queensland Mental Health Commission (QMHC).

The QMHC was established as an independent statutory body on 1 July 2013 under the Queensland Mental Health Commission Act 2013, to reform the mental health and alcohol and drug systems, drive research and innovation, and promote the mental health and wellbeing of all Queenslanders.

Improvements to the Mental Health Act 2000 are being done in collaboration with a diverse range of key stakeholders including:

- the Queensland Mental Health Commission
- legal and advocacy groups
- those responsible for administering the legislation, including authorised mental health services and the Mental Health Review Tribunal
- government agencies
- peak bodies
- individuals with specific areas of interest such as victims and patients’ families and carers
- the general public.

Two rounds of consultation have been included as part of the review of the Act, as it is recognised there is a diverse range of stakeholders to consult with on a complex range of issues.

The first round of consultation was completed in mid-2013. The release of this discussion paper represents the second round of consultation.

Further information about the review, including the terms of reference can be found at www.health.qld.gov.au/mentalhealth/news/MHA2000-review.asp

Further information about the Queensland Mental Health Commission is available at www.qmhc.qld.gov.au

Objective

Mental health legislation aims to improve and maintain the health and wellbeing of people with a mental illness who do not have the capacity to consent to treatment, and those who have been found to have been of unsound mind at the time of committing an unlawful act.

The proposed changes to the legislation aim to:

- safeguard the rights of people with a mental illness
- promote an individual’s recovery and ability to live in the community without the need for involuntary treatment and care
- strengthen the importance of family, carers and other support people to a patient’s treatment and recovery
- adversely affect an individual’s rights and liberties only if there is no less restrictive way to protect the health and safety of the individual or others
- provide for simpler and fairer processes under the Act.
First round of consultation

In June 2013, the Terms of Reference for the review were released for feedback on areas of improvement in the Act.

The Terms of Reference recognised that the Act and the way it is administered can have significant effect on individuals, and deals with a complex and sensitive range of issues.

During the two-month initial consultation period, meetings and workshops were held with key stakeholders including:

- users of mental health services, their families and carers
- peak bodies (e.g. mental health professional organisations, Queensland Voice, Carers Queensland)
- non-government and private sector agencies that deliver services to people with a mental illness
- legal agencies (e.g. Legal Aid Queensland, Aboriginal and Torres Strait Islander Legal Service, Queensland Law Society)
- authorised mental health services
- victims of crime
- government agencies (e.g. the Department of Justice and Attorney-General, the Adult Guardian, the Public Advocate, the Director of Public Prosecutions)
- the Director of Mental Health and the Director of Forensic Disability
- the Mental Health Court
- the Mental Health Commissioner
- the Mental Health Review Tribunal.

The first round of public consultation was highly successful with approximately 100 written submissions being received.

More than 200 recommendations have been developed in response to issues raised during the initial consultation to improve mental health legislation in Queensland.

Although it was not originally anticipated that a rewrite of the legislation would be required, due to the significant response to the initial consultation, the Mental Health Act 2000 will need to be repealed and replaced to implement the extensive changes recommended.

Second round of consultation

All individuals and organisations are welcome to contribute their ideas, thoughts and suggestions to the second round of consultation on the review of the Act. All individuals and organisations can respond to the questions posed in this discussion paper, comment on the details of the recommendations, or offer new ideas or alternative solutions for the proposed legislation.

Workshops and meetings with key stakeholders will take place with the release of this discussion paper.

All interest groups, organisations and individuals who made submissions to the initial consultation or who expressed an interest in being consulted on the review are being advised of the availability of this discussion paper.

Please note the recommendations do not represent government policy, which will be determined after analysis of feedback received.

Additional information on the recommendations can be found in background papers available on the Queensland Health website: www.health.qld.gov.au/mentalhealth/news/MHA2000-review.asp
The background papers deal with the following issues:

1. Involuntary examinations and assessments
2. Individuals held in custody
3. Assessment of individuals charged with an offence
4. Orders and other actions following court findings
5. Treatment and care of involuntary patients
6. Treatment in the community
7. Support for involuntary patients
8. Support for victims
9. Mental Health Review Tribunal
10. Interstate transfers
11. Forensic disability
12. Guardianship and attorneys
13. Restraint and seclusion
14. Regulated treatments
15. Transport issues
16. Regional, rural and remote issues
17. Indigenous and multicultural issues
18. Children and adolescents
19. Streamlined processes
20. Other legal issues
21. Other issues
22. Impact of proposals.

**Consultation process**

**Process**

Your feedback is welcome on any or all of the recommendations included in this discussion paper, as well as any additional suggestions or ideas you may have.

You do not need to provide feedback on every recommendation. If you do not support a recommendation, please feel free to offer an alternative suggestion.

Your response to the recommendations should be made in writing. Please provide a reference to the recommendation number in your feedback and comments (e.g. 1.1, 13.4).

In addition to the recommendations in this discussion paper, you are invited to include feedback on the impact of the recommendations on stakeholder groups, as outlined in background paper 22.

**Who can make submissions**

The Queensland Government encourages any individual or organisation to make a submission.

Your submission should indicate whether you are responding to the discussion paper as an individual or as an organisation.

**How will submissions be treated**

Submissions will not be made publicly available. However, submissions may be subject to disclosure under the *Right to Information Act 2009*.

**How and when to respond**

Please send your submission by email or letter to:

Mental Health Act Review
Department of Health
PO Box 2368
Fortitude Valley BC QLD 4006
MHA.Review@health.qld.gov.au

**Closing date for submissions:**

Friday, 25 July 2014
## Recommendations

### 1. Involuntary examinations and assessments

<table>
<thead>
<tr>
<th>Issues identified</th>
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<tbody>
<tr>
<td><strong>Too many documents leading to involuntary treatment.</strong></td>
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<tr>
<td><strong>Insufficient checks and balances in the making of justices examination orders.</strong></td>
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<td><strong>Majority of individuals placed on emergency examination orders have no underlying mental illness.</strong></td>
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<td><strong>Treatment criteria not unequivocally based on a person’s lack of capacity to consent to treatment.</strong></td>
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<td><strong>Treatment criteria do not take a longitudinal approach to diagnosis.</strong></td>
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#### Documents leading to involuntary treatment

1.1 The documents required under the Act that may lead to involuntary treatment be as follows:
- an involuntary examination authority (replacing the justices examination order)
- a recommendation for involuntary assessment
- an involuntary treatment order.

#### Involuntary examination authority

1.2 A person applying for an involuntary examination authority be required to seek advice from a doctor or authorised mental health practitioner prior to seeking the authority on:
- the behaviour and other factors that make the person believe the other person may have a mental illness to the extent that involuntary treatment may be warranted
- treatment and care options for the person
- how the person may be encouraged to seek voluntary treatment and care
- the treatment criteria.

1.3 The applicant be required to document this advice in the application for an authority if it is proceeded with.

1.4 Applications must be made to a magistrate or a category of specially authorised and trained justices of the peace.

1.5 The magistrate or authorised justice of the peace must obtain oral or written advice from a doctor or authorised mental health practitioner before issuing an authority, including on whether the stated behaviour and other factors may or may not indicate a mental illness to the extent that involuntary treatment may be warranted.

1.6 A magistrate or authorised justice of the peace must only issue an authority if satisfied:
- the person appears to have a mental illness
- the person appears to lack the capacity to consent to be treated
- attempts at encouraging the person to be treated voluntarily have not succeeded or are not practicable
- there is an imminent risk that the person may cause serious harm to himself, herself or someone else, or suffer serious mental or physical deterioration because of the illness if the person does not receive involuntary treatment.

1.7 The Act to include statutory protections and a clear outline of powers that may be exercised under an involuntary examination authority.

1.8 A person for whom an involuntary examination authority is made be able to apply to the Director of Mental Health for a review of the making, and implementation, of the authority.

1.9 The Director of Mental Health be required to prepare a report within 60 days of receiving an application on the actions, if any, that should be taken as a result of the application.
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| **Emergency transport, examination, assessment and treatment** | 1.10 A police officer may take into consideration advice received from a health practitioner in forming a view about whether there is an imminent risk of injury to a person for the purpose of section 609 of the Police Powers and Responsibilities Act 2000.  
1.11 Emergency transport provisions be placed in an Act other than mental health legislation to apply where a police officer or ambulance officer reasonably believes:  
  • a person appears to have a serious mental impairment as a result of the effects of drugs or alcohol  
  • there is an imminent risk of the person causing harm to himself or herself, and  
  • the person requires urgent treatment or care for the mental impairment or  
  • a person appears to have a mental illness  
  • there is an imminent risk of the person causing harm to himself, herself or someone else, and  
  • an examination of the person may result in a recommendation for assessment being made for the person, or  
  • the person requires urgent treatment and care for the mental illness.  
1.12 Where these criteria apply, a police officer or ambulance officer may detain and transport a person to a place where the person may receive treatment and care for the condition, including a public sector hospital, the person’s home or another place.  
1.13 Where a person brought to a hospital under the emergency transport provisions appears to have a mental illness, the person may be detained for six hours to allow an examination under the Act to be undertaken; this period may be extended for a further six hours by an authorised doctor if an examination is not possible within the initial six hours.  
1.14 The fact and time of the person’s admission for assessment for a mental illness be documented by the police officer or ambulance officer in a notice to verify the commencement of the period of detention.  
| **Request for assessment**                                    | 1.15 The requirement for a ‘request for assessment’ be discontinued.                                                                                                                                                                                                                                                                                     |
| **Assessment criteria**                                       | 1.16 The assessment criteria be discontinued, with the legislation instead requiring a doctor or authorised mental health practitioner to make a recommendation for assessment based on whether an authorised doctor may reasonably form the view that the treatment criteria apply to the person.                                                                                                                                                           |

**Question:**  
Will the recommendations provide for fairer, simpler and more transparent processes leading to involuntary treatment?
<table>
<thead>
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<tr>
<td><strong>Treatment criteria</strong></td>
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<tr>
<td></td>
<td>• the person has a mental illness</td>
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<td>• the person lacks the capacity to consent to be treated for the illness</td>
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<td>• because of the person’s illness, the absence of involuntary treatment (or continued involuntary treatment) is likely to result in:</td>
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<td>1.18 A person has capacity to consent to treatment, if the person is able to:</td>
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<td>• understand the nature and purpose of the treatment</td>
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<td>• understand the benefits and risks of the treatment, and alternatives to the treatment</td>
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<td>• understand the consequences of not receiving the treatment</td>
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<td>• assess the advantages and disadvantages of the treatment in order to arrive at a decision, and</td>
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<td>• communicate the decision.</td>
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<td>1.19 An authorised psychiatrist may maintain a person on an involuntary treatment order, notwithstanding that a person appears to have capacity to consent, if the psychiatrist reasonably believes that revoking the order is likely to result in the person:</td>
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<td>• causing harm to himself, herself or someone else, or</td>
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<td></td>
<td>• suffering serious mental or physical deterioration.</td>
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<tr>
<td><strong>Making of involuntary treatment order</strong></td>
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</table>
## 2. Individuals held in custody

<table>
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<tr>
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</table>
| • Too many documents leading to involuntary treatment for individuals in custody. | **Transfer of individuals to an authorised mental health service for assessment** 2.1 A person in custody may be transferred to an authorised mental health service for assessment under the proposed generic assessment documents (recommendation 1.1), while continuing the requirements:  
  • for a custodian’s transfer authority (in an approved form), including the information on the person held in custody, and  
  • for the agreement, in writing, from the authorised mental health service to the transfer of the person. |
| • Very difficult to understand classified patient provisions. | **Transfer of individuals to an authorised mental health service by consent** 2.2 A person in custody may be transferred to an authorised mental health service for treatment and care if:  
  • a doctor or authorised mental health practitioner believes the transfer is necessary to provide treatment and care to the person for the person’s mental illness  
  • the person consents to be transferred to the service  
  • the custodian agrees to the transfer in a custodian’s transfer authority, and  
  • the authorised mental health service agrees, in writing, to the transfer. |
| • Unacceptable delays in acutely unwell individuals in prisons being transferred to an authorised mental health service. | **Transfer of individuals who are already on a forensic order or involuntary treatment order to an authorised mental health service** 2.3 A person in custody who is already on an involuntary treatment order or a forensic order may be transferred to an authorised mental health service for treatment and care if:  
  • a doctor or authorised mental health practitioner believes the transfer is necessary to provide treatment and care to the person for the person’s mental illness  
  • the custodian agrees to the transfer in a custodian’s transfer authority, and  
  • the authorised mental health service agrees, in writing, to the transfer. |

### More information

Background paper 2—Individuals held in custody.

### Question:

Will the recommendations provide for fairer, simpler and more transparent processes leading to involuntary treatment for persons in custody?

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*Review of the Mental Health Act 2000 discussion paper 11*
<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
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<tr>
<td>Admission of individuals to an authorised mental health service</td>
<td>2.6 For all individuals transferred to an authorised mental health service, an authorised doctor must decide if it is necessary for the person to remain in the authorised mental health service to provide treatment and care for the patient or, if this is not required, return the patient to custody.</td>
</tr>
</tbody>
</table>
| Admission of individuals who are already on an involuntary treatment order or forensic order | 2.7 On admission of a patient who is already on an involuntary treatment order or forensic order:  
- a community category of an involuntary treatment order or forensic order for the patient is to automatically change to an in-patient category  
- any limited community treatment approved by an authorised doctor for the patient is revoked, and  
- an authorised doctor must review the patient’s treatment needs, document the changed treatment, and talk to the patient about the treatment. |
| Treatment and care of classified patients | 2.8 The regular assessments of a patient under the Act (see recommendation 5.3) must, for a classified patient, include an assessment of whether the person can be appropriately treated and cared for in custody, rather than in the authorised mental health service. |
| Ceasing to be a classified patient | 2.9 Clarify that a person ceases to be a classified patient if:  
- apart from this Act, there is no lawful basis for the person’s detention (e.g. the person is granted bail)  
- the Director of Mental Health decides there is no longer a clinical need for the person to remain in the authorised mental health service and the person leaves the authorised mental health service in lawful custody  
- for a person who consented to remaining in the authorised mental health service as a classified patient, the person withdraws his or her consent and the person leaves the authorised mental health service in lawful custody  
- the patient’s involuntary treatment order or forensic order is revoked, the person does not consent to remain in the authorised mental health service, and the person leaves the service in lawful custody, or  
- the Mental Health Court makes a decision in relation to a referral for the person. |
| Return of person to lawful custody | 2.10 Clarify the provisions relating to returning a person to lawful custody by stating that the person must be returned to the custodian from whom the person was initially transferred. |
| Terminology | 2.11 The term ‘classified patient’ be replaced with ‘restricted community access patient’, to better describe this category of patients. |
Assessment of individuals charged with an offence

### Issues identified
- Mandatory psychiatric reports for individuals charged with offences, breach rights and achieve limited benefits.
- Inadequate statutory protections for individuals subject to mandatory psychiatric reports.
- Mandatory psychiatric reports divert public sector resources from higher value service delivery.
- 51 per cent of mandatory psychiatric reports reviewed by the Director of Mental Health are for simple offences.

### Review recommendations

#### Offences that can be heard summarily

3.1 Mandatory psychiatric reports for individuals subject to forensic orders or involuntary treatment orders for offences that can be heard summarily be discontinued.

#### Offences that must be heard on indictment

3.2 Mandatory psychiatric reports for individuals subject to forensic orders or involuntary treatment orders for offences that must be heard on indictment be discontinued.

3.3 An authorised mental health service be required to prepare a psychiatric report on the request of a person charged with an offence that must be heard on indictment (or other prescribed indictable offences), if the person was on an involuntary treatment order or forensic order at the time of (or since) the alleged offence.

3.4 A request for a psychiatric report may also be made by the person’s representative, such as a personal guardian or attorney, if the person is unable to consent.

3.5 The Director of Mental Health to have authority to direct a psychiatric assessment of a person who may have been of unsound mind at the time of an alleged offence or unfit for trial where the alleged offence must be heard on indictment (or other prescribed indictable offences) if the Director believes it is in the public interest.

3.6 The Director of Mental Health to have the authority to refer a person to the Mental Health Court where the psychiatric assessment directed by the Director of Mental Health indicates that a person may have been of unsound mind at the time of the alleged offence or unfit for trial.

#### Rights and protections in psychiatric examinations

3.7 Where the Director of Mental Health directs a psychiatric assessment, the Act to state that:
- the purpose of the assessment is to provide an opinion on fitness for trial and unsoundness of mind at the time of the alleged offence for the purposes of referral to, and consideration by, the Mental Health Court
- the person must attend for an interview
- if the person has capacity, he or she may nominate another person to attend the interview, including a lawyer
- if the person does not have capacity, the authorised mental health service must ensure an independent person attends the interview, such as a personal guardian, attorney or lawyer
- the person is not required to answer self-incriminating questions
- the psychiatric report is to be provided to the person (unless unsafe to do so) and the person’s personal guardian, attorney or lawyer, and
- the psychiatric report cannot be used for any other purpose without the consent of the person or the person’s representative.

### More information

Background paper 3—Assessment of individuals charged with an offence.

**Question:** Will the recommendations result in a fairer and more cost-effective way of assisting individuals who may have a mental health defence?
## Issues identified

- The range of offences for which forensic orders may be made is too broad.
- Limited options for the Mental Health Court in actions it can take where a person is found of unsound mind or unfit for trial.
- Model of forensic orders does not allow a patient to 'step-down' from a forensic order to a less-intensive order.
- Possibility of forensic orders being revoked shortly after being made creates uncertainty.
- Individuals found unfit for trial do not get the opportunity for a jury to determine whether the person did the alleged unlawful act.
- Magistrates Courts have no express powers to deal with individuals of unsound mind or unfit for trial.
- 43 per cent of forensic orders are for offences that must be heard on indictment.

## Review recommendations

### Principles of unsoundness of mind

1. The Act state the fundamental principle that if a person was of unsound mind at the time of an alleged offence:
   - the person is not criminally responsible for the offence and is not to be punished for the offence, and
   - an order of a court as a result of the alleged offence may only infringe on the person's rights and liberty to the extent necessary to protect the community.

### Mental Health Court jurisdiction

2. The jurisdiction of the Mental Health Court be to consider offences that must be heard on indictment, other prescribed indictable offences and indictable offences referred from a magistrate.

### Mental Health Court actions following a finding of unsoundness of mind or unfitness for trial

3. On a finding of unsoundness of mind or unfitness for trial, the Mental Health Court's options include making an involuntary treatment order that can only be revoked by the Mental Health Review Tribunal.

4. An involuntary treatment order that can only be revoked by the Tribunal may be made by the Court if, on an assessment of relevant risks, the Court determines the community cannot be adequately protected by a 'standard' involuntary treatment order or voluntary treatment from:
   - serious harm to other individuals
   - serious property damage, or
   - repeat offending of the type the person was charged with.

5. A forensic order may be made by the Court if, on an assessment of relevant risks, the Court determines the community cannot be adequately protected by an involuntary treatment order that can only be revoked by the Tribunal from:
   - serious harm to other individuals
   - serious property damage, or
   - repeat offending of the type the person was charged with.

6. In considering these matters, the Court to have regard to:
   - the patient's current mental state and psychiatric history
   - the nature of the unlawful act
   - the patient's social circumstances
   - the patient's response to treatment and willingness to continue treatment, and
   - where relevant, the patient's compliance with previous obligations while on limited community treatment or a community category order.

7. The assessment of risk in determining the above to be based on generally accepted community standards.

8. An involuntary treatment order that can only be revoked by the Mental Health Review Tribunal to otherwise be the same as a 'standard' involuntary treatment order.

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### More information

Background paper 4—Orders and other actions following Court findings.
### Criminal Code and Minister’s forensic orders

4.9 Where a court makes an order under the Criminal Code to detain a person as a result of a jury finding of unsoundness or unfitness or, in a Supreme Court or District Court, the prosecution and the defence agree that the accused person is unfit for trial:

- the court order is not to be treated as a forensic order
- if there is a charge before the court that is within the Mental Health Court’s jurisdiction (see recommendation 4.2), the judge must refer the person to the Mental Health Court for a determination of any orders, with the monitoring of temporary fitness by the Mental Health Tribunal applying as with other orders, and
- if there is no charge within the Mental Health Court’s jurisdiction, the judge has the same powers as a magistrate (see recommendations 4.24–4.29).

4.10 Minister’s forensic orders be discontinued.

### Conditions attached to forensic orders

4.11 The Mental Health Court be able to attach conditions to forensic orders recommending the authorised mental health service or the forensic disability service consider specific interventions such as drug and alcohol programs or anger management counselling.

4.12 The implementation of this condition, including the patient’s willingness to participate in such programs, be considered during Mental Health Review Tribunal reviews.

### Duration and revocation of forensic orders

4.13 To provide greater certainty and stability during the early stages of a forensic order, the Mental Health Court have authority to impose a non-revoke period for a forensic order of up to three years; where the charges are murder or attempted murder, the proposed period to be up to seven years.

4.14 At a Mental Health Review Tribunal review of a forensic order (after any non-revoke period), the Tribunal may:

- continue the forensic order
- revoke the order and replace it with an involuntary treatment order that can only be revoked by the Tribunal
- revoke the order and replace it with a ‘standard’ involuntary treatment order, or
- revoke the forensic order.

4.15 An involuntary treatment order that can only be revoked by the Tribunal to otherwise be the same as a ‘standard’ involuntary treatment order.

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**Question:**

Will the recommendations improve the system for dealing with individuals found of unsound mind or unfit for trial?
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<thead>
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<tr>
<td>4.16</td>
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<td>4.17</td>
<td>The Tribunal must revoke a forensic order (subject to recommendation 4.31) and make a 'standard' involuntary treatment order or make no other order if, on an assessment of relevant risks, the Tribunal determines the community no longer requires protection from:</td>
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<td>4.18</td>
<td>The Tribunal must revoke an involuntary treatment order that can only be revoked by the Tribunal and make a ‘standard’ involuntary treatment order or make no other order if, on an assessment of relevant risks, the Tribunal determines the community no longer requires protection from:</td>
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</table>

**Special hearings following finding of unfitness for trial**

4.21 Where the Mental Health Court makes a forensic order or an involuntary treatment order following a finding of permanent unfitness for trial or where a finding of temporary unfitness extends over 12 months, a lawyer representing the accused, in consultation with a substitute decision-maker, may elect to have a special hearing heard by the District Court or the Mental Health Court sitting as a judge alone.

4.22 The purpose of a special hearing be to determine on the available evidence whether the accused person did the act that constituted the offence:

- if the finding is no, the accused person is discharged and the relevant order is revoked
- if the finding is yes, the order is confirmed.
<table>
<thead>
<tr>
<th>Issue identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.23</td>
<td>For the purpose of the special hearing, the accused's lawyer must act in the best interests of the accused, and the court may make any adjustments to normal trial processes that are appropriate in the circumstances.</td>
</tr>
<tr>
<td><strong>Magistrates Court powers on finding of unsoundness of mind or unfitness for trial</strong></td>
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<tr>
<td>4.24</td>
<td>Where a magistrate is satisfied a person is likely to be, or appears, unfit for trial or of unsound mind due to a mental illness, the magistrate may:</td>
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<td>• discharge the person unconditionally, or</td>
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<td>• discharge the person and order an involuntary treatment order with a non-revoke period of up to six months for summary offences and up to 12 months for indictable offences.</td>
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<tr>
<td>4.25</td>
<td>However, if the magistrate believes the person might become fit for trial within six months, the magistrate may adjourn the charge and make a non-revokable involuntary treatment order; if the person is still unfit for trial at the end of six months, the magistrate must act as above (recommendation 4.24).</td>
</tr>
<tr>
<td>4.26</td>
<td>In making an involuntary treatment order with a non-revoke period, the magistrate must be satisfied the community cannot be adequately protected by voluntary treatment or a ‘standard’ involuntary treatment order from harm, property damage or repeat offending of the type the person was charged with.</td>
</tr>
<tr>
<td>4.27</td>
<td>An involuntary treatment order with a non-revoke period otherwise to be the same as a ‘standard’ involuntary treatment order, and automatically becomes a ‘standard’ involuntary treatment order at the end of the non-revoke period.</td>
</tr>
<tr>
<td>4.28</td>
<td>Where a magistrate is satisfied a person is likely to be, or appears, unfit for trial or of unsound mind due to an intellectual disability, the magistrate:</td>
</tr>
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<td>• must discharge the person unconditionally, and</td>
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<td>• may refer the person to the Department of Communities, Child Safety and Disability Services to consider whether appropriate care can be provided to the person.</td>
</tr>
<tr>
<td>4.29</td>
<td>Where a magistrate is satisfied a person charged with an indictable offence is unfit for trial or of unsound mind due to a mental illness or intellectual disability, the magistrate may refer the matter to the Director of Mental Health or the Director of Forensic Disability to assess whether the matter should be referred to the Mental Health Court.</td>
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<tr>
<td>Issue identified</td>
<td>Review recommendations</td>
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<tr>
<td><strong>Evaluation</strong></td>
<td>4.30 An independent evaluation of the revised arrangements for the Magistrates Court powers be undertaken after three years.</td>
</tr>
<tr>
<td><strong>Special notification forensic patients</strong></td>
<td>4.31 The category of ‘special notification forensic patients’ be discontinued. If a forensic order is not to be replaced by an involuntary treatment order that can only be revoked by the Tribunal, the revocation of the order to be subject to an independent second psychiatrist’s opinion.</td>
</tr>
<tr>
<td><strong>Review of forensic orders</strong></td>
<td>4.32 To align with the Criminal Code any ‘mental disease or natural mental infirmity’ that resulted in a forensic order or involuntary treatment order being made by the Mental Health Court be taken into account when the Mental Health Review Tribunal is considering whether to:</td>
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<td>• revoke the order, or</td>
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<td>• order or approve community treatment.</td>
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</table>
5. Treatment and care of involuntary patients

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Purpose and benefit of ‘treatment plans’ is not sufficiently clear.</td>
<td><strong>Separate treatment and care provisions in the Act</strong></td>
</tr>
<tr>
<td>• Statutory requirements for the treatment and care of involuntary patients do not</td>
<td>5.1 The provisions related to the treatment and care of involuntary patients be</td>
</tr>
<tr>
<td>adequately align with good clinical practice.</td>
<td>placed in one part of the proposed legislation.</td>
</tr>
<tr>
<td>• Patients cannot have an independent review of treatment being provided.</td>
<td><strong>Provision of treatment and care</strong></td>
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<tr>
<td>• Patients receive inadequate information on their treatment in the community</td>
<td>5.2 On admission of an involuntary patient, an authorised doctor must decide and record</td>
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<td>in appropriate clinical records, the proposed treatment and care to be provided to the</td>
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<td>patient.</td>
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<td>5.3 The authorised doctor to ensure the treatment and care provided to a patient</td>
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<td>continues to be appropriate to the patient’s needs including, for example, by regularly</td>
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<td>reviewing the patient’s needs.</td>
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<td>5.4 An authorised doctor must decide and review a patient’s treatment and care in</td>
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<td>consultation with the patient and, as far as practicable, family, carers and other</td>
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<td>support persons.</td>
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<td>5.5 The administrator of each authorised mental health service be required to:</td>
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<td>• take reasonable steps to ensure that involuntary patients receive appropriate</td>
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<td>treatment and care for their mental illness and for other illnesses or conditions, and</td>
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<td>• ensure the systems for recording treatment and care (proposed and provided) can be</td>
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<td>audited.</td>
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<td><strong>Regular assessments</strong></td>
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<td>5.6 In relation to regular assessments of involuntary patients:</td>
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<td>• clarify that the purpose of an assessment is to determine whether the treatment</td>
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<td>criteria continue to apply to the patient, and</td>
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<td>• state that if, after an assessment, the authorised doctor decides the treatment</td>
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<td>criteria continue to apply to the patient, the doctor must also decide, and document,</td>
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<td>when the next assessment is to occur.</td>
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<td><strong>Other assessments</strong></td>
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<td>5.7 An authorised doctor to assess a patient against the treatment criteria if, at any</td>
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<td>time, the doctor reasonably believes the treatment criteria may no longer apply to the</td>
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<td>patient.</td>
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<td></td>
<td><strong>Review of treatment</strong></td>
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<td>5.8 A patient or the patient’s representative (e.g. family, carer or other support</td>
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<td>person) be able to apply to the Mental Health Review Tribunal for a review of the</td>
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<td>patient’s treatment or care after having sought a review of the patient’s treatment</td>
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<td>and care from the administrator of the authorised mental health service.</td>
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<td>The provisions related to frivolous or vexatious applications to apply to these</td>
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<td>applications.</td>
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<td>5.9 The Tribunal have the authority to direct the authorised mental health service to</td>
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<td>review the patient’s treatment or care and report back to the Tribunal if needed, noting</td>
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<td>that the Tribunal will not have the authority to direct treatment.</td>
</tr>
</tbody>
</table>

Question: Will the recommendations provide better statutory protections for involuntary patients that are consistent with good clinical practice?
<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment in the community</strong></td>
<td></td>
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<tr>
<td>5.10 Prior to an involuntary patient leaving an authorised mental health service on a community category or limited community treatment for overnight or longer, the authorised doctor must:</td>
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<tr>
<td>• decide and document the treatment and care to be provided to the patient in the community in consultation with the patient and, as far as practicable, family, carers and other support persons</td>
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<tr>
<td>• decide and document a statement about the patient’s obligations while in the community, including scheduled health appointments</td>
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<tr>
<td>• provide to the patient a summary of the treatment and care to be provided in the community and the statement about the patient’s obligations</td>
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<tr>
<td>• discuss with the patient and, as far as practicable, family, carers and other support persons, the treatment and care to be provided, and the patient’s obligations under the statement.</td>
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<tr>
<td>5.11 The above requirements in relation to the statement about the patient’s obligations while in the community also to apply where an involuntary patient leaves an authorised mental health service on unescorted day leave.</td>
<td></td>
</tr>
<tr>
<td><strong>Director of Mental Health policies</strong></td>
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<tr>
<td>5.12 The Director of Mental Health to continue to have the authority to establish policies and practice guidelines about the treatment and care of involuntary patients, including the way in which treatment and care is provided and recorded.</td>
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<tr>
<td>5.13 Require all policies and practice guidelines issued by the Director of Mental Health to be published on the internet.</td>
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</tbody>
</table>
### 6. Treatment in the community

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Purpose of ‘limited community treatment’ is not sufficiently clear</td>
<td><strong>Limited community treatment—involuntary treatment orders and forensic orders</strong></td>
</tr>
<tr>
<td>• Inconsistencies and inadequate transparency in the way the Act deals with treatment in the community</td>
<td>6.1 Consistent with the least restrictive principle, the purpose of limited community treatment be to support the recovery of involuntary patients by transitioning patients to living back in the community, with appropriate treatment and care.</td>
</tr>
<tr>
<td>• Criteria for community treatment not sufficiently clear or consistent</td>
<td><strong>Forensic orders—limited community treatment and community category</strong></td>
</tr>
<tr>
<td>• Monitoring conditions do not apply to all involuntary patients, and safeguards could be strengthened</td>
<td>6.2 The use of limited community treatment for forensic patients align with its use for patients on involuntary treatment orders by limiting the maximum period to seven days.</td>
</tr>
<tr>
<td>• Inadequate clarity about how community treatment applies to individuals in custody</td>
<td>6.3 A community category of forensic order be established for forensic patients living continuously in the community, with the same criteria applying for a patient going into the community on limited community treatment or a community category.</td>
</tr>
</tbody>
</table>

**Further information**

Background paper 6—Treatment in the community.

- **Limited community treatment—involuntary treatment orders and forensic orders**
  - 6.1 Consistent with the least restrictive principle, the purpose of limited community treatment be to support the recovery of involuntary patients by transitioning patients to living back in the community, with appropriate treatment and care.

- **Forensic orders—limited community treatment and community category**
  - 6.2 The use of limited community treatment for forensic patients align with its use for patients on involuntary treatment orders by limiting the maximum period to seven days.
  - 6.3 A community category of forensic order be established for forensic patients living continuously in the community, with the same criteria applying for a patient going into the community on limited community treatment or a community category.

- **Forensic orders—criteria for limited community treatment or community category**
  - 6.4 The Mental Health Court and Mental Health Review Tribunal may only approve or order limited community treatment or a community category for a forensic patient if, on an assessment of relevant risks, the Court or Tribunal determines the community will be adequately protected from:
    - serious harm to other people
    - serious property damage, or
    - repeat offending of the type that was the basis for the order.
  - 6.5 In considering these matters, the Court and Tribunal to have regard to:
    - the patient’s current mental state and psychiatric history
    - the nature of the unlawful act and the time since the unlawful act
    - the patient’s social circumstances
    - the patient’s response to treatment or care and willingness to continue treatment or care, and
    - where relevant, the patient’s compliance with previous obligations while on limited community treatment or a community category order.
  - 6.6 The assessment of risk in deciding the above to be based on generally accepted community standards.
  - 6.7 The above criteria may be met by limiting the level of community access or by placing conditions on the patient’s order.
  - 6.8 The Mental Health Court or Tribunal, in deciding whether to approve limited community treatment or a community category order may take into account the assessment of risks that must be made by the authorised doctor in authorising limited community treatment or a community category order.
  - 6.9 An authorised doctor to consider the same criteria (recommendations 6.4 to 6.7) in approving limited community treatment or a community category order.

**Question:**

Will the recommendations provide for more transparent, consistent approaches to treatment in the community?
### Issues identified

<table>
<thead>
<tr>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Classified patients – limited community treatment</strong></td>
</tr>
<tr>
<td>6.10 The criteria and other matters for approving limited community treatment for forensic patients also apply to the Director of Mental Health in approving limited community treatment for classified patients.</td>
</tr>
</tbody>
</table>

| **Involuntary treatment orders – criteria for limited community treatment and community category** |
| 6.11 Clarify that a patient should only be placed on an in-patient involuntary treatment order, and continue to be on that order, if the authorised doctor believes the patient’s treatment and care needs, and the safety and well-being of the patient and others cannot be reasonably met if the patient was on a community category order, having regard to: |
| • the patient’s current mental state and psychiatric history |
| • the patient’s social circumstances |
| • the patient’s response to treatment, and |
| • where relevant, the patient’s compliance with previous obligations while on a community category order. |
| 6.12 The same criteria to apply when an authorised doctor is considering whether a person on an in-patient category of an involuntary treatment order should be granted limited community treatment and the nature of the limited community treatment. |

| **Monitoring conditions** |
| 6.13 The Director of Mental Health be authorised to apply monitoring conditions to any involuntary patient (i.e. a forensic patient, classified patient, court order patient (under section 273 of the Act), or a patient on an involuntary treatment order) while in the community if: |
| • there is significant risk that the patient would not return to the authorised mental health service as required, or |
| • the patient has not complied with previous obligations while in the community and this non-compliance has resulted in a significant risk of harm to the patient or others. |
| 6.14 The Mental Health Review Tribunal review the imposition of monitoring conditions on a patient within 21 days of the decision to apply the conditions. |
| 6.15 The ability for patients to review the imposition of monitoring conditions include classified patients and court order patients (under section 273 of the Act). |
| 6.16 Clarify that the general powers for the Mental Health Court and the Mental Health Review Tribunal to apply conditions to patients accessing limited community treatment may include monitoring conditions. |
### Community treatment and care for patients in custody

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
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<tbody>
<tr>
<td>6.17 The category of a patient's involuntary order (in-patient or community) and</td>
<td>The category of a patient's involuntary order (in-patient or community) and any authority for limited community treatment approved or ordered by the Mental Health Court or the Mental Health Review Tribunal be unaffected by the person being detained in custody under another Act (e.g. being detained in a corrective services facility).</td>
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<tr>
<td>any authority for limited community treatment approved or ordered by the Mental</td>
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<tr>
<td>Health Court or the Mental Health Review Tribunal be unaffected by the person</td>
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<td>being detained in custody under another Act (e.g. being detained in a corrective</td>
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<td>services facility).</td>
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<tr>
<td>6.18 The person's custodial status under another Act to take precedence over any</td>
<td>The person's custodial status under another Act to take precedence over any order, approval, authority or other right for the person to be in the community under an involuntary order for the period that the custodial status is in force. This does not apply when the classified patient provisions apply or where a patient is subject to specific court orders under the Act which authorise the patient's detention in an authorised mental health service.</td>
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<tr>
<td>order, approval, authority or other right for the person to be in the community</td>
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<td>under an involuntary order for the period that the custodial status is in force.</td>
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<tr>
<td>6.19 Decisions about a person's rights to be in the community under an involuntary</td>
<td>Decisions about a person's rights to be in the community under an involuntary order to be based on the criteria stated in the Act and not on the fact of the person's custodial status under another Act.</td>
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<tr>
<td>order to be based on the criteria stated in the Act and not on the fact of the</td>
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<td>person's custodial status under another Act.</td>
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## 7. Support for involuntary patients

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<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
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</table>
| • Act does not give adequate recognition to the role of family, carers and other support persons. | **Principles**
| • 'Allied person' model has proved to be ineffective. | 7.1 The principles in the Act strengthen the importance of family, carers and other support persons to a patient’s treatment and recovery, based on relevant principles in the Australian Mental Health Statement of Rights and Responsibilities as follows:

Family, carers and other support people have the right to:
- contact the patient while the patient is undergoing treatment
- participate in treatment decisions and decisions about ongoing care
- seek and receive additional information about the patient’s support, care, treatment, rehabilitation and recovery
- be consulted by the treating team about treatment approaches being considered for the patient
- arrange other support services for the patient, such as respite care, counselling and community care, and
- be provided with any information that the patient requests they should receive.

To ensure that these rights are used constructively, the family, carers and other support persons to have the responsibility to:
- respect the humanity and dignity of the patient
- consider the opinions and skills of professional and other staff who provide assessment, individualised care planning, support, care, treatment, recovery and rehabilitation services to patients, and
- cooperate, as far as is possible, with reasonable programs of assessment, individualised care planning, support, care, treatment, recovery and rehabilitation.

7.2 The principles in the Act emphasise the importance of recovery-oriented services and the reduction of stigma associated with mental illness.

| • Involuntary patients would benefit from having access to an independent person to advise of patients' rights and obligations. | **Allied persons**
| • Rights of patients at Tribunal hearings could be improved. | 7.3 The ‘allied persons’ model in the Act be discontinued.

### More information

**Background paper 7—Support for involuntary patients.**

### Question:

**Will the recommendations improve the support provided to involuntary patients?**
### Issues identified | Review recommendations

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<thead>
<tr>
<th><strong>Patient information</strong></th>
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<tr>
<td><strong>7.5</strong> The Act note that, under the <em>Hospital and Health Boards Act 2011</em>, family, carers and other support persons may be provided information about a patient’s treatment and care if the information is for the purpose of treatment and care, or if the person has sufficient personal interest in the patient’s health and welfare.</td>
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<tr>
<th><strong>Independent patient companion</strong></th>
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<tr>
<td><strong>7.6</strong> Require each authorised mental health service to employ or engage (e.g. from a non-government organisation) a person or persons as an ‘Independent Patient Companion’, who is to report directly to the administrator of the authorised mental health service and not be part of the treating team.</td>
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<td><strong>7.7</strong> The role of the Independent Patient Companion be to:</td>
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<tr>
<td>• advise involuntary patients, family, carers and other support persons of the patient’s rights and obligations under the Act</td>
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<tr>
<td>• assist involuntary patients, family, carers and other support persons to constructively engage with the treating team about the patient’s treatment and care</td>
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<td>• advise patients, family, carers and other support persons of upcoming Mental Health Review Tribunal proceedings, the patient’s rights at Tribunal proceedings, and engaging an advocate or legal representative for a hearing</td>
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<td>• attend Tribunal hearings as an advocate or support person, if requested by the patient</td>
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<td>• actively identify if the patient has a personal guardian or attorney and, if one exists, work co-operatively with the guardian or attorney to further the patient’s interests, and</td>
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<td>• advise patients, where appropriate, of the benefits of having an advance health directive or enduring power of attorney to address future times when the patient does not have capacity.</td>
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<tr>
<th><strong>Attendance at Mental Health Review Tribunal hearings</strong></th>
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<tr>
<td><strong>7.8</strong> Provide that at a Mental Health Review Tribunal hearing a patient:</td>
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<tr>
<td>• may be represented by a lawyer or other person (e.g. an advocate) unless excluded by the Tribunal, and</td>
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<tr>
<td>• may be accompanied by a support person at the hearing, unless excluded by the Tribunal.</td>
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8. Support for victims

<table>
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<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
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<tr>
<td>• Act does not include principles for supporting victims of unlawful acts.</td>
<td><strong>Recognition of victims in the principles of the Act</strong> 8.1 The Act to include a statement of principles in relation to victims, to provide guidance to those administering the Act, namely that a person involved in the administration of this Act is to:  • recognise with compassion the physical, psychological and emotional harm caused to a victim by an unlawful act of another person  • recognise the benefits to a victim of being advised in a timely way of the proceedings against the person under the Act  • recognise the benefits to a victim of being given the opportunity to express his or her views on the impact of the unlawful act to decision-making entities under the Act  • recognise the benefits to a victim of a timely completion of proceedings against the person  • recognise the benefits to a victim of being advised in a timely way of decisions to allow the person to go into the community, and  • recognise the benefits of counselling, advice on the nature of proceedings under the Act and other support services to a victim’s recovery from the harm caused by the unlawful act. In these principles, a reference to an unlawful act includes an alleged unlawful act.</td>
</tr>
<tr>
<td>• Statutory barriers exist to providing information to identify individuals who may be victims.</td>
<td><strong>Identifying and providing services to victims</strong> 8.2 Enable the Department of Health, a Hospital and Health Service, the Queensland Police Service, the Department of Justice and Attorney-General and the Director of Public Prosecutions to use and disclose information to:  • assist the identification of a person who may be a victim, or  • to provide information and assistance to a person who may be, or is, a victim. 8.3 The Act to state that this provision to over-ride any confidentiality or privacy duties under the Hospital and Health Boards Act 2011, the Information Privacy Act 2009 or any other Act.</td>
</tr>
<tr>
<td>• Purpose of victim submissions, and the need to re-submit submissions, could be clarified.</td>
<td><strong>Victim submissions</strong> 8.4 Clarify that victim submissions to the Mental Health Court and the Mental Health Review Tribunal are of the nature of victim impact statements equivalent to victim impact statements made under the Victims of Crimes Assistance Act 2009. 8.5 Victim submissions to remain confidential unless otherwise requested by the victim.</td>
</tr>
<tr>
<td>• Inadequate information is provided under forensic information orders.</td>
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</table>

**More information**  
Background paper 8–Support for victims.

**Question:**  
Will the recommendations improve support for victims of unlawful acts?
## Re-submission of victim submissions
8.6 The initial victim submission to the Mental Health Court or the Mental Health Review Tribunal to be automatically read into subsequent Tribunal proceedings on each occasion unless the victim wishes to make a new submission.

## Notice of hearing for revocation of forensic order
8.7 Require the Mental Health Review Tribunal to notify a victim of an application to revoke a forensic order.

## Forensic information orders
8.8 The Mental Health Review Tribunal to provide a victim who has a forensic information order with a statement of reasons and a summary of the risk assessment that led to a decision for a forensic patient to be granted access to the community or for the revocation of a forensic order.
8.9 Forensic information orders require a victim to also be notified of:
- the outcome of a Mental Health Review Tribunal review of fitness for trial, and
- the fact that an appeal has been lodged in the Mental Health Court in relation to the forensic order and the outcomes of the appeal.
8.10 The Director of Mental Health to approve forensic information orders instead of the Mental Health Review Tribunal.
8.11 Classified patient information orders be streamlined by replacing orders with the ability for the Department of Health and the Queensland Health Victim Support Service to disclose relevant information to a victim.

## Non-contact with victims
8.12 Continue the ability for the Mental Health Court and the Mental Health Review Tribunal to impose ‘non-contact’ conditions on limited community treatment.
8.13 The ability to make a ‘non-contact order’ when the Court or Tribunal has decided that the person does not represent a risk to the community be discontinued.
8.14 The Act give legal authority for an authorised mental health service to prevent an in-patient from attempting to contact a person by phone, email, mail or other means if requested by the person.
9. Mental Health Review Tribunal

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low level of legal representation for patients at Tribunal hearings.</td>
<td>Deputy President</td>
</tr>
<tr>
<td>• Act not sufficiently clear on the purpose of Tribunal hearings, decisions that can be made, and criteria for decisions.</td>
<td>9.1 Provide for the position of Deputy President of the Tribunal, to have the same minimum qualifications as the President and who would act as President in the President’s absence.</td>
</tr>
<tr>
<td>• Limited ability for patients to present evidence at Tribunal hearings.</td>
<td>Legal representation</td>
</tr>
<tr>
<td>• Opportunities exist to improve the cost-effectiveness of Tribunal proceedings.</td>
<td>9.2 Patients to have legal representation at Tribunal hearings, without cost to the patient, for:</td>
</tr>
<tr>
<td>• In 2012-13, 11,978 matters were listed for hearing by the Tribunal.</td>
<td>• hearings involving minors</td>
</tr>
<tr>
<td></td>
<td>• fitness for trial reviews, and</td>
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<td></td>
<td>• reviews where the State is legally represented by the Attorney-General.</td>
</tr>
<tr>
<td></td>
<td>Tribunal hearings – purpose, applications and decisions</td>
</tr>
<tr>
<td></td>
<td>9.3 The Act clearly state the following:</td>
</tr>
<tr>
<td></td>
<td>• how Tribunal hearings are initiated (including who may make an application and what can be applied for)</td>
</tr>
<tr>
<td></td>
<td>• the purpose of each type of hearing</td>
</tr>
<tr>
<td></td>
<td>• the decision the Tribunal may make at a hearing, and</td>
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<tr>
<td></td>
<td>• the criteria for the decisions.</td>
</tr>
<tr>
<td></td>
<td>Statement of reasons</td>
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<tr>
<td></td>
<td>9.4 A function of the Tribunal include publishing de-identified decisions and statements of reasons for Tribunal decisions that may be of precedential value.</td>
</tr>
<tr>
<td></td>
<td>Evidence</td>
</tr>
<tr>
<td></td>
<td>9.5 The Tribunal allow individuals to provide evidence at a hearing where requested by a patient or other party.</td>
</tr>
<tr>
<td></td>
<td>Time-frames for review of involuntary treatment orders</td>
</tr>
<tr>
<td></td>
<td>9.6 Reviews of involuntary treatment orders by the Mental Health Review Tribunal be conducted 12 monthly, while retaining the initial six week review and the right of a patient, or the patient’s representative, to apply for a review at any time.</td>
</tr>
<tr>
<td></td>
<td>Missing persons</td>
</tr>
<tr>
<td></td>
<td>9.7 Reviews of forensic patients be suspended if the patient is absent without permission.</td>
</tr>
<tr>
<td></td>
<td>9.8 The Tribunal be able to revoke a forensic order if a patient is absent without permission for over five years and the available information indicates that the person is unlikely to return to the State or is presumed to have died.</td>
</tr>
</tbody>
</table>

More information
Background paper 9—Mental Health Review Tribunal.

Question:
Will the recommendations provide for fairer more cost-effective Tribunal proceedings?
<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearings by teleconferencing or on the papers</strong></td>
<td>9.9 The Tribunal be able to conduct hearings by remote conferencing, including video-conferencing, teleconferencing or another form of communication that allows a person to take part in discussions as they happen.</td>
</tr>
<tr>
<td></td>
<td>9.10 The Tribunal be able to conduct a review hearing of an involuntary treatment order entirely on the basis of documents, without the patient, the patient’s representative or the treating team appearing at the hearing if the patient or the patient’s representative does not wish to attend a hearing.</td>
</tr>
<tr>
<td><strong>Detention of minors in high security facilities</strong></td>
<td>9.11 The legislative requirement for the Tribunal to review young patients detained in high security units be discontinued.</td>
</tr>
</tbody>
</table>
## 10. Interstate transfers

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provisions of the Act in relation to interstate transfers are largely ineffective.</td>
<td><strong>Interstate transfers—Ministerial agreements</strong></td>
</tr>
<tr>
<td>• Purpose and benefit of the ‘move’ provisions in the Act are not clear.</td>
<td>10.1 The requirement for Ministerial agreements with other States for the interstate transfer of involuntary patients be discontinued.</td>
</tr>
</tbody>
</table>

### Transfer of patients on forensic orders

10.2 The transfer of forensic patients out of Queensland to take place as follows:

- a patient or representative to apply to the Director of Mental Health to transfer to a mental health service interstate, providing information on why the transfer would be in the patient’s interests and the willingness of the interstate service to receive the patient
- the Director of Mental Health may approve the application if:
  - the transfer is in the patient’s interests, for example, to be in closer proximity to family and support persons who would assist the patient’s recovery
  - suitable treatment and care is available for the person at the destination mental health service, and
  - the person in the destination jurisdiction that is legally authorised to agree to the transfer agrees to the transfer
- the forensic order is suspended when the patient leaves the State, and
- the Mental Health Review Tribunal is advised of the transfer.

The forensic order is suspended when the patient leaves the State, and the Mental Health Review Tribunal is advised of the transfer.

10.3 If a patient is transferred interstate and the patient returns to Queensland within three years, the forensic order in Queensland is automatically reinstated.

### More information

Background paper 10—Interstate transfers.

**Question:**

Will the recommendations provide effective arrangements for the interstate transfer of patients?
<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
</table>
| 10.4              | The transfer of patients who are on the equivalent of a forensic order in another State into Queensland to take place as follows:  
  - a request for a transfer to be made to the Mental Health Review Tribunal by the patient or the patient’s representative  
  - in making the application, the patient or the patient’s representative is to provide information on why the transfer would be in the patient’s interests (e.g. closer proximity to family and support persons who would assist the patient’s recovery)  
  - the Tribunal may approve a transfer into Queensland of an equivalent forensic patient if:  
    - the transfer is in the patient’s interests, for example, to be in closer proximity to family and support persons who would assist the patient’s recovery  
    - suitable treatment and care is available for the person at an authorised mental health service  
    - the person in the destination jurisdiction that is legally authorised to agree to the transfer agrees to the transfer, and  
    - the forensic order will adequately protect the community from serious harm to other people, serious property damage or repeat offending of the type that was the basis for the equivalent order interstate  
  - the Tribunal decides the category of order and any conditions, having regard to the equivalent order and conditions that applied interstate, and  
  - the forensic order is effective immediately the patient enters Queensland. |
|                   | Transfer of patients on involuntary treatment orders  
  10.5              | The transfer of patients on involuntary treatment orders (or equivalent interstate) into, and out of, Queensland to be approved by the administrator of the authorised mental health service. |
|                   | Transfer of patients living in the community  
  10.6              | The requirement that interstate patients on an involuntary order must be ‘detained’ before being transferred into Queensland be discontinued. |
|                   | Move provisions  
  10.7              | The provisions in the Act related to the ‘move’ of involuntary patients be discontinued. |
### 11. Forensic disability

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
</table>
| • Inadequate clarity in the Mental Health Court making forensic orders for individuals with a dual diagnosis. | **Forensic orders for individuals with dual diagnosis**<br>11.1 The Mental Health Court be able to make a 'standard' forensic order for a person with a dual diagnosis (i.e. mental illness and intellectual disability) if the Court believes the person requires involuntary treatment and care for a mental illness as well as care for the intellectual disability.  
11.2 The Mental Health Review Tribunal be given authority in a review of a person with a dual diagnosis to amend a 'standard' forensic order to a forensic order (disability) if the person no longer requires involuntary treatment for the mental illness. |
| • Management of forensic orders (disability) and the care of individuals on forensic orders (disability) are not adequately aligned. | **Management of forensic orders (disability)**<br>11.3 The legislative, administrative and operational arrangements for the management of forensic orders and the care of a person on a forensic order (disability) be aligned. |
| More information                                                                   | **Clinicians assisting the Mental Health Court**<br>11.4 For proceedings for a person with an intellectual disability, the Mental Health Court may be assisted by a person with expertise in the care of people with an intellectual disability, such as a forensic psychologist. |
|                                                                                   | **Co-existing application of an involuntary treatment order and a forensic order (disability)**<br>11.5 Ensure that an involuntary treatment order and a forensic order (disability) can co-exist for a person, regardless of which order is made first. |

**Question:**
Will the recommendations improve the arrangements for individuals on forensic orders (disability)?
## 12. Guardianship and attorneys

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Relationship between mental health legislation and guardianship legislation could be clarified in one area.</td>
<td>12.1 Clarify that the emergency transport and examination provisions in the proposed mental health legislation do not affect the operation of the <em>Guardianship and Administration Act 2000</em>, particularly section 63 (Urgent Health Care).</td>
</tr>
</tbody>
</table>

**More information**  
Background paper 12—Guardianship and attorneys.

**Question:**  
Will the recommendations clarify the relationship between mental health legislation and guardianship legislation in emergencies?
### 13. Restraint and seclusion

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Act to support the reduction in the use of seclusion and mechanical restraint.</td>
<td><strong>Extension of mechanical restraint and seclusion</strong></td>
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<tr>
<td>• Safeguards in the use of mechanical restraint could be strengthened.</td>
<td>13.1 Clarify that the authorisation of seclusion or mechanical restraint for three</td>
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<td>• Consistency, clarity and effectiveness of restraint and seclusion provisions could be improved.</td>
<td>hours may be re-authorised if the criteria continue to apply, noting that the</td>
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<td></td>
<td>Director of Mental Health must approve the use of mechanical restraint (see</td>
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<td>recommendation 13.9).</td>
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<td>13.2 The use of seclusion and mechanical restraint in the high security unit may be</td>
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<td>used for a particular patient for periods longer than three hours without a re-</td>
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<td>authorisation if the Director of Mental Health has approved a management plan for</td>
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<td>the patient.</td>
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<td>13.3 A management plan must include strategies to reduce seclusion or mechanical</td>
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<td>restraint for the patient and must be reviewed monthly.</td>
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<td></td>
<td><strong>Extensions to the mechanical restraint offence and offences under other laws</strong></td>
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<td>13.4 Clarify that the mechanical restraint offence does not prevent the use of a</td>
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<td>mechanical restraint if the use is lawful under another law (e.g. the use of</td>
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<td>hand-cuffs by the police if the use is authorised under the *Police Powers and</td>
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<td>Responsibilities Act 2000*).</td>
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<td>13.5 Clarify that a person does not commit an offence under another law (e.g. the</td>
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<tr>
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<td>Criminal Code) if the person uses a mechanical restraint in accordance with the</td>
</tr>
<tr>
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<td>Act.</td>
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<td></td>
<td><strong>Exceptions to the seclusion offence and offences under other laws</strong></td>
</tr>
<tr>
<td></td>
<td>13.6 Clarify that the seclusion offence does not prevent the use of seclusion if it</td>
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<td>is lawful under another law.</td>
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<tr>
<td></td>
<td>13.7 Clarify that a person does not commit an offence under another law (e.g. the</td>
</tr>
<tr>
<td></td>
<td>Criminal Code) if the person uses seclusion in accordance with the Act.</td>
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<td></td>
<td><strong>Approval of mechanical restraint and seclusion</strong></td>
</tr>
<tr>
<td></td>
<td>13.8 Mechanical restraints only to be used in a high security unit or another</td>
</tr>
<tr>
<td></td>
<td>authorised mental health service approved by the Director of Mental Health.</td>
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<tr>
<td></td>
<td>13.9 Mechanical restraints only to be used with the prior written approval of the</td>
</tr>
<tr>
<td></td>
<td>Director of Mental Health.</td>
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<td></td>
<td>13.10 The Director of Mental Health can direct that seclusion not be used in a</td>
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<td>particular authorised mental health service or not be used for a particular</td>
</tr>
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<td></td>
<td>patient.</td>
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<td></td>
<td>13.11 Require the Director of Mental Health to issue binding policies on the use</td>
</tr>
<tr>
<td></td>
<td>of mechanical restraint and seclusion to minimise its use and impact on patients.</td>
</tr>
</tbody>
</table>

**Question:**
Will the recommendations strengthen the safeguards and effectiveness of the restraint and seclusion provisions?
### Issues identified

| Review recommendations |

**Notification of mechanical restraint and seclusion**

13.12 Require the notification to the Director of Mental Health on the use of mechanical restraint or seclusion to be done in the way, and within the time, directed by the Director, on a general basis or for particular authorised mental health services.

**Definition of mechanical restraint**

13.13 The definition of ‘mechanical restraint’ be revised to “any device or apparatus used to prevent the free movement of a person’s body or a limb”.

**Offence of mechanical restraint**

13.14 The mechanical restraint offence state that it is an offence for a person to apply a mechanical restraint to an involuntary patient in an authorised mental health service, unless the restraint is of a type approved by the Director of Mental Health and in accordance with the Act.

**Definition of seclusion**

13.15 The definition of ‘seclusion’ be revised so that it does not apply if the person consents (e.g. for the person’s privacy).

13.16 Define ‘overnight’ (which is excluded from the definition of seclusion in a high security unit) as being a period of no more than 10 hours between 8:00 pm and 8:00 am as determined by the administrator of the authorised mental health service.

**Release from seclusion**

13.17 A senior registered nurse who placed a patient in seclusion in urgent circumstances be able to release the person from seclusion if satisfied the patient’s seclusion is no longer necessary, while retaining the requirement for the patient to be examined by a doctor as soon as practicable.

**Basis for authorising the use of a mechanical restraint and seclusion**

13.18 Enable the authorisation of the use of mechanical restraint to be on the same basis as the authorisation of seclusion (i.e. necessary to protect the patient or other people from imminent physical harm, and there is not less restrictive way of ensuring the safety of the patient or others).
### 14. Regulated treatments

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
</table>
| • Act to have adequate safeguards for the use of ECT and psychosurgery. | **Psychosurgery**  
14.1 The term ‘psychosurgery’ be replaced with ‘neurosurgery for psychiatric conditions’ and be defined as follows:  
• Neurosurgery for psychiatric conditions’ means a neurological procedure to treat or ameliorate symptoms of a psychiatric condition.  
• To remove doubt, neurosurgery for psychiatric conditions does not include neurosurgery for treating epilepsy, Parkinson’s disease, Gilles de la Tourette syndrome or another neurological disorder.  
14.2 Non-ablative procedures (such as deep brain stimulation) be excluded from the definition of ‘neurosurgery for psychiatric conditions’, with the protections under the *Guardianship and Administration Act 2000* being retained. |
| • Terminology related to regulated treatments not contemporary. | **Electroconvulsive therapy**  
14.3 The definition of electroconvulsive therapy (ECT) clearly link the procedure with the treatment of mental illness by including ‘for the purpose of treatment of mental illness’ in the definition.  
14.4 The two-day timeframe for notices of hearings about ECT applications may be waived by the patient or the patient’s representative.  
14.5 The seven-day timeframe for notices of hearings of appeals to the Mental Health Court about ECT applications may be waived by the patient or the patient’s representative.  
14.6 Where an existing application for ECT has been made to the Mental Health Review Tribunal, the psychiatrist be required to notify the Tribunal if emergency ECT is undertaken, rather than requiring a new application to be made |
| • Time-frames for hearings could be expedited. | **More information**  
Background paper 14—Regulated treatments. |

**Question:**  
Will the recommendations improve the effectiveness of the provisions related to regulated treatments?
## 15. Transport issues

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Powers to transport involuntary patients are inconsistent and inadequate.</td>
<td><strong>Inconsistent transport powers</strong></td>
</tr>
<tr>
<td>• Police may receive inadequate information to effectively respond to requests to return patients.</td>
<td>15.1 The Act include one set of provisions that consistently authorises the transport of individuals to, from, and within authorised mental health services, who is authorised to transport individuals, the use of reasonable force, and the authority to use medication if required.</td>
</tr>
<tr>
<td>• Act does not require individuals who are involuntarily transported from the community to be returned in all instances.</td>
<td><strong>Police assistance</strong></td>
</tr>
<tr>
<td>• Circumstances where a person may be detained and transported to an authorised mental health service are not sufficiently clear.</td>
<td>15.2 Where an authorised mental health service is seeking police assistance to transport a person to the service, the service is to advise police of the reason the person requires transportation, the reason that police assistance is required, and risk information about the person.</td>
</tr>
<tr>
<td></td>
<td>15.3 When requested by an authorised mental health service, police to provide assistance, of the nature and in the time that is reasonable in the circumstances, having regard to the reason the person is to be transported, and the risk information provided by the service.</td>
</tr>
<tr>
<td>More information</td>
<td><strong>Use of mechanical restraint</strong></td>
</tr>
<tr>
<td>Background paper 15—Transport issues.</td>
<td>15.4 The use of mechanical restraint be permitted when transporting high security patients, if clinically required, to ensure the safety of the patient or others, in accordance with policies issued by the Director of Mental Health.</td>
</tr>
<tr>
<td></td>
<td><strong>Appearances before court</strong></td>
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<td></td>
<td>15.5 Clarify the arrangements for a patient to appear before a court via video-link from an authorised mental health service, including the power to detain a patient if the patient’s status under the Act changes as a result of court proceedings via video-link.</td>
</tr>
</tbody>
</table>

**Question:**
Will the recommendations provide for clear, consistent powers to transport individuals?
<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
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</thead>
<tbody>
<tr>
<td><strong>Returning individuals to relevant place</strong></td>
<td>15.6 The circumstances where the administrator of an authorised mental health service be required to ensure that a person is reasonably returned to a place in the community be expanded to include all situations where a person has been taken to an authorised mental health service under an involuntary process of the Act.</td>
</tr>
<tr>
<td><strong>Authority to return patients</strong></td>
<td>15.7 The Act to clearly state the circumstances where a person can be detained and returned involuntarily to an authorised mental health service, namely:</td>
</tr>
<tr>
<td></td>
<td>• a person absconds while being lawfully detained under the Act</td>
</tr>
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<td></td>
<td>• a person on limited community treatment absconds from escorted leave, does not attend for treatment as required, or does not return to the service as required</td>
</tr>
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<td></td>
<td>• a person on a community category order does not attend for treatment as required</td>
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<td></td>
<td>• a person on a temporary absence absconds or does not return to the service as required</td>
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<td></td>
<td>• a person who is not in an authorised mental health service is placed on an involuntary treatment order, forensic order, or court order as an in-patient, or</td>
</tr>
<tr>
<td></td>
<td>• a person for whom limited community treatment is revoked or suspended, a community category order is changed to an in-patient order, or a temporary absence is revoked.</td>
</tr>
<tr>
<td><strong>Entry of places and warrants</strong></td>
<td>15.8 Clarify that a warrant is not required if a classified patient, forensic patient, or a person detained under a court order under the Act is required to return to an authorised mental health service, due to the operation of section 21 of the Police Powers and Responsibilities Act 2000.</td>
</tr>
</tbody>
</table>
## 16. Regional, rural and remote issues

<table>
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<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased flexibility under the Act could improve the provision of services in regional, rural and remote areas of Queensland.</td>
<td>16.1 The Director of Mental Health have the authority to approve authorised mental health services with conditions or limitations to enable small rural or remote health facilities to provide a limited range of in-patient treatment for involuntary patients.</td>
</tr>
<tr>
<td></td>
<td>16.2 The restrictions on the use of audio-visual facilities for assessments be discontinued, with it being at the discretion of the relevant clinician to determine whether the use of audio-visual facilities is appropriate in each case.</td>
</tr>
<tr>
<td></td>
<td>16.3 For regional, rural and remote areas designated by the Director of Mental Health, a second assessment (to confirm or revoke an involuntary treatment order) be required in seven days rather than three days if the patient is being detained as an in-patient in an authorised mental health service, and 14 days if the patient is placed on a community category order.</td>
</tr>
<tr>
<td></td>
<td>16.4 Clarify that community treatment may be provided at any clinically-appropriate place determined by the relevant clinician, such as an authorised mental health service, a community mental health service, a primary healthcare centre or another place, such as a person’s home.</td>
</tr>
<tr>
<td></td>
<td>16.5 The administrator of an authorised mental health service in a regional, rural or remote area designated by the Director of Mental Health may extend the time period for an assessment of a person for an additional 72 hours if it is necessary to enable transportation of the person to a suitable place for the assessment.</td>
</tr>
</tbody>
</table>

### More information
Background paper 16—Regional, rural and remote issues.

### Question:
Will the recommendations increase the flexibility of service provision in regional, rural and remote areas?
### 17. Indigenous and multicultural issues

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
</table>
| • The Act should give recognition to providing services to Aboriginal people, Torres Strait Islander people and people from culturally and linguistically diverse backgrounds. | 17.1 The following two principles be included in the Act:  
• the cultural, communication, and other unique contexts and needs of Aboriginal people, Torres Strait Islander people and people from culturally and linguistically diverse backgrounds must be recognised and taken into account, and  
• to the extent that is practicable and appropriate to do so, services provided to Aboriginal people and Torres Strait Islander people are to have regard to the person’s cultural and spiritual beliefs and practices, and the views of families and significant members of the person’s community. |

**More information**  
Background paper 17—Indigenous and multicultural issues.

**Question:**  
Will the recommendations adequately recognise the needs of Aboriginal people, Torres Strait Islander people and people from culturally and linguistically diverse backgrounds?
### 18. Children and adolescents

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
</table>
| • Consent to treatment by minors, and by a minor’s parents or guardians, could be clarified in legislation. | **Consistent use of terminology**  
18.1 The term ‘minor’ replace the terms child, young person and young patient, with a minor meaning a person under the age of 18 years. |
| • There would be benefit in having an expert in child psychiatry participating in Tribunal hearings for minors. | **Children within adult facilities**  
18.2 The Act include a principle that, wherever practicable, minors should be held separately from adults in in-patient facilities. |
| **More information**  
Background paper 18—Children and adolescents. | **Capacity to consent**  
18.3 For the purposes of the Act, a minor be presumed to have capacity to consent to treatment if the minor has the maturity and intelligence to fully understand the decisions being made.  
18.4 Clarify that the Act does not affect the common law in relation to parents or guardians consenting to a minor’s treatment, noting that this would not prevent a doctor proceeding under the Act if the parents or guardians did not agree to treatment and the doctor believed the treatment was in the minor’s best interests. |

### Question:
Will the recommendations adequately recognise minors?
### 19. Streamlined processes

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
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<tbody>
<tr>
<td>• Too many forms and other paperwork required in administering the legislation.</td>
<td>19.1 The requirements to complete forms under the Act be streamlined and clarified to distinguish between: • approved forms • requirements to notify or document a matter in another way (including in electronic form), and • template forms which are discretionary to use. The requirements to be in line with Addendum A of Background Paper 19.</td>
</tr>
<tr>
<td><strong>More information</strong> Background paper 19—Streamlined processes.</td>
<td>19.2 The powers and responsibilities of authorised positions be modified in line with Addendum B of Background Paper 19.</td>
</tr>
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<td></td>
<td>19.3 The Act to include provisions for authorised persons to investigate offences under the Act.</td>
</tr>
</tbody>
</table>

**Question:**
Will the recommendations streamline processes in administering the legislation?
### 20. Other legal issues

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
</table>
| A number of legal issues could be addressed in the new legislation. | **Presentation of indictment within six months of committal**  
20.1 The requirement of the Criminal Code (section 590) to present an indictment within six months of a committal to apply, notwithstanding that proceedings have been suspended under the Act. |
| | **Definition of ‘unfit for trial’**  
20.2 Provide that a person is mentally unfit to stand trial on a charge of an offence if the person is mentally impaired to the extent that the person is:  
• unable to understand, or to respond rationally to, the charge or the allegations on which the charge is based  
• unable to exercise (or to give rational instructions about the exercise of) procedural rights (such as, for example, the right to challenge jurors)  
• unable to understand the nature of the proceedings or to follow the evidence or the course of the proceedings, or  
• unable to endure the person’s trial without serious adverse consequences to the person’s mental condition.  
A person is not unfit to stand trial only because he or she is suffering from memory loss. |
| | **Intoxication and unsoundness of mind**  
20.3 The definition of ‘unsound mind’ refer directly to sections 27 and 28 of the Criminal Code. |
| | **Mental Health Court proceedings where the charge is disputed**  
20.4 Where there may be a reasonable doubt that a person committed an alleged offence, but not one that affects the expert psychiatric evidence, the Act allow the Mental Health Court to make a determination of unsoundness of mind. Options presented for feedback for how this determination could occur are:  
• prior to the matters in dispute being referred to a criminal court for decision  
• after the matters in dispute are referred to a Mental Health Court judge sitting alone for decision (if the judge rejects the other defences), or  
• after the matters in dispute are referred to a criminal court for decision (if the jury rejects the other defences). |
| | **Disputed facts relevant to expert opinion**  
20.5 Where there is a dispute of a fact that is material to an expert opinion, the matter in dispute be determined by a Mental Health Court judge sitting alone and then returned to the full Mental Health Court for a determination of unsoundness. |
| | **Youth justice officers attending the Mental Health Court**  
20.6 The chief executive of the youth justice department be entitled to be heard by the Mental Health Court in a similar way to proceedings before the Childrens Court. |

**Question:**  
Will the recommendations address other relevant legal issues?
### Issues identified | Review recommendations
--- | ---
**Managing capacity, clinical needs and forensic order admissions**
20.7 Where a forensic order is made for a patient to be detained to a high security unit, the Mental Health Court must stay the order for a period of up to seven days if requested by the Director of Mental Health to enable the facility to make a place available for the patient.
20.8 The Mental Health Court may refuse to grant a stay, or may grant a stay for a shorter period than requested by the Director of Mental Health, where it is satisfied the person should be urgently admitted to a high security unit for treatment and care.

**Admissibility of Mental Health Court decisions in sentencing**
20.9 Clarify that Mental Health Court decisions are admissible in sentencing where there is a trial for an alleged offence after a Mental Health Court finding.

**Making of forensic orders on appeals from Mental Health Review Tribunal fitness for trial decisions**
20.10 Allow the Mental Health Court to make a forensic order (or an involuntary treatment order that can only be revoked by the Tribunal) if, on appeal from a Mental Health Review Tribunal decision that a person is fit for trial, the Court decides the person is unfit for trial.

**Miscellaneous confidentiality issues**
20.11 Define ‘publish’, for the purposes of Chapter 14, part 5 (Confidentiality), as including the public dissemination of information, such as distributing information via leaflets in letterboxes, or announcing the information at a meeting.
20.12 Define ‘report’, for the purposes of Chapter 14, part 5 (Confidentiality), to include any account of all or part of the proceedings.
20.13 Allow the provision of confidential information for bona fide research along the lines of the provisions of the *Youth Justice Act 1992* (section 297).
20.14 Authorise the sharing of information between police, courts, other relevant departments and Queensland Health to facilitate the identification of individuals who may have a defence related to a mental illness or an intellectual disability.

**Access to health records for private psychiatrist’s reports**
20.15 An authorised mental health service to grant access to a patient’s medical records to a lawyer or psychiatrist acting for the patient where the patient may have been of unsound mind at the time of an alleged offence or may be unfit for trial, and the patient does not have capacity to give written consent to the access.
## 21. Other issues

<table>
<thead>
<tr>
<th>Issues identified</th>
<th>Review recommendations</th>
</tr>
</thead>
</table>
| • Objectives of the Act could be improved. | **Objectives of Act**  
21.1 The main objectives of the Act be as follows:  
• to improve and maintain the health and well-being of people with a mental illness who do not have the capacity to consent to treatment  
• to enable people to be diverted from the criminal justice system where found to have been of unsound mind at the time of an unlawful act or unfit for trial, and  
• to protect the community where people diverted from the criminal justice system may be at risk of harming others.  
These objectives to be achieved in a way that:  
• safeguards the rights of individuals  
• affects a person’s rights and liberties in an adverse way only if there is no less restrictive way to protect the health and safety of the person or others, and  
• promotes the person’s recovery, and ability to live in the community, without the need for involuntary treatment and care. |
| • A number of other issues could be addressed in the new legislation. | **Notifications**  
21.2 All provisions in the Act where individuals are to be notified of a decision or other event to clearly and consistently state the individuals to be notified, who is responsible for the notification and the time-frame for the notification.  
21.3 All notifications should be subject to a qualification that the person does not need to make a notification if it may cause harm to a patient’s health or put the safety of any person at risk. |
| **More information**  
Background paper 21—Other issues. | **Director of Mental Health annual report**  
21.4 The Act to expand on the content and timing of the annual report issued by the Director of Mental Health.  
21.5 The annual report to include details of each recommendation to rectify a serious non-compliance under the Act by an authorised mental health service and the actions taken in response. |
| **Terminology**  
21.6 The following changes to terminology apply under the Act:  
• ‘senior registered nurse on duty’ be replaced with ‘registered nurse in charge of the shift’  
• ‘audio visual link’ be defined using the definition in the *Evidence Act 1977*, and  
• the title ‘Director of Mental Health’ be replaced with ‘Chief Psychiatrist’. | Question:  
Will the recommendations address other relevant issues? |
<table>
<thead>
<tr>
<th>Issue/s</th>
<th>Review recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorised mental health service where treatment and care may be provided</strong></td>
<td></td>
</tr>
<tr>
<td>21.7</td>
<td>Ensure that an involuntary patient may be treated or cared for by an authorised mental health service other than the designated service responsible for the person’s involuntary status.</td>
</tr>
<tr>
<td><strong>Searches</strong></td>
<td></td>
</tr>
<tr>
<td>21.8</td>
<td>The search provisions ensure that non-consensual searches within authorised mental health services only apply to individuals involuntarily detained under the Act.</td>
</tr>
<tr>
<td>21.9</td>
<td>The search provisions also apply to public sector health service facilities where a person is admitted under the emergency transport provisions or as a result of the making of a recommendation for assessment.</td>
</tr>
<tr>
<td>21.10</td>
<td>A doctor or registered nurse in charge of the shift at an authorised mental health service be authorised to conduct a search of a patient or their possessions if he or she believes a search is reasonably necessary for the patient’s or another person’s safety.</td>
</tr>
<tr>
<td>21.11</td>
<td>Ensure that the provisions that apply for the searches of visitors at the high security unit do not prevent other authorised mental health services undertaking reasonable searches of visitors if the service believes it necessary for the safety and welfare of patients, staff and others at the service.</td>
</tr>
<tr>
<td><strong>Terms for assisting psychiatrists</strong></td>
<td></td>
</tr>
<tr>
<td>21.12</td>
<td>Assisting psychiatrists for the Mental Health Court be appointed for a maximum of two consecutive terms.</td>
</tr>
<tr>
<td><strong>Automatic cessation of involuntary treatment orders</strong></td>
<td></td>
</tr>
<tr>
<td>21.13</td>
<td>The automatic cessation of an involuntary treatment order after six months of non-contact with an authorised mental health service be discontinued.</td>
</tr>
</tbody>
</table>
Great state. Great opportunity.
Review of the Mental Health Act 2000

Background Papers

May 2014
1. Involuntary Examinations and Assessments

1.1 Background

1.1.1 Making of assessment documents

Chapter 2 of the Mental Health Act 2000 deals with the processes leading to the making of an involuntary treatment order (ITO) for a person, other than in circumstances where the person is detained in custody\(^1\). The provisions of the Act enable an involuntary assessment to be made of a person’s mental health in an authorised mental health service (AMHS) if the statutory ‘assessment documents’ are made. The assessment documents are a ‘request for assessment’ and a ‘recommendation for assessment’.

A request for assessment may be made by any adult who reasonably believes:

- the person has a mental illness of a nature, or to an extent, that involuntary assessment is necessary, and
- has observed the person within three days before making the request.

A recommendation for assessment may be made by a doctor or an authorised mental health practitioner. A recommendation for assessment can only be made if the doctor or authorised mental health practitioner has examined the person within the preceding three days (including by audio-visual link) and is satisfied the assessment criteria\(^2\) apply for the person. The request for assessment and the recommendation for assessment must be made by different persons.

The Act provides that a health practitioner or an ambulance officer may take a person for whom assessment documents are in force to an AMHS for assessment. For the purposes of Chapter 2, an AMHS does not include a high security unit, but does include a public hospital if there is no AMHS readily accessible.

Data on assessment documents made over the past five years is shown in the table below.

---

\(^1\) Background Paper 2 deals with persons detained in custody.

\(^2\) The assessment criteria are outlined in the Glossary.
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Data on assessment documents made over the past five years is shown in the table below.

¹ Background Paper 2 deals with persons detained in custody.
² The assessment criteria are outlined in the Glossary.
### Table 1.1 Request and Recommendation for Assessment Made – 2008-09 to 2012-13

<table>
<thead>
<tr>
<th>Year</th>
<th>Assessment documents only*</th>
<th>Following JEO</th>
<th>Following EEO</th>
<th>Total</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>6940</td>
<td>256</td>
<td>2379</td>
<td>9575</td>
<td>-</td>
</tr>
<tr>
<td>2009-10</td>
<td>6717</td>
<td>274</td>
<td>2491</td>
<td>9482</td>
<td>-1%</td>
</tr>
<tr>
<td>2010-11</td>
<td>6842</td>
<td>249</td>
<td>3034</td>
<td>10,125</td>
<td>6.8%</td>
</tr>
<tr>
<td>2011-12</td>
<td>7508</td>
<td>300</td>
<td>3561</td>
<td>11,369</td>
<td>12.3%</td>
</tr>
<tr>
<td>2012-13</td>
<td>7893</td>
<td>305</td>
<td>3314</td>
<td>11,512</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

* Excludes the making of assessment documents following a justices examination order (JEO) or emergency examination order (EEO)

(Source: Director of Mental Health Annual Reports, 2008-09 to 2012-13)

#### 1.1.2 Justices examination orders

The making of a recommendation for assessment is dependent on a doctor or authorised mental health practitioner examining a person and forming the view that the assessment criteria are met. There are three ways that this may occur:

- an examination may occur voluntarily, for example, if a person is in hospital
- an examination is authorised in an emergency (see section 1.1.3), or
- an examination is undertaken under a justices examination order (JEO).

Under the JEO provisions, any person may apply to a magistrate or a justice of the peace for a JEO. The application must be sworn and state the grounds on which it is made. The magistrate or justice of the peace may make the JEO if the magistrate or justice reasonably believes:

- the person has a mental illness
- the person should be examined to decide whether a recommendation for assessment should be made, and
- an examination cannot properly be carried out unless the order is made.³

The order authorises a doctor or authorised mental health practitioner to examine the person to decide whether a recommendation for assessment should be made (section 30). For the purpose of an examination, a doctor or health practitioner may enter the place stated in the order, or another place where it is reasonably believed the person may be found. The exercise of these powers may be assisted by a police officer, who may detain the person for the purpose of the examination.

Data on justices examination orders made over the past five years is shown in the table below.

³ Section 28 of the Act.
1.1.3 Emergency examination orders

The Act also enables a police officer or an ambulance officer to take a person to an AMHS (or a public hospital if there is no AMHS readily accessible) in emergency circumstances. This applies where the police officer or ambulance officer reasonably believes:

- a person has a mental illness
- there is an imminent risk of physical harm being sustained by the person or someone else
- using the JEO provisions would cause a dangerous delay and significantly increase the risk of harm to the person or someone else, and
- the person should be taken to an AMHS for examination to decide whether assessment documents should be made for the person.4

Once the person is taken to the AMHS, the police officer or ambulance officer must make an EEO, which authorises the person to be detained for no longer than six hours for examination by a doctor or an authorised mental health practitioner to decide if a recommendation for assessment should be made.

Similar provisions also enable a psychiatrist to make an EEO. These provisions are primarily used by private psychiatrists.

Data on emergency examination orders made over the past five years is shown in the table below.

---

4 Section 33 of the Act.
Table 1.3  Emergency Examination Orders Made – 2008-09 to 2012-13

<table>
<thead>
<tr>
<th>Year</th>
<th>Orders made</th>
<th>Increase</th>
<th>Assess. criteria met</th>
<th>Assess. criteria not met</th>
<th>Other*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ambul.</td>
<td>Police</td>
<td>Psych.</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>2008-09</td>
<td>1758</td>
<td>3827</td>
<td>14</td>
<td>5599</td>
<td>-</td>
</tr>
<tr>
<td>2009-10</td>
<td>2480</td>
<td>4113</td>
<td>23</td>
<td>6616</td>
<td>18.2%</td>
</tr>
<tr>
<td>2010-11</td>
<td>3820</td>
<td>4852</td>
<td>14</td>
<td>8686</td>
<td>31.3%</td>
</tr>
<tr>
<td>2011-12</td>
<td>4522</td>
<td>5556</td>
<td>29</td>
<td>10,107</td>
<td>16.4%</td>
</tr>
<tr>
<td>2012-13</td>
<td>4754</td>
<td>5868</td>
<td>26</td>
<td>10,648</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

* This applies where the order ends before the examination or where the person had a pre-existing involuntary status.

(Source: Director of Mental Health Annual Reports, 2008-09 to 2012-13)

1.1.4 Assessment of persons

Where assessment documents are made for a person (a ‘request for assessment’ and a ‘recommendation for assessment’), the Act provides that the person may be detained in an AMHS for an authorised doctor to determine whether the treatment criteria\(^5\) apply to the person. The period for which a person may be detained is 24 hours, with the capacity to extend this up to 72 hours (section 44). If the authorised doctor determines the treatment criteria apply to the person, the doctor may make an ITO for the person.

1.2 Issues

1.2.1 General

The provisions of the Act leading to involuntarily treatment are unnecessarily complex. When combined with the provisions that apply for classified persons (see Background Paper 2), the Act refers to 10 documents\(^6\) that may be used prior to, and including, an ITO.

There are, however, only three basic steps involved: Examine – Assess – Treat. The Act should follow this process. Where a person is not located at an AMHS or another appropriate place where an examination, assessment or treatment can take place, a legal authority to involuntarily transport the person may be required (see Background Paper 15).

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\(^5\) The treatment criteria are outlined in the Glossary.

\(^6\) Request for assessment, recommendation for assessment, JEO, EEO (police or ambulance officer), EEO (psychiatrist), recommendation for assessment (person in custody or before a court), agreement for assessment, court assessment order, custodian’s assessment authority, involuntary treatment order.
It is proposed that the only statutory documents leading to involuntary treatment be:

- an involuntary examination authority (replacing the JEO)
- a recommendation for involuntary assessment, and
- an involuntary treatment order.

### 1.2.2 Justices examination orders

**Inappropriate use of powers**

Submissions to the Review, and consultations undertaken as part of the Review, indicated widespread concerns with how justice examination orders operate. The Review was advised that orders are sought for vexatious reasons, such as in family disputes, where orders may be sought against estranged spouses and children living with estranged spouses. Concerns were also expressed that orders are used as a vehicle to discredit elderly persons as leverage to gain guardianship control over property.

The Review was also advised that orders may be used by genuinely concerned parents in relation to an adolescent child in circumstances where the child does not have a mental illness, but may be engaging in drug-taking, excessive alcohol consumption or in other high-risk or confronting behaviour.

This occurs although the applicant is required to swear an oath, and an offence applies for stating anything false or misleading in a document made under the Act.

Data on the percentage of justice examination orders that resulted in involuntary treatment orders over the past five years is shown below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of JEOs</th>
<th>Assessment criteria met</th>
<th>ITO made</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>2008-09</td>
<td>792</td>
<td>256</td>
<td>32.3%</td>
</tr>
<tr>
<td>2009-10</td>
<td>822</td>
<td>274</td>
<td>33.3%</td>
</tr>
<tr>
<td>2010-11</td>
<td>865</td>
<td>249</td>
<td>28.8%</td>
</tr>
<tr>
<td>2011-12</td>
<td>990</td>
<td>300</td>
<td>30.3%</td>
</tr>
<tr>
<td>2012-13</td>
<td>1039</td>
<td>305</td>
<td>29.4%</td>
</tr>
</tbody>
</table>

(Source: Director of Mental Health Annual Reports, 2008-09 to 2012-13)

The data highlights the concerns expressed to the Review. In the vast majority of cases, there is no basis on which the person subject to a JEO is assessed as meeting the criteria for involuntary assessment.

These outcomes are mitigated by the fact that, in many instances, persons may voluntarily accept treatment. In 2012-13, approximately 40 percent of persons who did

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7 An additional document is proposed for classified patients (see Background Paper 2).
not meet the assessment criteria voluntarily accepted mental health services (either in-
patient or outpatient) within the following 14 days.\(^8\) This highlights the importance of
encouraging persons to seek voluntary treatment in the first instance.

It needs to be highlighted that a JEO gives the power to enter premises and detain a
person for the purposes of an examination.\(^9\) This is a serious infringement of an
individual's liberty and should only be used where justified. It has been highlighted to
the Review that the use of these powers can be traumatic to individuals, the effect of
which may continue well after the event has occurred. This ongoing trauma may occur
notwithstanding that, on examination, the person is found not to have a mental illness
and is promptly released.

The fundamental challenge is to structure the legislation such that legitimate uses of
examination powers without consent can be maintained, while minimising the risk of
the powers being used inappropriately.

It is proposed to address this in three ways, namely:

1. Requiring clinical input into the decision-making process
2. Strengthening the criteria for making an order, and
3. Limiting the persons able to make orders.

To better communicate the nature of an order, it is proposed to rename a JEO to an
‘involuntary examination authority’.

- **Clinical input**

One of the fundamental problems in the existing model is that a magistrate or justice of
the peace is required to form a reasonable belief that a person has a mental illness. Although some justices of the peace may contact the local AMHS for advice, there is
no requirement to do so.

It is not evident how a magistrate or a justice of a peace would be able to form a
reasonable belief that a person has a mental illness in the absence of clinical advice.
The magistrate or a justice of the peace does not see the person and is reliant totally
on the information provided by the applicant.

A person who genuinely believes someone has a mental illness to the extent that
involuntary treatment may be warranted should, in the first instance, seek clinical
advice from an authorised mental health practitioner\(^10\) or a doctor. This provides the
opportunity for the clinician to explain how the criteria for a magistrate or justice of the
peace to issue an involuntary examination authority apply. It also provides the
opportunity to refer the person to more appropriate treatment, for example, for drug and
alcohol abuse. Wherever possible, the person for whom there are concerns about his
or her mental health should be encouraged to speak to a doctor directly.

In the absence of examining the person, it is not expected that a practitioner would
definitively form a view as to whether or not the assessment criteria apply to the
person. However, if the concerned person who has contacted the practitioner honestly

\(^8\) Source: Department of Health data.

\(^9\) Note that Background Paper 15 indicates there is uncertainty as to whether a warrant is
required to use force to gain entry.

\(^10\) Authorised mental health practitioners are located in authorised mental health services and in
some courts.
presents the facts to the practitioner, the process of consulting with the practitioner would significantly improve the prospect of any subsequent authority being used only in appropriate circumstances. Some applicants currently seek such advice, and it would be beneficial for it to be made a requirement under the Act. The applicant should be required to document this advice in the application for an involuntary examination authority if it is proceeded with.

In addition, the justice of the peace or magistrate should be required to obtain similar clinical input from an authorised mental health practitioner or doctor. This would remove any risk that the applicant misrepresented or misinterpreted the views of the authorised mental health practitioner or doctor. This advice may be sought by way of a statement commenting on whether the stated behaviour, and other factors, indicate the presence of a mental illness to the extent that involuntary treatment may be warranted. These proposals would not prevent a doctor or an authorised mental health practitioner from applying directly for an involuntary examination authority where appropriate.

- **Criteria for issuing an authority**

The criteria for the making of a JEO (see section 1.1.2) are broad in their nature and do not adequately relate to the assessment and treatment criteria.\(^\text{11}\) As the basis of an involuntary examination is to determine whether an involuntary assessment or involuntary treatment is required, key aspects of the treatment criteria must also apply to authorise an involuntary examination. For an involuntary examination authority to be issued there should be a prima facie case the treatment criteria apply for the person. Evidence the person may lack the capacity to consent to treatment is fundamental to the Act and to deciding whether an involuntary examination is required. Any adult has the right to refuse treatment for an illness, even if others in the community may not understand the reason for the refusal or would not do so themselves. It should be no different for person with a mental illness.

It is proposed that a magistrate or justice of the peace must only issue an involuntary examination authority if satisfied:

- the person appears to have a mental illness
- the person appears to lack the capacity to consent to treatment
- attempts to encourage the person to be treated voluntarily have not succeeded or have not been practicable, and
- there is an imminent risk that the person may cause serious harm to himself, herself or someone else, or suffer serious mental or physical deterioration because of the illness if the person does not receive involuntary treatment.

- **Who may make an authority**

The vast majority of justice examination orders are made by justices of the peace. For 2012-13, justice examination orders were made by justices of the peace on 990 occasions (95 percent) and by magistrates on 49 occasions (5 percent)\(^\text{12}\). This is due to the easier access to justices of the peace. It appears most applications are made to justices of the peace located in courthouses, most likely on the basis of suggestions to

\(^{11}\) See section 1.2.5 where it is proposed to dispense with separate assessment criteria.

\(^{12}\) Source: Director of Mental Health Annual Report 2012-13
the applicant by authorised mental health services. This does not necessarily mean the justice of the peace considering the application is experienced or has expertise or training in these matters as a volunteer justice of the peace may be on duty in the courthouse.

The Justices of the Peace and Commissioners for Declarations Act 1991 split the single role of Justice of the Peace into three separate positions, Commissioners for Declarations, Justices of the Peace (Qualified) and Justices of the Peace (Magistrates Court), with increasing levels of powers and responsibilities. Under the Mental Health Act, a Justice of the Peace (Qualified) and a Justice of the Peace (Magistrates Court) are authorised to make justice examination orders.

There are approximately 35,000 Justices of the Peace (Qualified) in Queensland (although a proportion of these would be inactive), and approximately 700 Justices of the Peace (Magistrates Court)\(^\text{13}\).

Justices of the peace are expected to act under a large number of Acts. This primarily involves witnessing documents such as statutory declarations, oaths, wills and powers of attorney. On application by a police officer, a justice of the peace is also authorised to issue summonses and warrants.

Most of the matters which a justice of the peace are required to act on would not have the implications for an individual’s rights provided for under this Act, especially as the application may be made by any member of the public. This was confirmed by consultation during the Review where it was indicated that some justices of the peace believe they were only witnessing a signature or taking an oath, rather than issuing a warrant to enter premises (including a person’s home), detain a person and examine the person without consent.

Of further concern to the Review is advice that some applicants engage in “JP-shopping” - approaching multiple justices of the peace until the applicant can find one who agrees to make an order.

The Department of Justice and Attorney-General has programs in place to train justices of the peace. This includes working with the Department of Health in providing training to justices of the peace on matters under the Act. However, given the very large number of justices of the peace, it would be impossible to effectively train this group of people in these very significant matters.

To remedy this, it is proposed to only authorise a category of justices of the peace to issue involuntary examination authorities, in addition to magistrates. This group of justices of the peace would receive specific training on issuing authorities under the Act.

It is expected that the extra safeguards proposed under the Act will significantly reduce the number of authorities sought.

- **Powers exercised under an authority**

It is proposed that an involuntary examination authority would authorise the same matters as a JEO, namely, the power to enter a premises and detain a person for an examination to determine whether a recommendation for assessment should be made.

\(^{13}\) Source: The Department of Justice and Attorney-General
It is standard in contemporary legislation to clearly state what powers may be exercised under such authorities, and the protections afforded to a person when an authority is exercised. These provisions should be strengthened in the Act.

It is proposed the legislation incorporate standard provisions such as:
- giving the person a copy of the authority
- giving the person an opportunity to allow entry without the use of force
- stating the powers that may be exercised, namely to detain the person for the purposes of an examination and to conduct the examination, and
- limiting the time of the detention and examination.

1.2.3 Emergency examination orders

- Use of Police Powers and Responsibilities Act 2000

Police and ambulance officers are frequently called upon to deal with emergencies in the community. Section 609 of the *Police Powers and Responsibilities Act 2000* enables a police officer to enter a place to prevent an offence, injury or domestic violence. This power may be exercised, for example, if a police officer reasonably suspects there is an imminent risk of injury to a person. Using these powers, a police officer may detain anyone at the place for the time reasonably necessary to establish whether the reason for the entry exists. Police officers may use these powers to enter premises and, under the emergency powers of the Mental Health Act, then transport a person to an AMHS.

As outlined in Background Paper 15, advice from health practitioners and the Queensland Police Service indicates some uncertainty among police regarding when a warrant is required and under what circumstances entry can be forced. This may arise if, for example, a health practitioner is aware a person’s mental health has deteriorated significantly such that the persons poses an imminent risk to himself or herself, but when the police attend the relevant premises there are no overt signs to satisfy police under section 609 of the *Police Powers and Responsibilities Act 2000*. In these cases, current police practice is likely to require a warrant to be sought. This can lead to a delay in the police being able to enter the premises.

To clarify this situation, it is proposed that the relevant legislation state that a police officer may take into consideration advice received from a health practitioner in forming a view as to whether there is an imminent risk of injury to a person for the purpose of section 609 of the *Police Powers and Responsibilities Act 2000*.

- Alcohol and drug abuse

The Review has been advised that, in a large number of cases, persons taken to an AMHS under the emergency provisions are suffering from drug or alcohol abuse, rather than a mental illness. In some cases, persons under the influence of drugs or alcohol may mention ‘suicide’, which would trigger this action under current police practice. Stating an intention to ‘suicide’ may not indicate a real intention to do so and does not of itself indicate a mental illness. The Review was advised on a number of occasions that persons, particularly adolescents, flippantly mention ‘suicide’ to police so they will be taken to a hospital rather than a watch-house.
However, as police place a high priority on suicide prevention, their actions in taking any such persons to an AMHS under the Act are understandable, particularly in the absence of other powers to do so.

As a result, the vast majority of persons taken to an AMHS for examination are found to have no underlying mental illness that warrants action under the Act. Data on the outcomes of emergency examination orders made over the past five years is shown in the table below.

Table 1.5 Emergency Examination Orders that Resulted in Involuntary Treatment Orders - 2008-09 to 2012-13

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of EEOs</th>
<th>Assessment criteria met</th>
<th>ITO made</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage (%)</td>
<td>Number</td>
</tr>
<tr>
<td>2008-09</td>
<td>5599</td>
<td>2379</td>
<td>930</td>
</tr>
<tr>
<td>2009-10</td>
<td>6616</td>
<td>2491</td>
<td>978</td>
</tr>
<tr>
<td>2010-11</td>
<td>8686</td>
<td>3034</td>
<td>1089</td>
</tr>
<tr>
<td>2011-12</td>
<td>10,107</td>
<td>3561</td>
<td>1276</td>
</tr>
<tr>
<td>2012-13</td>
<td>10,648</td>
<td>3314</td>
<td>1303</td>
</tr>
</tbody>
</table>

(Source: Director of Mental Health Annual Reports, 2008-09 to 2012-13)

This situation is complicated by the fact that the Act only allows for a person to be detained for emergency examination for a maximum of six hours. Where a person is suffering the effects of drug or alcohol abuse, a period of six hours is often insufficient time for the person to detoxify to the extent that a proper clinical assessment can be made of any underlying mental illness. In these circumstances, clinicians may make a recommendation and request for assessment for the purpose of detaining a person for a further period of time.

It is evident that protecting persons who have engaged in drug use or excessive alcohol consumption is a necessary function for police, ambulance officers, and health services. It is not appropriate, however, to use involuntary mental health powers when, in the majority of instances, there is no underlying mental illness.

It is therefore proposed to extend the powers for police and ambulance officers to deal with persons in emergency circumstances whether it results from drug use, excessive alcohol consumption or an underlying mental illness.

It is proposed that the existing powers in the Act be extended to include situations where a person appears to have a serious mental impairment as a result of the effects of drugs or alcohol and there is an imminent risk of the person causing harm to himself or herself. In these circumstances, the person may be taken to a place, including a public sector health service facility, for urgent treatment and care. Given that this is a wider public health and safety issue, these provisions should be placed in an Act other than mental health legislation.

To ensure the adequate documentation of this process, the health service will be required to complete a brief notice (e.g. an “emergency transport notice”) on admission of the person to the health service facility.
To address the issue of the period of detention for a person who may have an underlying mental illness, it is proposed that a person may be detained for a further period of six hours to enable an assessment to be made under the Act.

- **Psychiatrist examination orders**
  
  It is proposed to discontinue the powers in the Act for psychiatrists to issue emergency examination orders. These provisions are rarely used (26 in 2012-13\(^{14}\)), and adequate powers exist under the revised emergency transport provisions and the extended police powers outlined above. If a psychiatrist has a concern about a patient, he or she can contact the police or the ambulance service.

- **Review of exercise of powers**
  
  A number of individuals have sought redress for the inappropriate making of justice examination orders under the Act, including that action be taken against the person who made the application, the relevant justice of the peace or the police, or to have health records amended.

  The Act requires the relevant doctor or authorised mental health practitioner to notify the Director of Mental Health (DMH) if a recommendation for assessment is not made as a result of a JEO. Given the large number of these notifications, it is not possible for the DMH to review all of these notifications unless the person the subject of the order raises concerns with the order.

  As an additional accountability measure, an aggrieved person should be able to apply to the DMH for a review of the making, and implementation, of an involuntary examination authority. The DMH would be required to prepare a report within 60 days of receiving a request. The report could include:

  - a recommendation that action be taken against a person for a false or misleading application (an offence under the Act)
  - a matter be referred to the Crime and Misconduct Commission or the police service
  - feedback be provided to authorised mental health services, doctors, magistrates and authorised justices of the peace on improvements to the authority process
  - amendments be made to health records to accurately reflect medical diagnosis and other matters
  - advice to the applicant on the processes under the Act, or
  - no further action be taken.

  It is not proposed that the review process would bring into question a magistrate’s decision. It is also not proposed that a review would allow the identity of the applicant to be revealed to the aggrieved person.

  It is not proposed to have a capacity to review the exercise of the emergency powers as there is no application and related decision-making process involved. If a person was concerned about the use of police powers, this could be raised with the police service or the Crime and Misconduct Commission. Amendments to health records to accurately reflect medical diagnosis and other matters can be sought under the *Right to Information Act 2009*.

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\(^{14}\) Source: Director of Mental Health Annual Report 2012-13
1.2.4 Request for assessment

As indicated above, a request for assessment may be made by any adult who reasonably believes a person has a mental illness to the extent that an involuntary assessment is necessary.

It may have been intended this provision would enable a person such as a family member to request an authorised mental health practitioner to make a recommendation for assessment. However, in practice, requests for assessment are almost always made by another staff member of the AMHS after the recommendation for assessment is made, for the purpose of complying with the Act.

As this process creates no additional safeguards it should be discontinued. This does not prevent a clinician from seeking a second opinion on a matter if the clinician thinks it appropriate in a particular situation.

1.2.5 Assessment criteria

As outlined above, the assessment criteria are the basis for a doctor or authorised mental health practitioner to decide if a recommendation for assessment should be made. The assessment criteria are merely a backward modification of the treatment criteria. Their inclusion in the Act adds to its complexity.

It is proposed to discontinue the assessment criteria in the proposed legislation and instead require a doctor or authorised mental health practitioner to make a recommendation for assessment based on whether an authorised doctor may reasonably form the view that the treatment criteria apply.

1.2.6 Treatment criteria

Section 14 of the Act sets out the treatment criteria, which are the basis for making an ITO, namely:

a) the person has a mental illness
b) the person’s illness requires immediate treatment
c) the proposed treatment is available at an authorised mental health service
d) because of the person’s illness –
   i) there is an imminent risk that the person may cause harm to himself, herself or someone else, or
   ii) the person is likely to suffer serious mental or physical deterioration
e) there is no less restrictive way of ensuring the person receives appropriate treatment for the illness, and
f) the person lacks the capacity to consent to be treated for the illness or has capacity but unreasonably refuses the proposed treatment.

It should be noted that all of the criteria must apply for an ITO to be made. The treatment criteria are critical to the operation of the Act as they form the basis on which a person may be placed on an ITO. In addition, if an authorised doctor or the Mental Health Review Tribunal forms the view that the treatment criteria no longer apply, the ITO must be revoked.
An analysis of the criteria, and an understanding of how they apply in practice, indicate significant problems with the criteria.

- **Capacity to consent to treatment**
  The Act defines ‘capacity’ (in relation to assessment, treatment or care) as meaning a person is capable of:
  a) understanding the nature and effect of decisions about the person’s assessment, treatment (or) care
  b) freely and voluntarily making decisions about the person’s assessment, treatment (or) care, and
  c) communicating the decisions in some way.\(^{15}\)
  This definition confuses capacity to consent with actual consent in that item (b) in the definition relates to consent rather than capacity to consent. In the context of the treatment criteria, a person’s capacity to consent is the relevant consideration. A better definition of capacity to consent to treatment would be as follows:
  A person has capacity to consent to treatment if the person is able to:
  • understand the nature and purpose of the treatment or care
  • understand the benefits and risks of the treatment or care, and alternatives to the treatment or care
  • understand the consequences of not receiving the treatment or care
  • assess the advantages and disadvantages of the treatment or care in order to arrive at a decision, and
  • communicate the decision.

- **Unreasonable refusal**
  The treatment criteria permit treatment to be provided if a person ‘unreasonably refuses’ the treatment. This concept is based on the United Nations Principles for the Protection of Persons with Mental Illness, which refers to a patient unreasonably withholding consent “having regard to the patient's own safety or the safety of others” (Principle 11, section 6(b)).
  However, if the basis of the unreasonable refusal is that the person is at risk of harming himself, herself or others, then capacity to consent is effectively made irrelevant as the clinician has already formed the view that the person is at risk of harming himself or herself (paragraph (d)).
  A broader interpretation of ‘unreasonable refusal’ is merely that the doctor and the patient do not agree, which is not an acceptable approach.

- **Cross-sectional v. longitudinal diagnosis**
  The criteria in the Act require an authorised doctor to take a cross-sectional (or ‘point-in-time’) diagnosis of a person. This is required due to the ‘immediate treatment’ element of criteria (b) and the ‘imminent risk’ element of criteria (d)(i). While this approach may work satisfactorily on initial diagnosis, it becomes problematic after this point. Once a person becomes stable, the immediacy of the treatment or care passes

\(^{15}\) See the Schedule to the Act (Dictionary).
and, on proper interpretation of the criteria, an authorised doctor must revoke the order. This is also the case once the person has recovered sufficiently to regain capacity.

Revoking an ITO would be appropriate in circumstances where the treating clinician is of the view that the person will return to the community and engage voluntarily in a treatment and care program to manage his or her illness as required, or where no further treatment is warranted.

However, a constant theme from stakeholders consulted in the Review is the high risk of serious deterioration of patients when they are removed from an involuntary treatment regime. Clinicians have advised the Review that predictive factors in this regard are:

- failure to continue to take medication (especially where persons have a history of this)
- use of illicit drugs or excessive use of alcohol (especially where persons have a history of this), and
- returning to an unstable living environment in the community.

For these reasons, a cross-sectional approach to diagnosis is likely to result in many persons ‘cycling’ on and off involuntary treatment orders. This is not in the interests of the patient or the community and does not, over time, support a least restrictive approach to the person’s treatment.

For these reasons, it is proposed that the treatment criteria in the proposed legislation support a more longitudinal diagnosis of patients.

• **Conclusion**

For the reasons outlined above, it is proposed the treatment criteria in the Act be as follows:

a) the person has a mental illness

b) the person lacks the capacity to consent to be treated for the illness

c) because of the person’s illness, the absence of involuntary treatment (or continued involuntary treatment) is likely to result in:

   i) imminent serious harm to the person or someone else, or

   ii) the person suffering serious mental or physical deterioration.

These criteria maintain the primacy of a person’s right to consent to treatment if the person has capacity to do so. If a person did not have insight into his or her condition, the criteria may be met as ‘capacity to consent’ requires a person to understand the consequences of not receiving treatment to have capacity. However, while having more robust criteria of what constitutes capacity to consent will assist clinicians making assessments against the treatment criteria, definitively assessing a person’s capacity can be uncertain and changeable. Where a person’s capacity fluctuates, risk to the person’s health may arise.

To provide clarity in this matter, it is also proposed to expressly state that an authorised psychiatrist may maintain a person on an involuntary treatment order, even if the person appears to have capacity, if the doctor reasonably believes that revoking the order would place the person or others at serious risk of harm, or the person’s physical or mental state would deteriorate in a serious way.
1.2.7 Who make an involuntary treatment order

The Act prevents an authorised doctor who is a psychiatrist from making a recommendation for assessment and an ITO for the same person. This protection, however, is not extended to other authorised doctors. The safeguard in the system is that a psychiatrist must then confirm the order within three days.

This leaves open the possibility that an authorised doctor can make both a recommendation for an assessment, and carry out the assessment. This does not provide an adequate safeguard given that a person may be involuntarily detained and treated pending the confirmation or revocation of the order by a psychiatrist. It is therefore proposed that, in most circumstances, the Act should prevent an authorised doctor making a recommendation for assessment and an ITO for the same person in the same examination and assessment process.

However, this may restrict the provision of mental health services in regional, rural and remote areas of the State, where there are fewer authorised doctors. For this reason it is proposed to retain the ability for an authorised doctor to make a recommendation for assessment and an ITO in regional, rural and remote areas designated by the DMH.
Review of the Mental Health Act 2000

Background Paper

May 2014
2. Individuals Held in Custody

2.1 Background

This Background Paper deals with:

- persons held in custody in a watch-house, prison or youth detention centre as a result of being charged with an offence, or
- persons serving a sentence of imprisonment in a prison, or a period of detention in a youth detention centre.

These provisions are primarily located in Chapter 3 of the *Mental Health Act 2000*.

A person in custody may suffer an acute phase of a mental illness. When this occurs, the Act authorises the person to be transferred to an authorised mental health service (AMHS). For the transfer to occur, ‘assessment documents’ must be made for the person, namely:

- a recommendation for assessment (made by a doctor or authorised mental health practitioner)
- an agreement for assessment (made by an AMHS), and
- a custodian’s assessment authority (made by the person’s custodian).

A recommendation for assessment may be made if the assessment criteria apply to the person. However, in the case of persons in custody, the criterion that requires a person to lack capacity for a recommendation for assessment to be made does not apply. The effect of this is that a person who has capacity may consent to treatment in an AMHS. This gives persons in custody comparable access to voluntary treatment in an AMHS that applies to persons in the community.

Although it is not evident from the Act, persons who are already on an involuntary treatment order (ITO) or forensic order may also be transferred to an AMHS under these provisions.

As such, there are three categories of persons in custody who may be transferred to an AMHS:

- persons who require assessment to decide if an ITO should be made for the person
- persons who consent to treatment in an AMHS, and
- persons who are already on an ITO or forensic order.

As soon as practicable after the assessment documents are made, a police officer, correctional officer or detention centre officer (for a youth detention centre) must take the person to the AMHS.

In 2012-13, persons taken to an AMHS under these assessment documents are outlined below.

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1 The assessment criteria are outlined in the Glossary.
Table 2.1  Classified Patient Admissions – 2012-13

<table>
<thead>
<tr>
<th></th>
<th>From Corrective Services</th>
<th>From Watchhouses</th>
<th>From Court</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of admissions</td>
<td>136</td>
<td>32</td>
<td>8</td>
<td>176</td>
</tr>
<tr>
<td>Percentage</td>
<td>77.2%</td>
<td>18.1%</td>
<td>4.5%</td>
<td>-</td>
</tr>
</tbody>
</table>

(Source: Director of Mental Health Annual Report, 2012-13)

On a person being admitted to an AMHS, the person is detained as a ‘classified patient’. Proceedings for any offence against the person are automatically suspended (for other than Commonwealth offences). This does not prevent the person being granted bail or the prosecution being discontinued.

On admission, an authorised doctor must decide if the treatment and care needs of the patient require the patient to remain in the AMHS or be returned to custody.

For persons transferred to an AMHS for assessment to decide if an ITO should be made, an authorised doctor must undertake the assessment and decide whether or not to make an ITO. Of the 176 classified patient admissions in 2012-13, 97 patients (55.1 percent) had an ITO made during their admission.4

Once assessments are completed, there are two types of classified patients:

- patients on involuntary treatment orders (made prior to, or after, admission) or forensic orders, where the authorised doctor believes the patient should remain in the AMHS for treatment and care, and
- voluntary patients (where the patient consents to treatment in an AMHS), where the authorised doctor believes the patient should remain in the AMHS for treatment and care.

Given that classified patients would be held in custody if not being detained under the Mental Health Act, additional restrictions apply to these patients, namely:

- classified patients on an ITO must be placed on an in-patient order category, rather than a community category
- the Director of Mental Health (DMH) must approve limited community treatment (LCT) for classified patients
- the DMH may require monitoring conditions5 to be put in place for classified patients on LCT
- a classified patient serving a sentence of imprisonment or detention must be accompanied by an employee of the health service while on LCT
- a classified patient may only be transferred between authorised mental health services on the order of the DMH, and

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2 Court powers are dealt with in Background Paper 4.
3 Commonwealth offences are not suspended under the Act. However, the court may order that the classified patient be remanded in custody, with the place of custody being an authorised mental health service.
4 Source: Department of Health data.
5 A monitoring condition may require a patient to wear a GPS tracking device.
• the DMH must approve temporary absences for classified patients, for example, to receive medical treatment or to appear before court.

Although it is not clear from the Act, a person ceases to be a classified patient if:
• the authorised doctor decides on initial assessment, or at a future time, that the person does not need to be remain the AMHS for treatment and care (in these cases, the doctor must report this fact to the DMH who may then authorise the person’s return to custody)
• for a voluntary patient – the patient withdraws his or her consent
• for a patient on an ITO or a forensic order – the order is cancelled (unless the patient consents to remaining in the AMHS as a voluntary patient), or
• the basis for the person’s lawful custody outside of the Act ends (e.g. the person is granted bail, proceedings against the person are discontinued or withdrawn, the relevant period of imprisonment ends, the person is granted parole, or the Mental Health Court makes a decision in relation to the person).

2.2 Issues

2.2.1 General

The classified patient model is generally seen as being effective in ensuring that persons in custody who suffer an acute phase of a mental illness can have their treatment and care needs met without compromising community safety.

However, the provisions in the Act are not clearly presented and are unnecessarily complex. In many cases, it would not be possible for a person outside of the mental health system to understand the provisions or how they apply in practice.

For these reasons, the provisions of the Act related to classified patients are to be drafted in a clear and unambiguous way in the proposed legislation.

2.2.2 Assessment documents

The provisions related to the making of assessment documents should be simplified. The process for the making of assessment documents should, as far as is possible, utilise the general assessment documents as proposed in Background Paper 1.

Under this approach, the only additional requirement to the general assessment documents would be for the relevant custodian and the AMHS to agree to the person’s transfer to the service. The custodian’s agreement for the transfer should be documented in an approved form (a ‘custodian’s transfer authority’) as it contains valuable information about the person’s custodial status. The agreement of the AMHS need only be done in writing, for example, on the recommendation for assessment.

2.2.3 Capacity of authorised mental health services to receive classified patients

An issue of concern raised during the Review is the capacity of authorised mental health services to receive a person from prison who has become acutely unwell and requires treatment in an AMHS.
The Act states that the administrator of an AMHS may agree for the person to be assessed at the health service if:

- the service has the capacity to carry out the assessment, and
- for other than a high security unit, the person does not present an unreasonable risk to the safety of the person or other persons.

If the administrator of the AMHS does not agree to an assessment in the AMHS, the DMH may over-ride the administrator’s decision and agree to the assessment.

The Review was advised that some authorised mental health services may be unable or reluctant to accept a person due to the security requirements of managing the person, inadequate secure facilities (such as a high dependency unit), and the need to keep beds ‘open’ as a contingency for persons admitted through the emergency department.

Data provided to the Review indicated that some persons have been waiting long periods of time for admission. This is of concern, given that prisoners with acute mental illness would be among the most vulnerable persons in society.

The DMH plays a critical role in ensuring that persons in this situation are admitted to an AMHS as promptly as possible and with regard to the patient’s security needs. This can only be assessed on a case-by-case basis if the doctor or authorised mental health practitioner making the recommendation and the AMHS cannot otherwise agree.

It is proposed that the Act strengthen the role of the DMH by requiring the doctor or authorised mental health practitioner who made the recommendation for assessment to notify the DMH if agreement is not reached for a transfer within 72 hours.

The DMH must then take reasonable steps to arrange for the person’s transfer to an AMHS.

2.2.4 Consent to treatment

As indicated above, where a person is in custody, the assessment criteria that relate to consent do not apply. In practice, this is used to enable a person who consents to treatment to be transferred to an AMHS.

To clarify the intention of these provisions, the Act is to state that a person in custody may consent to being transferred to an AMHS for treatment and care. With the agreement of the custodian and the AMHS, the transfer to the service may then take place.

2.2.5 Application of classified patient provisions to persons already on an involuntary treatment order or forensic order

The classified patient provisions do not work satisfactorily in circumstances where the person in custody is already on an ITO or forensic order. In these circumstances, the outcome sought is for the person to be transferred to an AMHS for treatment and care, rather than for the person to be assessed against the treatment criteria.

Where a person is already on an ITO or forensic order, the following model is proposed:

- assessment documents are not required
• a police officer, correctional officer or detention centre officer is authorised to take the person to an AMHS if a doctor or authorised mental health practitioner believes it is necessary to provide treatment and care to the person for the person’s mental illness, and the AMHS and custodian agrees to the transfer

• on admission to the AMHS, the person becomes a classified patient and may be detained at the service for treatment

• for a patient on an ITO, the category of the order must be an in-patient category, and

• any current LCT approved by an authorised doctor is revoked and any new LCT will require DMH approval while the person is a classified patient.

2.2.6 Administration of medication while being transported to an authorised mental health service

The Act does not allow the administration of medication when taking a person to an AMHS from a place of custody. It is proposed to enact consistent provisions enabling the administration of medication where clinically required (see Background Paper 15).

2.2.7 Actions on admission

For persons transferred to an AMHS for assessment to decide if an ITO should be made, an authorised doctor must undertake the assessment and decide whether an ITO should be made for the person.

The Act needs to clearly state that, for all classified patients, the authorised doctor must decide if the person should remain in the AMHS for treatment as an involuntary patient (on an ITO or forensic order) or a voluntary patient if the patient consents to remaining in the AMHS.

If the patient consents to remaining in the AMHS for treatment and care, the Act should state that the person may withdraw his or her consent at any time.

2.2.8 Treatment and care of classified patients

Background Paper 5 deals with the treatment and care of involuntary patients, and recommends that all provisions about treatment and care be placed in one area of the Act.

These provisions will also require the following:

• for a classified patient who is already on an ITO or a forensic order, an authorised doctor must review the patient’s treatment needs on admission, document the changed treatment, and talk to the patient about the treatment, and

• on regular reviews of a classified patient, the authorised doctor must also decide if the patient’s treatment needs can be met in custody or whether the patient should remain in an AMHS.

2.2.9 Ceasing to be a classified patient

The provisions in the Act dealing with when a patient ceases to be a classified patient are unnecessarily complex and should be simplified. The legislation needs to
distinguish between circumstances where the person’s status as a classified patient ends as a result of there no longer being a clinical need for the patient remaining in the AMHS, and changes in the person’s legal status outside of the Mental Health Act.

Where there is no longer a clinical need for the person to remain in an AMHS, the legislation should state that the person is to be returned to the custodian from whom the person was initially transferred.

2.2.10 Terminology

Under the proposed legislation, it is proposed that ‘classified patients’ be referred to as ‘restricted community access patients’ to better describe the nature of this category of patients.
Review of the Mental Health Act 2000

Background Paper

May 2014
3. Assessment of Individuals Charged with an Offence

3.1 Background

This Background Paper addresses the assessment of persons charged with an offence who may have been of unsound mind at the time of the offence, or who may be unfit for trial.

There are two different processes for assessing persons charged with an offence - one for persons on an involuntary treatment order (ITO) or forensic order, and another for other persons.

3.1.1 People subject to an ITO or forensic order

Chapter 7, part 2 of the Mental Health Act 2000 applies if a person has an outstanding charge for any offence and is the subject of an ITO or a forensic order. It is immaterial which happens first, as long as both the charge and the order are current. If the ITO or forensic order is revoked, Chapter 7, part 2 ceases to apply.

Where an authorised mental health service (AMHS) becomes aware that Chapter 7, part 2 applies to a person, the Act requires the service to arrange an examination and report by a psychiatrist within 21 days (a ‘section 238 report’). The report is to include an opinion on the person’s mental capacity when the alleged offence was committed and the person’s fitness for trial.

The process of identifying persons who may have been of unsound mind at the time of an offence or unfit for trial is assisted by the Court Liaison Service in the south-east of the State, and local AMHS staff elsewhere, who obtain publicly available court lists and enter each name into the Queensland Health mental health database to ascertain if the person is on an ITO or forensic order.

Chapter 7, part 2 applies for every alleged offence from serious offences, such as attempted murder, to minor offences such as travelling on a train without a ticket. Multiple offences (such as another minor offence of the same kind half an hour later), can be dealt with in a single Chapter 7, part 2 process, but a separate assessment is required for each charge.

In 2012-13, Chapter 7, part 2 processes were initiated 1688 times. This represents a trebling in the number of assessments since the commencement of the Act (from 515 in 2002–03)\(^1\). Procedures for identifying people to whom Chapter 7, part 2 applies have changed during that period so the increase does not necessarily indicate an increase in crime rates by persons on involuntary treatment orders or forensic orders.

The psychiatrist’s report is forwarded to the Director of Mental Health (DMH) who must decide whether to refer the matter to the Mental Health Court (MHC) for hearing, or to the Director of Public Prosecutions (DPP) for decision as to the action to take for the offence.

\(^1\) Source: Director of Mental Health Annual Reports, 2002-03 and 2012-13.
Only indictable offences may be referred to the MHC. The DMH refers these offences to the MHC if the DMH believes the person may have been of unsound mind at the time of the offence or may be unfit for trial\(^2\).

In 2012-13, the DMH made 168 references to the MHC\(^3\).

The following table sets out the matters the DMH may refer to the DPP, and the possible outcomes.

### Table 3.1: Director of Mental Health Referrals to the Director of Public Prosecutions and Possible Outcomes

<table>
<thead>
<tr>
<th>DMH Referrals to DPP</th>
<th>Possible Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indictable offences of a ‘serious nature(^4), if the DMH considers the person is fit for trial and was not of unsound mind at the time of the offence</td>
<td>Proceedings ‘continue according to law’ (through the regular criminal courts)</td>
</tr>
<tr>
<td>Indictable offences that are not of a ‘serious nature’, regardless of whether the person may have been of unsound mind at the time of the offence or may be unfit for trial</td>
<td>If the person was of sound mind and is fit for trial: proceedings continue according to law</td>
</tr>
<tr>
<td>Summary offences</td>
<td>If sound and fit: proceedings continue according to law</td>
</tr>
<tr>
<td></td>
<td>If unsound and/or unfit: proceedings are discontinued</td>
</tr>
</tbody>
</table>

In 2012-13, there were 1188 referrals from the DMH to the DPP, with the following recommendations:

- 8 – permanently unfit for trial
- 12 – temporarily unfit for trial
- 428 – of unsound at the time of the offence
- 740 – of sound mind and fit for trial\(^5\)

In 2012-13, the MHC received 8 matters referred from the DPP\(^6\).

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\(^2\) While not explicit in the Act, the DMH exercises a discretion to refer matters to the MHC where a section 238 report indicates a person was of sound mind and fit for trial if the Director believes the determination of soundness of mind or fitness for trial requires further scrutiny.

\(^3\) Source: Director of Mental Health Annual Report, 2012-13. Note that MHC data indicate 120 references from the DMH; where a person is the subject of a reference already before the MHC, the MHC treats a new reference for that person (e.g. due to additional charges) as an amendment to the existing reference.

\(^4\) The term ‘serious nature’ is not defined in the Act.

\(^5\) Source: Department of Health data.

\(^6\) Source: Mental Health Court.
The Explanatory Notes to the Act offer the following rationale for the section 238 report process:

A significant feature of some mental illnesses is the inability of the patient to have insight into the nature and effect of their illness, which may prevent them from consenting to the examination or to the reference being made. These procedures are intended to protect those patients who are most vulnerable by ensuring examination of the relevant issues, in particular, the patient’s mental state at the time of the offence and their current fitness for trial. This pro-active approach better ensures identification of persons whose criminal behaviour results from mental illness and thus enables a response (i.e. treatment for mental illness) which provides greater protection against re-offending.

Chapter 7, part 2 therefore aims to ensure that people whose mental illness or intellectual disability may have prevented them from understanding what they were doing at the time of the alleged offence are identified and diverted from the criminal justice system. Imposing criminal convictions in these circumstances is contrary to the common law principle that a person should not be held liable for an act done when the person was deprived of understanding. Criminal penalties are also unlikely to address the true cause of the offending behaviour. Chapter 7, part 2 also aims to identify persons whose mental illness or intellectual disability might prevent them from having a fair trial. Continuing with legal proceedings in these circumstances would also be contrary to the common law.

3.1.2 People not subject to an ITO or a forensic order

Persons for whom Chapter 7, part 2 does not apply may want to have the question of unsoundness or fitness heard by the MHC or another court. These people must obtain their own psychiatric reports. This would include circumstances where Chapter 7, part 2 initially applied, but ceased to apply due to the revocation of an ITO or forensic order. Legal Aid is available for these psychiatric reports for people who meet the means and assets tests. However, lawyers advise that it can take some time to collate a brief to a psychiatrist, including obtaining records from Queensland Health. In addition, lawyers advise the amount of the standard grant is often insufficient for most psychiatrists to prepare a report of the quality reasonably required, and those psychiatrists willing to do reports at legal aid rates are often booked many months ahead.

It is not possible to determine how many people who may have a mental health defence, and to whom Chapter 7, part 2 does not apply, choose not to explore this defence. These people may prefer a timely criminal conviction and penalty to a lengthy psychiatric assessment and court processes and, for matters taken to the MHC, the potential of a forensic order for many years. Anecdotal evidence varies, but some lawyers consulted during the Review estimate over 50 percent of people charged with indictable offences who may have a mental health defence opt for a quick resolution. This would be consistent with the fact that psychotic illnesses are ten times more prevalent among prisoners (7 percent) than in the general community (0.7 percent)\(^7\).

is reasonable to assume that some proportion of this group of prisoners may have been of unsound mind at the time of their offence, but chose not to pursue that defence. Non-psychotic disorders such as major depression, anxiety disorders and post-traumatic stress disorder are less likely to deprive a person of sufficient capacity to amount to a mental health defence, but still do so on occasion. Rates of these illnesses amongst prisoners are between 25 percent and 50 percent\(^8\).

### 3.2 Issues

Some stakeholders supported the retention of the current arrangements, believing they assist in identifying people whose actions have been a result of their mental illness or intellectual disability, and diverting those people to treatment and care. Some stakeholders also pointed out that serious offending may be preceded by less serious offending, and that identifying and treating people early may be beneficial for the community and the offender.

However, most stakeholders expressed strong concerns with the current arrangements, including the breach of patients’ rights in mandating reports without consent, extensive delays in the preparation of reports, the resource implications of preparing reports for less serious offences, and the limited benefits of the model.

While the Chapter 7, part 2 process was put in place with good intentions, it is evident from the Review that there are major problems with the model to the extent that the current approach is not sustainable. The problems with the current arrangements relate to:

1. The scope of offences - Chapter 7, part 2 applies for every offence, from serious crimes to minor and trivial offences; this coverage imposes a high cost on the public sector health system for limited benefits
2. The scope of accused people – Chapter 7, part 2 is based on whether a person is on an ITO or forensic order; this is an inexact way of identifying persons who may have a mental health defence
3. Breach of rights - the mandated assessment denies a person the right to decide whether he or she wishes to pursue a mental health defence
4. Extensive delays in the section 238 report process
5. Lack of protections for persons the subject of the section 238 report process, and
6. Practical problems in identifying persons to whom Chapter 7, part 2 applies.

#### 3.2.1 Scope of offences for mandatory reports

As indicated above, section 238 reports are required for relatively minor and trivial offences. Offences for which reports are commonly prepared include urinating in public, fare evasion, begging, petty theft, simple trespass, using indecent language, shoplifting, and possession of drug implements.

Many stakeholders believe the current arrangements are unwarranted for less serious offences and that valuable public sector resources could be better utilised. These resources include not only psychiatrists’ time, but also the significant resources

devoted to identifying patients to whom Chapter 7, part 2 applies (see section 3.2.6), and the administrative resources supporting the process. This view was strongly expressed by staff in the public sector mental health system.

Department of Health data indicates the following breakdown for the most serious offence in section 238 reports received by the DMH for 2012-13:

- summary offences - 51 percent
- indictable offences that could be dealt with summarily (i.e. by a magistrate) regardless of the circumstances – 9 percent
- indictable offences that could be dealt with summarily (i.e. by a magistrate) in certain circumstances (e.g. on a plea of guilty) - 37 percent (it is likely that nearly all of these would have been dealt with summarily if not for the Chapter 7, part 2 process), and
- ‘serious’ indictable offences – i.e. indictable offences that must be heard on indictment (i.e. by the District or Supreme Court) – 2 percent.

On the basis of this data, approximately 95 percent of section 238 reports are prepared for offences that would be heard summarily by a magistrate in the normal criminal justice system.

The preparation of section 238 reports involves a number of Queensland Health staff, namely:

- Court liaison officers
- AMHS administrator delegates
- treating psychiatrists.
- Mental Health Act liaison officers
- Mental Health Act administration officers, and
- the Director of Mental Health.

As part of the Review, an analysis was undertaken of the costs involved in all aspects of the section 238 report process for Queensland Health. It should be noted that the actual preparation of the section 238 report is only one aspect of the process, which also involves requesting and reviewing police reports, accessing and reviewing patient records, obtaining other collateral information (e.g. statements from witnesses, family members), and arranging and conducting interviews with the patient.

The costing analysis used two methodologies – one for the process of identifying persons to whom Chapter 7, part 2 applies, and another for the processes involved in preparing section 238 reports and their referral to the DPP or MHC.

This analysis concluded the cost of the section 238 process to be $3.5 million per annum.\(^\text{10}\)

In addition, other parties are affected by the section 238 report process, including persons charged with offences (who do not benefit from the process but have substantial delays in the case being heard), their support people, police, corrective services, the courts and lawyers.

\(^9\) A Childrens Court judge also hears matters on indictment.

This high cost on the public sector health system of preparing section 238 reports for all offences cannot be justified by the limited benefits achieved. These resources would be more productively used delivering mental health services to the community, including treating forensic patients who have committed unlawful acts of greater concern to the community.

3.2.2 Scope of accused people for mandatory reports

Despite the broad scope in terms of offences covered, the scope of the section 238 report process is limited in terms of accused persons covered, and not well targeted. As indicated above (section 3.1.1), 740 of the 1188 references from the DMH to the DPP in 2012-13 (62 percent) recommended the person was of sound mind and fit for trial. These recommendations are invariably accepted by the DPP and the proceedings for the person continue according to law.

Those found unsound or unfit through a Chapter 7, part 2 process represent only a fraction of those who may have a mental health defence. For indictable offences, there were as many references to the MHC made by defence lawyers in 2012-13 (125) as through the Chapter 7, part 2 process (128 from DMH and DPP), and many people who may have a defence instruct their lawyers not to pursue it (see section 3.1.1). Many of the defendants in the other approximately 187,000 proceedings before magistrates each year may be unsound or unfit, but the matter is not raised by the defendant or noticed by the defence lawyer.

It is likely that lawyers for people accused of more serious offences, which result in detailed discussions between the lawyer and client, are in a position to more reliably identify who should explore a question of unsoundness or unfitness. The process of identifying persons who may have a mental defence is supported by court liaison staff whose role is to identify and divert accused persons to treatment. These staff accept referrals from lawyers, police and others, and provide written information about:

- whether the person has a mental illness
- whether the person requires assessment in an AMHS, and
- options available from mental health services should the person be granted bail or otherwise.

3.2.3 Breach of rights

Section 238 reports are required to determine unsoundness of mind at the time of the alleged offence, even if the person is fit for trial and could make his or her own decision about whether to explore the issue of unsoundness.

Some stakeholders expressed concern that the Act presumes incapacity as the person is given no choice as to whether to pursue a mental health defence.

If the rationale for these provisions is the protection of people who may not have the insight, because of their illness, to make decisions in their own best interests, then it is

11 Source: Mental Health Court data.
12 Source: Magistrates Court Annual Report 2012-13. Note: ‘defendant’ refers to a person with one or more or more charges registered at the same time.
a rationale only for a mandatory assessment of fitness for trial – not unsoundness of mind some time earlier at the time of an alleged offence.

People who are fit for trial can instruct their lawyers to explore mental health issues if they wish to – as is the case with any other defence, and as is the case for mental health issues for accused persons who are not currently subject to an ITO or forensic order. If a person is not fit, a substitute decision-maker could make decisions on the person’s behalf.

3.2.4 Delays

Many stakeholders expressed strong concerns with the extensive delays in the finalisation of section 238 reports and the burden of that delay on accused persons, victims, courts, and prosecution and defence resources.

Department of Health data\textsuperscript{13} indicates that in 2012-13:

- only 14 percent of reports were completed within the statutory 21 days
- 45 percent took more than 90 days, and
- 26 percent took more than six months.

<table>
<thead>
<tr>
<th>Table 3.2 Time-frame for Receipt of Section 238 Reports – 2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Less than 21 days</strong></td>
</tr>
<tr>
<td><strong>22-42 days</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

(Source: Department of Health Annual Report 2012-13)

The extensive time taken to prepare section 238 reports is unfair to all concerned. This includes people who were of sound mind at the time of the offence, people who were of unsound mind (particularly if the person is in custody on remand), and victims, many of whom expressed frustration in their submissions to the Review at the length of time matters take to resolve.

Magistrates, court registry staff, prosecutors and lawyers also have to manage large lists of accused people whose matters are adjourned multiple times while awaiting reports.

It is difficult to definitively identify and quantify the causes of delays in preparing psychiatric reports. Psychiatrists refer to delays in access to police material, patients being unable to be located or not attending for examinations, and patients too unwell to participate in an examination. It seems logical that in most cases any one of these factors would make completion of a report within 21 days impossible.

It is also evident that psychiatrists need to prioritise their work. It is likely that preparing reports for minor offences - noting that 95 percent of reports are prepared for matters that would otherwise be heard summarily - would not be a high priority for a psychiatrist.

\textsuperscript{13} Source: Director of Mental Health Annual Report 2012-13.
3.2.5 Protections for persons subject to section 238 processes

Although not expressly stated in the Act, the preparation of a section 238 report involves the patient attending for an interview before a psychiatrist to answer questions related to the person's state of mind currently, and at the time of the offence.

This interviewing process can have a profound effect on a person’s legal rights, most particularly, how the prosecution proceeds with charges against the person if the person is found to be of sound mind and fit for trial.

The Act is seriously deficient in protecting an individual's rights in the section 238 report process, including:

- there is no explicit statement of the purpose of a section 238 report
- there is no statement of the person’s obligations to attend for an interview; it is likely that the person believes that he or she is legally required to attend
- there is no statement of the person’s obligations when being interviewed by a psychiatrist, including whether the person is or is not required to answer self-incriminating questions, and
- there are no protections afforded the person on the use of the report once it is produced.

3.2.6 Identifying accused people to whom Chapter 7, part 2 applies

The process of identifying people to whom Chapter 7, part 2 applies is a manual, time-consuming, incomplete and inaccurate process. As noted above (section 3.1.1), the Court Liaison Service and other Queensland Health staff around the State obtain publicly available court lists and enter each name into the Queensland Health mental health database to determine whether an accused is on an ITO or forensic order. This takes many person-hours every day\(^\text{14}\) and is subject to human error. Childrens Court lists are not publicly available and are therefore not checked; Saturday court lists are checked sporadically, if at all; and fresh arrests appearing in court after the day’s list has been finalised are also missed.

The nature of this process limits its effectiveness in identifying persons to whom Chapter 7, part 2 applies.

It should also be noted that the Act does not require this process to be undertaken. It is undertaken as a discretionary service to assist in identifying persons to whom Chapter 7, part 2 may apply.

3.2.7 Conclusions

To address the issues identified above, a new model is proposed that differentiates between offences that can be heard summarily (by a magistrate) and offences that must be heard on indictment (i.e. must go to the District or Supreme Court). The table below provides examples of offences under the proposed model.

Table 3.3: Examples of Offences under Proposed Model

<table>
<thead>
<tr>
<th>Offences that can be heard summarily (i.e. by a Magistrate)</th>
<th>Offences that must be heard on indictment (i.e. must go to the District or Supreme Court)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary offences</strong></td>
<td><strong>Indictable offences that can be heard summarily</strong></td>
</tr>
<tr>
<td>Property: Shoplifting</td>
<td>Stealing</td>
</tr>
<tr>
<td>Violence: Disorderly behaviour</td>
<td>Simple assault</td>
</tr>
<tr>
<td>Drugs: - Drug possession</td>
<td>Drug trafficking</td>
</tr>
<tr>
<td>Other: Traveling on a train or bus without a ticket</td>
<td>Wilful damage</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Offences that can be heard summarily**

Due to the costs, delays, limited benefits and breach of rights in the current system, it is proposed to discontinue mandatory psychiatric reports for offences that can be dealt with summarily. For consistency, this would include offences that may only be determined summarily in certain circumstances, such as on a plea of guilty.

It is also possible that some offences that might give rise to greater concern from a forensic mental health perspective, such as stalking, could be treated in the same way as offences that must be heard on indictment (‘prescribed indictable offences’).

Identifying persons appearing before a Magistrates Court who have mental health issues would be undertaken by lawyers and watch-house officers, as occurs for the majority of matters currently, supported where appropriate by the Court Liaison Service in South-East Queensland and AMHS staff elsewhere in the State. Court liaison officers will play an important role in the revised arrangements. The ‘gap’ left by the discontinuation of mandatory psychiatric reports for many offences is likely to result in an increased demand for court liaison services. As part of the consultation process for the Review, an assessment will be made of the best way that court liaison officers can support the revised arrangements.

- **Offences that must be heard on indictment**

Four options were considered by the Review for offences that must be heard on indictment, namely:

Option 1: Discontinue mandatory psychiatric reports, and rely on defence lawyers, supported by the court liaison arrangements to identify persons who may have a mental health defence. Lawyers would then arrange their own psychiatric reports, with Legal Aid funding where necessary.

Option 2: Discontinue mandatory psychiatric reports, but provide them on the request of a person who was on an ITO or forensic order at the time of, or since,

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15 Matters that cannot be dealt with summarily still pass through a Magistrates Court or Childrens Court magistrate on their way to the higher courts.
the alleged offence, or if the person cannot consent, on the request of the person’s representative, such as a personal guardian or attorney.

Option 3: Require mandatory ‘fitness for trial’ psychiatric reports where a person was on an ITO or forensic order at the time of, or since, the alleged offence, with enhanced rights and protections for the person.

Option 4: Continue the current arrangements (mandatory unsoundness and ‘fitness for trial’ psychiatric reports) to apply where a person has been on an ITO or forensic order at the time or since the alleged offence, with enhanced rights and protections for the person.

A summary of the advantages and disadvantages of each option is outlined in the Addendum to this Background Paper.

Options 1 and 2 are the most respectful of individual rights. Option 1 is the most beneficial in terms of the flexible use of public sector health resources, but would involve increased costs for Legal Aid. This would not arise to the same extent in Option 2.

Option 3 breaches individual rights in that a fitness for trial assessment is done regardless of whether the person or the person’s representative agrees. This option may, however, result in a more expeditious assessment of the patient.

Option 4 is only justified if, for public protection, the accepted view is that a person who was of unsound mind at the time of a serious offence should go on a forensic order rather than receive a criminal conviction and penalty. If this argument is valid, the public interest may be argued to over-ride the breach of individual rights for the proportion of alleged offenders captured by the process.

Under any of these options, there would be significantly improved time-frames for assessments due to the removal of mandatory assessments for offences that can be heard summarily.

The analysis of the options has concluded that Option 2 is the most beneficial, with the additional safeguard that the DMH could direct a report for a matter that must be heard on indictment (or another prescribed indictable offence) where the DMH believes this is in the public interest.

This approach would require an AMHS to prepare a psychiatric report on the request of a person charged with an offence that must be heard on indictment (or other prescribed indictable offences), if the person was on an ITO or forensic order at the time of (or since) the alleged offence. A request for a psychiatric report may also be made by the person’s representative, such as a personal guardian or attorney, if the person is unable to consent.

Where the DMH directs a psychiatric assessment, the proposed Act is to provide safeguards for the patient.
### Addendum: Options for Assessing Persons Charged with Offences

<table>
<thead>
<tr>
<th>Option 1 - Discontinue mandatory</th>
<th>Rights of accused people</th>
<th>Timeliness of Assessment</th>
<th>Cost and Efficiency</th>
<th>Public Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No-one forced to have an assessment against his or her will (or against a substitute decision-maker’s decision)</td>
<td>Relies on defence lawyers being able to access clinical information promptly in order to brief psychiatrist, and psychiatrist being able to meet patient and prepare report promptly.</td>
<td>Most flexible option for the allocation of public sector health resources. Higher costs for Legal Aid than other options. Likely to be fewer assessments, but cost per assessment will be higher (as are done privately rather than by public sector psychiatrists).</td>
<td>Small chance that some persons may be missed (versus other options), but in most cases mental health issues will become apparent to lawyers in the course of discussions with their clients. Persons on ITO or forensic order are known to mental health services and therefore should be identified.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Option 2 - Election</th>
<th>Rights of accused people</th>
<th>Timeliness of Assessment</th>
<th>Cost and Efficiency</th>
<th>Public Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No-one forced to have an assessment against his or her will (or against a substitute decision-maker’s decision) Current inequity retained for people who want to explore a mental health defence, as service is offered only to those on an ITO or forensic order; others have to seek private report.</td>
<td>Where election is taken up, will be much quicker than current arrangements. For those not on an ITO or forensic order - relies on defence lawyers being able to access clinical information promptly in order to brief psychiatrist, and to meet patient and prepare report promptly.</td>
<td>Less flexible option for the allocation of public sector health resources, dependent on the take-up of the election.</td>
<td>Similar to Option 1.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Option 3 - Mandated fit for trial</th>
<th>Rights of accused people</th>
<th>Timeliness of Assessment</th>
<th>Cost and Efficiency</th>
<th>Public Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breach of patients’ rights in that a patient (or substitute decision-maker) does not have right to decline assessment (fit for trial) Current inequity retained for</td>
<td>Should be less delay than option 2 for people who are covered, as the process will start sooner. Assessment of unsoundness may need to be done privately at a later time.</td>
<td>Less flexible option for the allocation of public sector health resources. Simpler assessments and reports because</td>
<td>Possibility that additional persons may be picked up versus Options 1 and 2, although would be addressed once a substitute decision-maker or lawyer is engaged.</td>
<td></td>
</tr>
<tr>
<td>Rights of accused people</td>
<td>Timeliness of Assessment</td>
<td>Cost and Efficiency</td>
<td>Public Interest</td>
<td></td>
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<tr>
<td>--------------------------</td>
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<td></td>
</tr>
<tr>
<td>people who want to explore a mental health defence, as mandated only for those on an ITO or forensic order; others have to seek private report.</td>
<td>they will only cover fitness for trial. Assessment of unsoundness may need to be done privately at a later time.</td>
<td>Will be much quicker than current arrangements. More comprehensive report required than under Option 3.</td>
<td>Possibility that additional persons may be picked up versus Options 1 and 2. For the group of persons already on an ITO or forensic order, will increase the likelihood that the person goes on a forensic order rather than receives a criminal penalty which may be argued is a better public protection.</td>
<td></td>
</tr>
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**Option 4 - Mandated unsound-ness and fit for trial**

Breach of patients’ rights in that the patient (or substitute decision-maker) does not have right to decline assessment (fit for trial and unsoundness of mind)

Current inequity retained for people who want to explore a mental health defence, as mandated only for those on an ITO or forensic order; others have to seek private report.
Review of the Mental Health Act 2000

Background Paper

May 2014
4. Orders and Other Actions Following Court Findings

4.1 Background

When a person does an act that would constitute an offence but is of unsound mind at the time, the person is not criminally responsible for the offence. The Mental Health Act 2000 defines 'unsound mind' by reference to the Criminal Code, section 27, namely that:

the person is in such a state of mental disease or natural mental infirmity as to deprive the person of capacity to understand what the person is doing, or of capacity to control the person’s actions, or of capacity to know that the person ought not to do the act or make the omission.

Following a finding of unsoundness of mind at the time of the offence, the Mental Health Court (MHC) may make a forensic order having regard to:

- the seriousness of the offence
- the person’s treatment or care needs, and
- the protection of the community.¹

The only options open to the Court are to make, or not make, a forensic order.

The MHC may also determine that a person is not fit for trial. The Act defines ‘fit for trial’ as being:

- 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.²

Where the MHC decides a person is not fit for trial, the Court must also decide whether the unfitness is permanent or temporary. If the Court decides that the unfitness is permanent, it may make a forensic order. If the unfitness is considered temporary, a forensic order must be made by the Court. The person is then monitored by the Mental Health Review Tribunal to determine if the person becomes fit for trial at a future time. If the person does not become fit for trial within seven years for life offences, or three years for other offences, proceedings for the offence are discontinued (section 215), but the forensic order remains in force until it is revoked.

A Supreme or District Court may make an order when a jury makes findings of unsoundness or unfitness under the Criminal Code (section 299). Where the order is for a person to be detained in an authorised mental health service (AMHS), the order is taken to be a forensic order for the purposes of the Act. Where the order is that a person be detained in custody in another place (e.g. a corrective service facility), the Minister for Health may subsequently make a forensic order for the person (section 302) for the purpose of transferring the person to an AMHS.

Magistrates Courts have only one option following a finding of unsoundness – to discharge the defendant. This applies to all summary (simple) offences and indictable offences that can be dealt with summarily, although for those offences there is the option of a reference to the MHC

¹ See section 288(4) of the Act.
² See definition in the Schedule to the Act.
by the accused person, the Director of Public Prosecutions and, in some circumstances, the Director of Mental Health (DMH) (section 257).

There is no clear process for dealing with unfitness for trial in the Magistrates Court.

Once a forensic order is made, it is the responsibility of the Tribunal to review the order to decide, among other matters, whether the order should continue or be revoked. In deciding whether to revoke a forensic order, the Tribunal must consider (for patients with a mental illness3):

- the patient’s mental state
- each offence leading to the patient becoming a forensic patient
- the patient’s social circumstances
- the patient’s psychiatric history
- the patient’s response to treatment and willingness to continue treatment.

The Tribunal must not revoke the 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 (sections 203(6) and 204(1) of the Act).

The intention behind forensic orders is that they provide for treatment and care, and the protection of the community, where a person has committed an offence.

The framework of the current Act is that forensic orders and involuntary treatment orders are parallel regimes of involuntary treatment, with significantly different entry and exit criteria. Patients on forensic orders have strict limitations on going into the community. In addition, this model suggests that administrative arrangements will result in more intensive supervision and more rigorous oversight of treatment, care and supervision for forensic orders. DMH policies meet this expectation, determining the frequency with which forensic patients must be seen and other requirements regarding the treatment and care of forensic order patients at more intensive levels than for patients on involuntary treatment orders.

Criminal offences can be divided into indictable offences and summary (simple) offences. Indictable offences are more serious and are generally heard in the Supreme Court or District Court and, if contested, are usually decided by a jury. However, many indictable offences can be heard summarily (by a magistrate), depending on the seriousness of the offence and other factors. Examples of this are wilful damage and low-level stealing. Serious indictable offences, such as murder, rape and arson must be heard on indictment in the Supreme Court or District Court.

Summary (simple) offences, such as far evasion and public nuisance offences, are decided by a magistrate.

Table 3.2 in Background Paper 3 provides other examples of offences in the different categories.

The MHC can only hear matters related to indictable offences.

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3 Separate criteria apply for persons with an intellectual disability.
As at 30 June 2013, there were 843 forensic orders in effect for a total of 734 patients. The patients’ most serious charges were in the following proportions:

- 37 percent – indictable offences that could be dealt with summarily (i.e. by a magistrate) regardless of the circumstances
- 21 percent – indictable offences that could be dealt with summarily (i.e. by a magistrate) in certain circumstances (e.g. on a plea of guilty) – it is likely that nearly all of these would have been dealt with summarily if not for the Chapter 7 part 2 process, and
- 43 percent – ‘serious’ indictable offences - i.e. indictable offences that must be heard on indictment (i.e. by the District or Supreme Courts).

4.2 Issues

The following issues have been identified during the Review:

1. Principles of unsoundness of mind
2. Mental Health Court actions following a finding of unsoundness of mind or unfitness for trial
3. Criminal Code and Minister’s forensic orders
4. Conditions attached to forensic orders
5. Duration and revocation of forensic orders
6. Special hearings following finding of unfitness for trial
7. Magistrates Court powers on finding of unsoundness of mind or unfitness for trial
8. Special notification forensic patients, and

4.2.1 Principles of unsoundness of mind

The relevant provisions of the Criminal Code and the Act are premised on the assumption that a person is not criminally responsible for his or her actions while the person was of unsound mind. If this is the case, the person should not be punished for any offence. There is, however, justification for taking action – including infringing on the person’s rights and liberty – to the extent necessary to protect the community from harm or damage to property. It would be helpful if this principle were clearly articulated in the Act, as it is in a number of other jurisdictions.

4.2.2 Mental Health Court actions following a finding of unsoundness of mind or unfitness for trial

Many stakeholders consulted during the Review believed that too many forensic orders are made in Queensland. Stakeholders believed that, in many instances, forensic orders are not warranted given the nature of the offence and the risks to the community.

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4 Source: Department of Health data.
5 Source: Department of Health data.
The concern about the number of forensic orders made in Queensland is supported by a comparison with other jurisdictions. Queensland has significantly more forensic orders than other States and Territories. For example, Victoria has approximately 2.7 of its equivalent orders per 100,000 of population and NSW has 4.3 per 100,000 of population - while Queensland had 16.1 (as at 30 June 2013).

The difference is that NSW and Victoria reserve their forensic orders for the most serious cases, and have less intensive options for less serious offences.

As noted above (see section 4.1), over half of Queensland forensic orders are made for offences that could have been dealt with in the Magistrates Court. Many stakeholders believe forensic orders could be better targeted at more serious offences, with other options being available for meeting the treatment and care needs of patients and the community protection needs presented by less serious offences.

Stakeholders commented that extended periods of time on a forensic order can have a detrimental impact on the patient in circumstances where the close supervision and the stigma associated with being on a forensic order are disproportionate to the risk presented by the patient. There is a widespread view among patients that a forensic order is a form of punishment, and a lengthy forensic order can lead to hopelessness and malaise in patients, with a deleterious effect on their mental health and, perversely, increased risk to the community.

A further consequence of the extensive use of forensic orders in Queensland is that public sector mental health resources are being unnecessarily devoted to some patients, at the expense of higher priority services, including the treatment and monitoring of persons who have committed unlawful acts of greater concern to the community. While some clinicians pointed out that persons on involuntary treatment orders can be managed more closely if required, other clinicians cautioned that the need to prioritise resources, the legislative and administrative arrangements prioritising forensic orders, and the fact that a person on a forensic order has actually performed an unlawful act means that persons on involuntary treatment orders inevitably receive less vigilant oversight than those on forensic orders.

Stakeholders also expressed concern that, under the current Act, forensic orders are the only way to ensure treatment over a period of time, given that involuntary treatment orders can, and should, be revoked by treating teams as soon as the person does not require immediate treatment or represent an imminent risk to himself, herself or others. This view has been supported by the MHC which has referred to the ‘fragility’ of involuntary treatment orders – how easily they can (and should) be revoked – and that they do not guarantee ongoing treatment and care where the protection of the community is a consideration.

This raises the question of whether Queensland has an appropriate model for forensic orders in place.
An examination of other jurisdictions, indicates that there are various options possible for persons with a mental illness who commit unlawful acts:

- In NSW\(^6\), Victoria\(^7\), South Australia\(^8\) and the Northern Territory\(^9\), courts can detain a person as a forensic patient, release unconditionally, or release with conditions set by the court. This allows a court to impose whatever levels of supervision and monitoring are appropriate in the circumstances.

- Tasmania has a range of options, including unconditional release, through various community-based options (with or without supervision), detention as an in-patient in an approved hospital, and detention as an in-patient in a secure mental health unit.\(^10\)

- In Western Australia, a court may release unconditionally, make a custody order, or make a supervised order under the *Sentencing Act 1995 (WA)*\(^11\).

- In the ACT, for a serious offence, a court has two options – detain the person in custody until the ACT Civil and Administrative Tribunal (ACAT) orders his or her release, or refer the person to ACAT for consideration for a civil mental health order.\(^12\) For less serious offences, an ACT court can also make any other order it considers appropriate, including referring the matter to ACAT for recommendations as to how the person should be dealt with.\(^13\)

Where there is justification for infringing on a person’s rights – that is, for the protection of the community – the MHC probably has the least helpful set of options open to it of any equivalent court in the country, and this must be a primary driver of Queensland’s high rate of forensic orders. If intervention is necessary to protect the community, and the least intrusive option is a forensic order, the MHC will be justified in making one even if a forensic order is more than is needed.

Under the proposals, the MHC would only have jurisdiction to deal with matters that must be heard on indictment, as well as a limited number of prescribed other indictable offences, such as stalking (also see section 4.2.7 below, where it is proposed that other indictable matters may be referred from a magistrate to the MHC). As noted in section 4.1 above, 43 percent of patients currently on forensic orders had most serious charges that would require an indictment. A further five percent had charges of stalking.\(^14\)

These proposals mean the Mental Health Court will only be considering what orders to make for quite serious charges. However, that does not mean that a high-level intensive response (via a forensic order) will be justified in each case. It may be, for example, that the person’s role in the incident was relatively minor, or that the offence occurred sometime earlier when the person’s illness first manifested, and there has been insight, cooperation with treatment and stability ever

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\(^6\) *Mental Health (Forensic Provisions) Act 1990 (NSW)*, s.39
\(^7\) *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)*, ss.23 & 26
\(^8\) *Criminal Law Consolidation Act 1935 (SA)*, s.269O
\(^9\) *Criminal Code Act* (NT) s.43I & 43ZA
\(^10\) *Criminal Justice (Mental Impairment) Act 1999 (Tas)*, s.21
\(^11\) *Criminal Law (Mentally Impaired Accused) Act 1996 (WA)*, s.22
\(^12\) *Crimes Act 1900 (ACT)*, ss.324 & 329
\(^13\) *Crimes Act 1900 (ACT)*, ss.323 & 328
\(^14\) Source: Department of Health data.
An involuntary treatment order (ITO) that can only be revoked by the Tribunal is proposed. Where a person is already on an ITO, the condition could be attached to an existing ITO. The order would be an ITO that cannot be revoked by an authorised doctor, to mandate treatment and care deemed appropriate by the authorised doctor to treat the patient and minimise risk to the community. Other aspects of the operation of involuntary treatment orders would be unaffected.

It is proposed that the sole criterion for the making of an ITO that can only be revoked by the Tribunal, following a finding of unsoundness due to mental illness, is that voluntary treatment or a ‘standard’ ITO is not sufficient to ensure the protection of the community from serious harm or property damage, or repeat offending of the type the person was charged with.

It follows that the sole criterion for the making of a forensic order, following a finding of unsoundness due to mental illness, should be that an ITO that can only be revoked by the Tribunal is not sufficient to ensure the protection of the community from serious harm or property damage, or repeat offending of the type the person was charged with.

The Act should also provide clear guidance to the Court about how to assess risk. It is proposed that the Court be required to consider:

- the patient’s current mental state and psychiatric history
- the nature of the unlawful act
- the patient’s social circumstances
- the patient’s response to treatment and willingness to continue treatment, and
- where relevant, the patient’s compliance with previous obligations while on limited community treatment (LCT) or a community category order.

The assessment is to be based on generally accepted community standards.

For the same reasons, it is also proposed that the MHC be able to make an ITO that can only be revoked by the Tribunal for a person found permanently unfit for trial as an alternative to a forensic order. For a person found temporarily unfit for trial, the MHC may make an ITO, but it would remain in force in the same way as does a forensic order in these circumstances.

### 4.2.3 Criminal Code and Minister’s forensic orders

As indicated in section 4.1, sections in the Criminal Code allow courts to make orders that a person be detained following jury findings related to unsoundness of mind or unfitness for trial (sections 613, 645 and 647). If a court orders that the accused person be detained in an AMHS, the order is a forensic order for the purposes of the Act. If the person is ordered to be detained in another place (e.g. a prison), the order is called a ‘custody order’ under the Act. Where a custody order is made, and the Minister for Health is satisfied it is necessary for the proper treatment or care of the person, the Minister may make a forensic order for the patient, which has the effect of the person being transferred to, and detained in, an AMHS.

It would be preferable to have the MHC as the sole decision-maker in relation to the making of forensic orders as the MHC is established by the Act as a best practice model for these
decisions, and is duly equipped to do so. It has the benefit of having experienced counsel cross-examine experts who have written reports about the person, and has the assistance of two experienced psychiatrists who observe the proceedings and provide their opinions to the judge in open court. The MHC also has the benefit of the accumulated jurisprudence of past decisions and reasons. The MHC is also transparent and accountable – it is open, and subject to appeal to the Court of Appeal.

For consistency, it is proposed to manage the outcomes of jury findings under the Criminal Code in the same way that those offences would otherwise be dealt with. Where there is at least one offence that would be within the jurisdiction of the MHC (see section 4.2.2), the judge should refer all the charges to the MHC for consideration of whether a forensic order should be made. Otherwise, the judge should have the same powers as a magistrate (see section 4.2.7).

4.2.4 Conditions attached to forensic orders

Under the Act, there is no provision for attaching conditions to forensic orders. Some stakeholders, particularly victims, identified a need for interventions to address offending behaviour, similar to those that can be directed as part of some criminal sentence orders such as probation. The intention of this is not to punish, but to strengthen the protection given to the community. Examples given were to require patients to participate in drug and alcohol programs, anger management counselling or sexual offender programs.

On one view, this could be managed solely by treating clinicians. However, at the time of making a forensic order, the MHC has had the benefit of several expert reports, often the cross-examination of the report writers by experienced counsel, and the assisting psychiatrists’ advice about the needs of the person. This will amount to more cumulative experience and insight into the person’s condition and needs than the treating team will have at the outset. Given this context, allowing the MHC to impose conditions may be appropriate.

It is proposed that a condition be in the form of a direction to an AMHS or the forensic disability service to consider a particular intervention. It would need to be clear that the MHC cannot order particular medication – that will always be the exclusive responsibility of the treating team.

The AMHS or the forensic disability service would report to the Tribunal at forensic order reviews on the participation of the patient in these programs, which would be a relevant consideration in deciding matters such as community treatment.

4.2.5 Duration and revocation of forensic orders

Under the current arrangements, forensic orders are reviewed by the Tribunal within six months of being made, every six months thereafter, and at any time on the application of the patient or the DMH. At any review, a forensic order can be revoked if 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 (section 204).

The possibility that forensic orders related to serious offences can be revoked in a relatively short period of time after they are made can be seen as inadequate to assure the protection of the community.

However, for less serious offences, concerns were expressed to the Review that orders remain in force for too long, utilising public sector health resources unnecessarily, and potentially
having adverse impacts on community safety. Treating teams and patient advocates reported cases where patients are on forensic orders to manage risks and treatment needs that could easily be managed by way of an ITO, but because the Act does not allow a transition to an ITO, the forensic order is maintained.

Some stakeholders suggested minimum forensic order durations for serious offences on the basis that even a remote risk of reoffending, combined with the serious consequences if the person does reoffend, would make the person an unacceptable risk for some time. It was stated that the possibility of revocation every six months from the very beginning of the order is a significant barrier to recovery for victims of serious violent incidents, and that a period of certainty in the early stages of the journey to recovery would greatly assist.

Others proposed there should be maximum periods, stating that it is not uncommon for forensic orders to linger for extended periods due to the ongoing presence of treatment needs that could easily be met in a less intensive manner. This was particularly the case for less serious offences.

The duration of forensic orders and when they should be revoked is a complex topic.

On a strictly clinical approach, allowing forensic orders to be revoked at any point after they are made, even for the most serious offences, is theoretically justified. If the person quickly gains insight into his or her illness, engages with treatment and becomes stable within a short period of time, then revocation may be appropriate, recalling that the person is not criminally responsible for the incident and the purpose of the forensic order is not punishment.

However, for serious offences, where the worst case scenario is so serious that even a small risk of it occurring might be unacceptable, the community has a legitimate interest in mandating supervision for a period of time.

The anxiety experienced by victims of violent incidents and their recovery needs are also important to take into account, particularly early in the forensic order.

To address this, it is proposed that the MHC be able to set a non-revoke period of up to three years for a forensic order at the time it is made, to provide certainty and stability for the patient, the victim and the treating team during that period, and remove the preoccupation with possible revocation, resulting in an increased focus on treatment and care. Where the charges are murder or attempted murder, the proposed period is up to seven years.

The proposals for the MHC to focus on more serious offences will address stakeholder concerns that, for less serious offences, forensic orders remain in force for too long.

It is also proposed to give the Tribunal the ability to ‘step down’ from a forensic order to an ITO that can only be revoked by the Tribunal). This will enable a better targeting of resources according to risk, and will assist the patient to progress towards recovery with a transition from a highly directed and controlled relationship with mental health services to one where the patient has increasing levels of autonomy.

The Tribunal should be required to make this transition when satisfied that an ITO that can only be revoked by the Tribunal is sufficient to ensure the protection of the community from serious harm or property damage, or repeat offending of the type the person was charged with.

The Tribunal should also have the option to order a ‘standard’ ITO, and be required to order one when satisfied that a ‘standard’ ITO is sufficient to ensure the protection of the community from serious harm or property damage, or repeat offending, resulting from offences of the type the person was charged with.
These options and requirements will ensure that the community is protected, with the restriction of a patient’s rights never more than is justified to ensure the protection of the community. The Tribunal would retain the ability to revoke a forensic order outright as per the current arrangements.\(^\text{15}\)

For consistency with the making of orders by the MHC, it is proposed that the Tribunal be required to consider the same factors as the Court in revoking an order, namely:

- the patient’s current mental state and psychiatric history
- the nature of the unlawful act and the period of time since the act
- the patient’s social circumstances
- the patient’s response to treatment and willingness to continue treatment, and
- where relevant, the patient’s compliance with previous obligations while on LCT or a community category order.

The assessment is to be based on generally accepted community standards.

### 4.2.6 Special hearings following finding of unfitness for trial

In 2012-13, the MHC made 20 forensic orders following findings of permanent unfitness and seven following findings of temporary unfitness\(^\text{16}\). In these cases, the legal proceedings against the person end, without any finding of guilt. This means that it is possible for a person to be placed on a forensic order for a lengthy period of time when the person did not, in fact, commit the unlawful act that led to the order.

Every other State and Territory, except Western Australia, has a process for a ‘special hearing’ (however called) in which a court tests the evidence against the accused before making a forensic order. New Zealand and the United Kingdom also have special hearings.\(^\text{17}\)

The case of Marlon Noble\(^\text{18}\) in the only other jurisdiction without special hearings, Western Australia, illustrates the risk of not having special hearings. Mr Noble was detained for ten years and is now released but on strict conditions, for offences the complainants have reportedly said did not happen.

A ‘special hearing’ is a quasi-trial where the prosecution presents its evidence and a lawyer acting on behalf of the accused challenges that evidence and may also lead evidence. The purpose is to establish whether the accused person did the unlawful act. The accused person would be unable to fully instruct his or her lawyer, and possibly unable to give evidence. However, the court decides the matter on the evidence available.

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\(^{15}\) See section 4.2.9 which proposes that a second psychiatrist opinion be required if a forensic order is revoked and not replaced by an ITO that can only be revoked by the Tribunal.

\(^{16}\) Source: Mental Health Court data.

\(^{17}\) Mental Health (Forensic Provisions) Act 1990 (NSW), ss.19-28; Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic), part 3; Criminal Justice (Mental Impairment) Act 1999 (Tas), ss.15; Criminal Law Consolidation Act 1935 (SA), s.269M; Criminal Code Act (NT) s.43V; Crimes Act 1900 (ACT), s.316; Criminal Procedure (Mentally Impaired Persons) Act 2003 (NZ), ss.9-13; Criminal Procedure (Insanity) Act 1964 (UK), s.4A

\(^{18}\) See, for example, [http://www.abc.net.au/rampup/articles/2011/12/09/3387845.htm](http://www.abc.net.au/rampup/articles/2011/12/09/3387845.htm)
It is proposed to adopt an equivalent model in Queensland. Where the MHC finds a person permanently unfit for trial, or where a person is temporarily unfit beyond a period of 12 months, the person’s legal representative may elect to have a special hearing. The lawyer would act in the best interests of the person in consultation with the person (to the extent possible) and a substitute decision-maker, if one has been appointed. The lawyer may decide to waive the right to a special hearing where there is little prospect of success. A waiver would not amount to a plea of guilty by the person.

Where the special hearing finds the person did the unlawful act the order is justified and therefore continues, but the finding is not a finding of guilt. If in the case of temporary unfitness, the person later becomes fit for trial, a trial can be conducted. If the special hearing finds the person did not commit the unlawful act, the finding is an acquittal and the forensic order is revoked.

Options for who is to decide a special hearing include the District Court, with a jury, or the Mental Health Court constituted by a judge alone without a jury. The first option would have the advantage of having a jury decide the facts, as happens in other jurisdictions, but the second might involve less delay.

The number of these proceedings will be small, given the numbers of orders made, and would not represent a significant increase to the workload of the courts.

4.2.7 Magistrates Court powers on finding of unsoundness of mind or unfitness for trial

As indicated above (section 4.1), Magistrates Courts in Queensland have no effective powers to deal with matters where the defendant was of unsound of mind at the time of the offence or unfit for trial.

In a recent Court of Appeal decision, the court urged reform in relation to Magistrates Courts powers to deal with fitness for trial:

> It seems unsatisfactory that the laws of this State make no provision for the determination of the question of fitness to plead to summary offences. It is well documented that mental illness is a common and growing problem amongst those charged with criminal offences. The Magistrates Court has attempted to meet this problem through its Special Circumstances Court Diversion Program which apparently presently operates only in the Brisbane area. This program assists categories of vulnerable people including those with impaired decision-making capacity because of mental illness, intellectual disability, cognitive impairment, or brain and neurological disorders. This commendable initiative, which allows for suitable compassionate supervisory and supportive bail and sentencing orders to be made in appropriate cases, may well be effective in assisting these vulnerable people. But it does not and cannot provide a satisfactory legal solution where people charged with summary offences under the criminal justice system are unfit to plead to those charges. The legislature may wish to consider whether law reform is needed to correct this hiatus in the existing criminal justice system.19

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19 R v AAM; ex parte A-G (Qld) [2010] QCA 305 at par 9, per McMurdo P. with whom White JA and Cullinane J agreed.
Other jurisdictions have given magistrates various powers to effectively deal with matters where the defendant may have been of unsound of mind at the time of the offence or unfit for trial.

In NSW, magistrates deal with summary offences and indictable offences that can be dealt with summarily where the person presents with a mental illness, and have various options including unconditional discharge, community treatment orders, and involuntary assessment as an in-patient.\textsuperscript{20}

In Tasmania, magistrates decide unsoundness and unfitness for summary offences and indictable offences that can be dealt with summarily, and can make ‘continuing care’ or ‘community treatment’ orders, but not forensic orders. They can refer a matter to the Supreme Court if of the opinion that a forensic order should be made.\textsuperscript{21}

In South Australia\textsuperscript{22} and Western Australia\textsuperscript{23}, magistrates decide unsoundness and unfitness for summary offences and indictable offences that can be dealt with summarily, and have all the options of the higher courts.

In the Northern Territory, magistrates deal with accused persons who, ‘in the opinion of the court, may require treatment or care under this Act’ and can make various orders including dismissing the charge or referring for assessment, and possible admission for involuntary treatment. Magistrates can also request that an assessment consider the appropriateness of a voluntary treatment plan.\textsuperscript{24}

In the ACT, magistrates decide unsoundness and unfitness for summary offences and indictable offences that can be dealt with summarily, and have more or less the same options available to the higher court.\textsuperscript{25}

Where a person appears of unsound mind or unfit for trial the prosecution may discontinue the charge, and commonly does so where there are no or minor community risks. However, it is proposed to give magistrates an express power to discharge if satisfied, on the basis of the available information, that the accused person is likely to have been of unsound mind at the time of the offence or to be unfit for trial. This revised process should ensure the AAM\textsuperscript{26} scenario does not recur.

However, dismissing a charge on the basis of unsoundness or unfitness will not address the underlying issues that led to the charge, and will not meet the needs of the accused person, the victim (if relevant), or the broader community. Further options are therefore also proposed.

Where unsoundness or unfitness results wholly or partially from a mental illness and there appears to be a risk to other persons or their property, a power to make a non-revokable ITO is also proposed. This order would have a maximum period of six months for a summary offence and one year for an indictable offence.

\textsuperscript{20} Mental Health (Forensic Provisions) Act 1990 (NSW), ss.32-33
\textsuperscript{21} Criminal Justice (Mental Impairment) Act 1999 (Tas), ss.21-22
\textsuperscript{22} Criminal Law Consolidation Act 1935 (SA), s.269A, definition: ‘judge’ includes magistrate
\textsuperscript{23} Criminal Law (Mentally Impaired Accused) Act 1996 (WA), ss16 & 20
\textsuperscript{24} Mental Health and Related Services Act (NT), part 10
\textsuperscript{25} Crimes Act 1900 (ACT), part 13, division 13.6
\textsuperscript{26} R v AAM; ex parte A-G (Qld) [2010] QCA 305, AAM was convicted of numerous offences in the Magistrates Court over a period of time but later found unfit for trial and all the convictions were set aside.
Where the unfitness is temporary, the order would be mandatory, matching the MHC arrangements.

The threshold for making an order should be that the community cannot be adequately protected by voluntary treatment or a 'standard' ITO from harm, property damage or repeat offending of the type the person was charged with. In making an order on the basis of permanent unfitness, the magistrate should also consider the strength of the evidence against the accused before making an order.

Giving magistrates the authority to make a non-revokable ITO is considered appropriate given the relatively short period of time for the orders. It provides a simple way to link persons to treatment and care with the aim of addressing offending behaviour, with the extent of the treatment and care to be provided at the discretion of the treating team.

For temporary unfitness, it is proposed a magistrate could adjourn for periods totalling a maximum of six months, but must discharge the accused person after that time if the person is still not fit. If the person becomes fit for trial within this period, the order automatically ends when the person next appears in court for proceedings to continue.

For a non-revokable ITO, the magistrate would take advice from Queensland Health about which AMHS should administer the order.

There is no equivalent to an ITO for people without a mental illness. Where there is no mental illness involved and the unsoundness or unfitness results from an intellectual disability, it is proposed that the magistrate may make a referral to the Department of Communities, Child Safety and Disability Services (DCCSDS), but not a formal order. The purpose of the referral is for DCCSDS to be advised that a person may be in need of a disability support service.

A discretion to refer indictable charges to the MHC in exceptional circumstances would also be appropriate. This would apply where the magistrate considers that an ongoing risk to other persons, or their property, is so serious that a forensic order may be warranted. This would also apply for persons with an intellectual or cognitive disability. It is proposed that this referral would occur through the Director of Mental Health or the Director of Forensic Disability who could assess whether a referral was warranted. Appeals from magistrates' decisions should be to the MHC rather than the District Court, to ensure consistency.

For these arrangements to operate effectively, magistrates would need to receive evidence that an accused person was unfit for trial or of unsound mind. This information would need to be provided by defence lawyers supported by court liaison officers.

### 4.2.8 Evaluation

The proposals for the Magistrates Court represent a significant shift in practice. In order to ensure opportunities for good outcomes and efficiencies are maximised, and unintended consequences are identified and dealt with, a comprehensive and independent evaluation is proposed after three years.

It will be critical that the evaluator be appointed early so that a methodology can be developed and the necessary data identified and collected from the earliest possible date.
4.2.9 Special notification forensic patients

Under the Act (section 305A), a forensic patient is a special notification forensic patient (SNFP) if the offence leading to the making of the forensic order is an offence against one of the following provisions of the Criminal Code:

- Section 300 (Unlawful homicide)
- Section 306 (Attempt to murder)
- Section 308A(4) (Dangerous operation of a vehicle), but only if the commission of the offence involved the death of another person
- Section 349 (Rape)
- Section 351 (Assault with attempt to rape).

The purpose of this category is to enable a higher level of scrutiny to protect the community. To achieve this, the Act requires the Tribunal to obtain a second psychiatrist’s opinion before revoking a forensic order for an SNFP.

The rationale for the list of offences is not clear as there are other serious indictable offences that would be of equal concern to the community. If the SNFP provisions were retained, the provisions of the Criminal Code would need to be examined to expand the list of offences.

However, this category will no longer be required if the proposal to have forensic orders made only for serious offences was adopted (see section 4.2.2). The arrangements proposed in section 4.2.5 will ensure that the transition from forensic order to no order will be much more controlled and monitored than under the current arrangements, and the need to mandate a second opinion is therefore not considered necessary. Nothing prevents the Tribunal from obtaining a second opinion at any time in complex cases. However, the Tribunal would be required to obtain an independent second opinion if it was proposed to remove a forensic order and not replace it with an ITO that can only be revoked by the Tribunal.

4.2.10 Review of forensic orders for persons with a mental illness

Under the Act, the MHC may make a forensic order if a person was of unsound mind at the time of the offence. This basis of determining unsoundness is largely drawn from the Criminal Code and relates to the person’s ‘state of mental disease or natural mental infirmity’ (see section 4.1). Where the MHC makes a determination of unsoundness of mind, the Court may then make the following orders (section 288):

- if the unsoundness was as a result of an intellectual or cognitive disability – a forensic order (disability), or
- otherwise – a ‘standard’ forensic order

This leaves open the possibility that a ‘standard’ forensic order may be made for a person who does not have a mental illness, for example due to a neurological disorder such as epilepsy. While this in itself does not create a problem, an issue arises when, on review, the Tribunal is required to decide whether the person does not represent an unacceptable risk to the safety of the patient and others, having regard to the patient’s mental illness (section 204). The Tribunal is required to make this assessment when revoking a forensic order or approving LCT.
To remedy this, it is proposed that a Tribunal review would consider the risks associated with any ‘state of mental disease or natural mental infirmity’ that led to the unsoundness or unfitness finding.
Review of the Mental Health Act 2000

Background Paper

May 2014
5. Treatment and Care of Involuntary Patients

5.1 Background

Chapter 4 of the Mental Health Act 2000 deals, among other things, with treatment plans. The Act requires the following:

• the relevant authorised doctor must ensure a treatment plan is prepared for each patient on an involuntary treatment order (ITO)
• the authorised doctor must talk to the patient about the patient's treatment under the treatment plan
• the administrator of the relevant authorised mental health service (AMHS) must ensure the patient is treated as required under the patient's treatment plan, and
• the administrator must ensure an authorised psychiatrist for the health service carries out regular assessments of the patient as required under the treatment plan, including whether the treatment criteria\(^1\) continue to apply to the patient.

The treatment plan is also used as the basis for determining compliance with treatment under a community category of an ITO. The Act (section 117) provides that an authorised doctor may take steps to require a patient to return to an AMHS for treatment if the patient “has not complied with the patient's treatment plan”. This provision applies despite the Act not expressly requiring the treatment plan to state the patient’s obligations under the plan and what constitutes non-compliance with a plan.

The treatment plan is also used to authorise limited community treatment (LCT) (sections 129 to 131), including the conditions that apply for the LCT.

The Act also provides (section 507) that an authorised doctor may, by written notice, require a patient to return to the AMHS if the patient has not complied with the patient’s treatment plan. Although not expressly stated in the Act, these provisions are used to require a patient to return to an AMHS if the patient does not attend a scheduled appointment.

The requirement to have treatment plans in place is also stated in three other areas of the Act – for classified patients (sections 72 and 73), patients determined fit for trial by the Mental Health Court (MHC) (sections 278 and 279) and forensic patients (section 307 to 309).

The Act requires a treatment plan to have regard to any policies and practice guidelines issued by the Director of Mental Health (DMH) (section 124(5)). The Act also requires the DMH to issue policy and practice guidelines about the treatment and care of forensic patients (section 309A).

5.2 Issues

5.2.1 Treatment plans

Consultations during the Review indicated a high level of uncertainty about what constitutes a ‘treatment plan’ and how it should be documented. As a consequence, there are differing

\(^1\) The treatment criteria are outlined in the Glossary.
practices among authorised mental health services in relation to treatment plans. This is complicated by the fact that authorised mental health services keep electronic or hard copy clinical records for all patients, whether voluntary or involuntary, which deal with many of the same matters as treatment plans.

Some stakeholders also expressed concern that involuntary patients do not see the patient’s treatment plan or do not have a treatment plan in place.

The Department of Health has previously issued a pro forma ‘Treatment Plan’. This plan identifies the patient, the patient’s status under the Act, and provides space for an authorised doctor to write in details of the plan in accordance with the Act. However, the ‘Treatment Plan’ has largely been superseded by the ‘Consumer Care Review Summary and Plan’, which is used for both voluntary and involuntary mental health patients. This plan provides a more comprehensive documentation of the patient’s diagnosis, treatment and care, and risk assessment. The plan notes that it needs to be completed in accordance with the ‘treatment plan’ provisions of the Act, although the pro forma does not indicate how this should be done.

This uncertainty and diversity of practice stems from the unclear purpose of treatment plans under the Act.

The treatment and care of involuntary patients should align with good clinical practice. The purpose of statutory requirements under the Act in relation to treatment and care should be to provide additional safeguards given the involuntary basis of the person’s detention and treatment.

On admission, an authorised doctor needs to decide the treatment and care needs of an involuntary patient. This is a clinical judgement, based on the clinician’s training and experience. As outlined in the principles for the Act (section 8(1)(b)), a person is to be encouraged to take part in making decisions about treatment and, as far as practicable, the person’s views and the effect on his or her family or carers are to be taken into account.

It should be the responsibility of each AMHS to determine the most appropriate way to record a patient’s proposed, and actual, treatment and care in a way that is consistent with the service’s approach to clinical record-keeping generally.

As a safeguard, it is proposed that the administrator of each AMHS should have a statutory duty to take reasonable steps to ensure an involuntary patient’s treatment and care needs are met. This is not intended to replace the treating clinician’s primary role, but to add a further ‘check and balance’ in the system to protect the interests of potentially vulnerable patients. This duty would include any other treatment and care needs for the patient (for other than a mental illness).

As an additional safeguard, the administrator of each service should also ensure that the way clinical records are kept is auditable, should an issue arise in the future about a patient’s treatment and care.

The DMH should continue to issue policies and guidelines about the treatment and care of involuntary patients, including ways in which treatment and care are to be recorded. The Act should require these policies to be published on the Internet, which is current practice.

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2 See Background Paper 7 which proposes strengthening the role of family, carers and other support persons.
5.2.2 Access to health information

During consultations for the Review, some stakeholders expressed concern that involuntary patients or their family, carers or other support persons were not able to get adequate information about the treatment being provided, including access to the patient's health records. Access to a patient’s health records is a significant administrative policy for the health system in Queensland. This issue is comprehensively addressed in the Queensland Health policy – Health Information: Disclosure and Access Policy (February 2005). The Policy outlines the processes by which health records may be disclosed, consistent with legal requirements and confidentiality and privacy obligations. With the creation of Hospital and Health Services, this policy may be adopted by Hospital and Health Services, or a Service may choose to develop its own administrative access policy.

The Policy provides that, as a general rule, individuals seeking access to his or her own health records should, in most cases, be granted access through informal, administrative release processes. In these cases, an application under Right to Information Act 2009 is not required and generally there is no charge for administrative access to health records. In addition, a patient may give consent in writing for another person (such as a family member or carer) to have access to the patient's health information.

The Policy outlines exceptions to the right of a person to be given access to their health records. This includes where it is considered it would be prejudicial to the physical or mental health or well-being of the patient.

5.2.3 Review of treatment

During consultations for the Review, some stakeholders expressed concern that patients, family members or other support persons may not agree with the treatment being provided to the patient. These stakeholders sought a mechanism for an independent review of treatment in these circumstances.

The Act enables a health practitioner to visit and examine an involuntary patient and consult with the authorised doctor about the patient’s treatment or care (section 347). This may be used by the patient or the patient’s family, carer or other support person to obtain a second medical opinion. This would, however, involving the cost of engaging a private psychiatrist.

Some stakeholders referred to the Victorian legislation that provides some powers for the independent review of treatment. Under the Victorian Mental Health Act 1986, the Mental Health Review Board may review a patient’s treatment plan to determine whether the authorised psychiatrist has complied with Act in making, reviewing or revising the plan, and that the plan is capable of being implemented by the approved mental health service. If the board is not satisfied of these matters, it can order that the treatment plan be revised.

Any disagreement with the treating team should, wherever possible, be resolved through direct discussions with the treating team. It is envisaged that the Independent Patient Companion (see Background Paper 7) will greatly assist in these discussions.

However, as an additional accountability measure, it is proposed to allow a patient or the patient’s family, carer or other support person to apply to the Mental Health Review Tribunal for a review of the patient’s treatment or care. It is expected that this would be used as a last resort if the patient or patient’s representative had a strong and unresolved disagreement with the
treated by a treating team. To ensure this, the patient or the patient's family, carer or other support person would have to first seek a review of treatment from the administrator of the AMHS. The applications to the administrator and Tribunal could not be made in a frivolous or vexatious way.

It should be noted that the Tribunal would not have the power to direct particular treatment, but would rather have the authority to obtain, or require the AMHS to obtain, a second opinion if warranted. The Tribunal already has the authority to order another examination of a patient (section 457).

It is proposed that the Tribunal have the authority to direct the AMHS administrator to review the patient's treatment or care and, if needed, report back to the Tribunal on the outcome.

5.2.4 Regular assessments

Any patient, whether involuntary or voluntary, needs to have his or her treatment and care needs reviewed on an on-going basis. The way this happens must reflect good clinical practice.

The Act requires patients to be assessed at pre-determined intervals (section 116). When these assessments take place, the authorised psychiatrist must consider whether the treatment criteria continue to apply to the patient. It is not clear from the Act whether the regular assessments serve any other purpose.

It is a clinical judgement as to how a patient's treatment and care needs should be reviewed. The Act should state that the treating clinician has a duty to ensure that the treatment and care provided to a patient for a mental illness remains appropriate to the patient’s needs.

It is also proposed that the Act clarifies that the purpose of a ‘regular assessment’ is to determine whether the treatment criteria continue to apply to the patient, as opposed to reviews of the patient’s treatment and care needs. If, after an assessment, the treating clinician decides the treatment criteria continue to apply to the person, the clinician must also decide, and document, when the next assessment is to occur.

In addition, it is proposed that authorised doctors are to have an obligation to assess a patient if the doctor reasonably believes, at any time, the treatment criteria may no longer apply to the person.

5.2.5 Separate care and treatment provisions in the Act

The relationship between the treatment provisions in Chapter 4 of the Act and the treatment provisions elsewhere in the Act is unclear.

To remedy this, it is proposed that all ‘treatment and care’ provisions be placed in one part of the proposed legislation.

5.2.6 Risk management plan

The Act requires a risk management plan to be made for a forensic patient, although the Act provides no guidance as to what should be included in a risk management plan.

Risk assessment issues are identified in policies issued by the DMH. The ‘Consumer Care Review Summary and Plan’ also includes a risk screening tool under categories of suicide/self-harm, violence, vulnerability and absence without approval. This tool is used to assess risks associated with any patient with a mental illness.
It is proposed that assessing risks continue to be a matter for the AMHS, with the DMH issuing policies and practice guidelines on risk assessment as necessary.

### 5.2.7 Treatment in the Community

There are two critical elements for the effective treatment and care of a person in the community (community category or LCT), namely:

- to have a clear plan for the person’s treatment once the person leave the in-patient environment, and
- for the person to understand his or her obligations while living in the community.

The current arrangements do not adequately provide this.

Some submissions to the Review expressed concern that inadequate consideration may be given to how a patient is best treated outside of an in-patient environment, including taking into account the views of family, carers and other support persons.

To remedy this, it is proposed that the legislation require the authorised doctor to decide and document the way in which the patient is to be treated in the community, for example, in a discharge plan. The doctor should talk to the patient and, as far as is practicable, family, carers and other support persons, in formulating this plan.

It is also essential that the patient understands the patient’s obligations, including when and where the patient needs to attend for treatment. To achieve this, it is proposed that the authorised doctor be required to give each patient a statement of the patient’s obligations while in the community and talk to the patient and, as far as practicable, the patient’s family, carer or other support persons, about the person’s obligations.
Review of the Mental Health Act 2000

Background Paper

May 2014
6. Treatment in the Community

6.1 Background

Under the Mental Health Act 2000, patients that may be detained as an in-patient at an authorised mental health service (AMHS) are:

- patients on an involuntary treatment order (ITO) (in-patient category)
- classified patients (who may or may not also be on an ITO)
- forensic patients, and
- a person ordered by the Mental Health Court (MHC) to be detained at the AMHS pending a judicial outcome under section 273 of the Act.

All involuntary patients under the Act are linked to an AMHS and, unless authorisation is granted for the patient to be in the community, are required to be detained as an in-patient at a specified AMHS.

Access to the community for involuntary patients is a key component of treatment and care provided under the Act. There are three ways that an involuntary patient detained in an AMHS may lawfully go into the community:

- a patient’s ITO can be changed from an in-patient category to a community category
- a temporary leave of absence may be granted for specific purposes (e.g. for medical, legal or compassionate purposes), or
- with approved limited community treatment (LCT).

LCT enables patients to receive treatment or care in the community and provides these individuals with an opportunity to make a supported transition back into the community.

LCT is usually granted progressively in line with improvements in a patient’s mental condition or behaviour, as well as successful periods of escorted and unescorted LCT within and outside an in-patient facility. The Director of Mental Health (DMH) has outlined in policy the following general categories of LCT:

- escorted LCT (on or off hospital grounds), which requires the patient to be accompanied by a health service employee
- unescorted LCT (on or off hospital grounds), which includes LCT where the patient may be accompanied by a responsible adult (e.g. a relative or a non-government organisation worker) and LCT where the patient is unaccompanied
- overnight LCT, and
- more than overnight LCT (i.e. living in the community).

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1 Under sections 101 and 337 of the Act, a court may order a person’s detention in an AMHS while a trial is proceeding or during a Court of Appeal proceeding against a MHC decision. Individuals detained under these sections cannot access LCT.
6.2 Issues

The following issues with treatment in the community have been identified during the Review:

1. The purpose of LCT is not currently clear within the Act, and there should be improved transparency for forensic patients living in the community full time.
2. The basis for authorising LCT and changing a category of involuntary order should be more transparent and consistent.
3. Processes within the Act for applying monitoring conditions to certain patients can be improved, and
4. The status of a person’s LCT and category of involuntary order for a person in custody is unclear and inconsistent.

6.2.1 Purpose and transparency of LCT

The Act does not currently include a statement clearly outlining the purpose of LCT. While there is documentation in the DMH Resource Guide which supports the Act, there should be clarity and transparency regarding the purpose in the Act, particularly when it extends to patients who are living in the community full time. To clearly articulate the purpose of LCT for involuntary patients, the proposed legislation will include a purpose statement for LCT, namely:

Consistent with the least restrictive principle, the purpose of LCT is to support the recovery of involuntary patients by transitioning patients to living back in the community, with appropriate treatment and care.

Patients on involuntary treatment orders (in-patient category) can be placed on LCT for up to seven days. For periods beyond that, the patient must be placed on a community category order. As at 30 June 2013, 82 percent of patients on an ITO where placed on a community category order.

In contrast, patients on forensic orders can be placed on LCT indefinitely, with there being no community category order.

Currently, patients who are on forensic orders may live in the community on a full time basis if they are granted more than overnight LCT for an extended period. This level of LCT has the effect of the person remaining ‘attached’ to an AMHS without being required to stay overnight as an in-patient in hospital. Forensic patients living in the community will, for example, be required to attend regular appointments with a psychiatrist at a Community Mental Health Service.

As at 30 June 2013, 77 percent of forensic patients had approval to reside in the community on a full time basis.

For consistency and transparency, the proposed legislation is to provide that a forensic patient can be authorised to have LCT for a period of up to seven days. For periods greater than seven days, the forensic patient will be placed on a community category order. The criteria for a forensic patient to go into the community, whether on LCT or a community category, would be the same.
6.2.2 Authorisation of LCT and community category orders

The authorisation processes for LCT differ depending on the patient’s involuntary status. For patients on an ITO (in-patient category), LCT is managed by the authorised doctor who can approve and authorise LCT. For other involuntary patients (e.g. forensic and classified patients), a two-stage authorisation process applies whereby an approval must be granted by the DMH, MHC, or Mental Health Review Tribunal before an authorised doctor may authorise LCT. The MHC or Tribunal may also order LCT. The table below outlines the authorisation process for each category of involuntary patient under the Act:

Table 6.1 Authorisations for Limited Community Treatment

<table>
<thead>
<tr>
<th>Patient status</th>
<th>Approved or Ordered by *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntary treatment order (in-patient)</td>
<td>Separate approval process not required</td>
</tr>
<tr>
<td>Classified patient</td>
<td>Director of Mental Health</td>
</tr>
<tr>
<td>Forensic patient</td>
<td>Mental Health Court or Mental Health Review Tribunal</td>
</tr>
<tr>
<td>Court order patient (section 273 of Act)</td>
<td>Mental Health Court</td>
</tr>
</tbody>
</table>

* Where LCT is approved for a patient by the MHC, DMH or Tribunal, an authorised doctor may then authorise specific LCT at a future time for that patient.

When ordering or approving LCT, the MHC, DMH or Tribunal may also order or approve any conditions considered appropriate, and can also revoke or change (including decrease) LCT. In authorising LCT as part of the patient’s treatment and care, the authorised doctor is responsible for ensuring the authorisation occurs within the parameters established by the MHC, DMH or Tribunal. Within these parameters, the authorised doctor may also set conditions considered necessary for the clinical management of the patient, and to protect the health and safety of the patient or others, while the patient is on LCT.

The MHC, DMH and Tribunal must take into account risk and other factors in determining whether LCT should be granted to a patient (sections 129, 204, 275 and 289).

However, the criteria in each case are not the same, and are also not consistent with the criteria used to make and revoke a forensic order. To remedy this, it is proposed that the Act have one set of criteria to decide whether a person on a forensic order should go into the community on LCT or a community category order.

The MHC or Tribunal will only be able to approve or order LCT or a community category for a forensic patient if, on an assessment of relevant risks, the MHC or Tribunal determines the community will be adequately protected from serious harm to other persons, serious property damage or repeat offending of the type that was the basis for the order.

In considering these matters, the MHC and Tribunal are to have regard to:

- the patient’s current mental state and psychiatric history
- the nature of the unlawful act and the time since the unlawful act

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2 See section 4.2.5 of Background Paper 4.
• the patient’s social circumstances
• the patient’s response to treatment or care and willingness to continue treatment or care, and
• where relevant, the patient’s compliance with previous obligations while on LCT or a community category order.

The criteria may be met by limiting the level of community access or by placing conditions on the patient’s order. The assessment of risk in deciding the above is to be based on generally accepted community standards.

Where the MHC or Tribunal approves that LCT or a community category order may be authorised by an authorised doctor at a future time, the decision of the MHC or Tribunal may take into account the assessment of risks that must be made by the authorised doctor in authorising the LCT or community category order.

The same arrangements will apply to approvals made by the DMH for classified patients, and by the MHC for court order patients (under section 273 of the Act), to access LCT.

In addition, while the authorised doctor can only authorise LCT for forensic or classified patients within the limits set by the MHC, DMH or Tribunal, there are no specific requirements within the Act for authorised doctors to consider risk or any other factors prior to authorising LCT. While risk management by authorised doctors occurs as part of a patient’s treatment and care under an involuntary order, it is reasonable for the new legislation to be made transparent in relation to authorised doctors considering risk prior to authorising LCT or changing an ITO to a community category.

In addition, the Act does not clearly state the basis on which a patient on an ITO should be granted LCT or placed on an in-patient or community category order. To remedy this, it is proposed that a patient should only be placed on an ITO (in-patient category), and continue to be on an ITO (in-patient category), if the authorised doctor believes the patient’s treatment and care needs, and the safety and well-being of the patient and others cannot be reasonably met if the patient was on a community category order. In deciding this, the authorised doctor is to consider:

• the patient’s current mental state and psychiatric history
• the patient’s social circumstances
• the patient’s response to treatment, and
• where relevant, the patient’s compliance with previous obligations while on a community category order.

The same criteria are to apply in considering whether a patient on an ITO (in-patient category) should be granted LCT and the nature of the LCT.

6.2.3 Monitoring conditions

In March 2013, the Act was amended by the Queensland Mental Health Commission Act 2012 to enhance provisions within the Act designed to protect the community. In particular, amendments were made to enable the DMH to require that certain patients in particular circumstances be made subject to a monitoring condition while they are on LCT. These provisions apply to classified patients, forensic patients and court order patients (under section 273 of Act).
Examples of a monitoring condition are outlined in the Act and include such conditions as the application of a GPS monitoring device, a requirement for the person to carry a mobile phone, or detailed communication plans to be developed for the patient while on LCT.

Implementation of these amendments has resulted in the following processes being developed:
- notification from the administrator of the relevant AMHS to the DMH about forensic or high risk patients being considered for LCT
- review and assessment of clinical information by the DMH
- notification to the administrator of the relevant AMHS about the need (or otherwise) for a monitoring condition, and
- inclusion of the condition in the patient’s treatment plan.

From the commencement of these provisions to 31 December 2013, the DMH reviewed 57 patients for the purposes of considering whether a monitoring condition should be applied. During this period, the DMH applied a monitoring condition to a patient’s LCT plan on two occasions that required the patient to wear a GPS device while on unescorted LCT. In the remainder of cases, after investigation and review, the DMH was satisfied that the conditions applied by the treating psychiatrists were appropriate to address risk, and no additional conditions for the specific purpose of monitoring were required.

During the Review, stakeholders expressed concerns about the use of monitoring conditions for mental health patients. While similar concerns were expressed prior to the amendments being made, the implementation of these provisions has identified opportunities for the monitoring conditions to be made clearer and more transparent.

It is not currently clear in the Act that other LCT conditions that may be applied to a patient’s treatment are distinct from ‘monitoring conditions’, as the MHC, Tribunal, authorised doctor and DMH (for classified patients) all have a general legislative authority to apply conditions to a patient accessing LCT (sections 129, 131, 191, 203, 204, 289).

The distinction between these types of conditions for LCT should be clarified within the Act. It is intended to clarify that only the DMH, Tribunal or MHC may apply a ‘monitoring condition’ for the specific purpose of monitoring a patient’s location while on LCT. An authorised doctor would not be able to apply a monitoring condition, however, could apply other conditions considered necessary for the patient’s clinical management in the community.

For monitoring conditions set by the DMH, it is also proposed to make this process more transparent by requiring the Tribunal to review a decision by the DMH to apply a monitoring condition within 21 days.

The Act will also state criteria for applying monitoring conditions to an involuntary patient while in the community, namely:
- there is significant risk that the patient would not return to the AMHS as required, or
- the patient has not complied with previous obligations while in the community and this non-compliance has resulted in a significant risk of harm to the patient or others.

It is also proposed that the review avenues in the Act for monitoring conditions be expanded to include classified and court order patients (under section 273 of the Act), which are currently excluded from the review provisions.

In addition, it is proposed that monitoring conditions may be applied to any involuntary patient while in the community, namely a forensic patient, classified patient, court order patient (under
section 273 of the Act), or a patient on an ITO. The purpose of this proposal is to improve patient safety and care.

### 6.2.4 LCT and category of order for patients in custody

Some involuntary patients may also have a custodial status with Corrective Services requiring their detention in a correctional facility. For example, a forensic patient may commit a subsequent offence and be remanded in custody, or a patient on an ITO may be a sentenced prisoner.

Generally, a custodial status under the *Corrective Services Act 2006* takes precedence over an involuntary status under the *Mental Health Act* - that is, the patient is required to be in the custody of Corrective Services. However, the following patients are to be in the legal custody of the administrator of the AMHS, notwithstanding that they would otherwise be detained in a correctional facility:

- classified patients
- persons on a forensic order due to temporary unfitness to plead at a trial
- persons on a forensic order made by a jury under the Criminal Code, and
- persons detained under an order of a court (sections 101(2), 273(1)(b), or 337(6)).

In practice, decisions about whether an involuntary patient should remain in a correctional facility or be transferred to an AMHS are based on clinical judgement - that is, if the person does not require involuntary treatment in an AMHS, and has a custodial status, then the person will remain in, or be returned to, a correctional facility.

Currently, correctional facilities are viewed in two opposing ways under the Act:

- ITO patients in a correctional facility are placed on a community category ITO (the correctional facility is deemed to be part of the ‘community’), and
- forensic patients have LCT revoked or have no LCT authorised while the patient is in a correctional facility (the correctional facility is not deemed to be part of the ‘community’).

There are difficulties with the differences in how correctional facilities are viewed for different involuntary patients from a legal and practical perspective. These difficulties include:

- complications for forensic patients accessing bail on release from the correctional facility (i.e. LCT authorisation is also required in order for a patient to live in the community at a bail address)
- for forensic patients, the perceived creation of custodial settings as ‘quasi-authorised mental health services’, as patients remain ‘in-patients’ with no LCT, and
- using a community category ITO for involuntary patients in a correctional facility does not reflect the intention of community treatment which is to ensure patients are treated in the least restrictive setting possible.

To remedy these matters, it is proposed that the category of a patient’s involuntary order (in-patient or community) and any authority for LCT approved or ordered by the MHC or Tribunal is to be unaffected by the person being detained in custody under another Act (e.g. being detained in a corrective services facility).

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3 See section 4.2.3 of Background Paper 4.
In addition, a custodial status under another Act (e.g. the *Corrective Services Act 2006*) takes precedence over any order, approval, authority or other right for the person to be in the community under an involuntary order for the period that the custodial status is in force. An exception to this will apply for a classified patient, or a patient subject to specific court orders under the Act which authorise the patient’s detention in an AMHS (e.g. detained during a trial, a Court of Appeal process or awaiting a judicial outcome).

In line with making more transparent the purpose of LCT for patients generally, the Act is also to provide that decisions about a person’s rights to be in the community under an involuntary order are to be based on the criteria stated in the Act and not on the fact of the person’s custodial status under another Act.

The effect of these proposals is that decisions that enable a person with a custodial status to receive treatment and care for a mental illness in an AMHS will be able to be made solely on clinical judgement.

Ongoing collaborative relationships across the Prison Mental Health Service and Queensland Corrective Services will assist in ensuring a smooth transition for people leaving correctional facilities and returning to the community.
Review of the Mental Health Act 2000

Background Paper

May 2014
7. **Support for Involuntary Patients**

7.1 **Background**

The support for, and protection of, involuntary patients under the *Mental Health Act 2000* is dealt with in a number of ways, including:

- the general principles for the administration of the Act (section 8)
- the allied person provisions (Chapter 9)
- the provisions requiring the development of treatment plans (Chapter 4, Part 2)
- the requirement for the Director of Mental Health (DMH) to prepare a statement of rights (section 344), and
- the right of a health practitioner or legal or other adviser to visit an involuntary patient (section 347).

The Act also provides that a function of the DMH is to ensure the protection of the rights of involuntary patients under this Act while balancing their rights with the rights of other persons, to the extent that it is reasonably practicable (section 489).

The Mental Health Review Tribunal is also fundamental to ensuring involuntary treatment is used appropriately and is regularly reviewed to confirm that the treatment is meeting the patient’s needs.

The Act substitutes the right of a person to make decisions about mental health treatment, with decisions made by health professionals, overseen by the Mental Health Court and the Tribunal. The premise of involuntary treatment (and detention) is that the person lacks capacity to make decisions about his or her own treatment, requiring other entities to make decisions on his or her own behalf, primarily for the person’s own welfare. For persons who have committed crimes, involuntary treatment also has the objective of community protection.

As a result, the Act needs to be explicit on when, where and how a person’s rights and liberties can be curtailed with the objective of benefitting the person and the protection of the community. There is a growing shift towards supported decision making in the provision of mental health treatment to individuals, which places primary importance on the views and participation of the patient, the patient’s family, carers and other support persons, resulting in better and more sustained health outcomes. This needs to be the central premise of the provisions of the Act related to support for involuntary patients.

In relation to allied persons, the Act states (section 340):

> the function of an involuntary patient’s allied person is to help the patient to represent the patient’s views, wishes and interests relating to the patient’s assessment, detention, treatment and care under this Act.

The Act provides that an involuntary patient may choose a person, other than a health service employee at the patient’s treating service, to be an allied person. If the person does not have capacity to choose an allied person, and the patient has nominated someone to be an allied person under an advance health directive, then this nomination will apply.
Otherwise, the administrator of the authorised mental health service (AMHS) must choose someone to be an allied person from the list of persons stated in the Act (in order)\(^1\). If no-one is suitable or available, then the ‘default’ allied person is the adult guardian (for adults) or the child guardian (for children).

Currently, only 35 percent of patients have an allied person\(^2\), including circumstances where the adult guardian is the default allied person. An allied person attends Tribunal hearings on only 8.5 percent of occasions\(^3\).

The allied person has the right to appear at Tribunal hearings and to receive notices of the making, changing, transferring and revocation of orders (forensic, involuntary treatment order or classified patient status). The allied person is also advised of any pending hearings or reviews and the subsequent outcome.

### 7.2 Issues

#### 7.2.1 Allied persons

While consultation has affirmed the importance of providing support for involuntary patients, stakeholders have consistently stated that the allied person role is not working well in practice. Regular criticisms of the role are:

- **the role of the allied person is not sufficiently clear; the broad functions under the Act are not supported by other provisions in the Act other than those related to the Tribunal (e.g. the right to be notified and the right to attend Tribunal hearings)**
- **the role of the allied person versus the usual role of family, carers and other support persons is not clear; family, carers and other support persons don’t see the benefit of this role**
- **the role of the allied person versus the role of a personal guardian or attorney is not clear**
- **many allied persons have little understanding of how the mental health system works and are often not able to put forward views about assessment, detention or treatment and care on the patient’s behalf**
- **the allied person may have conflicting views to the patient or do not act in the patient’s best interests**
- **if the patient has capacity, but does not have a suitable allied person available, the patient cannot have an allied person**
- **some patients frequently change their allied person for no evident reason**
- **there is significant paperwork involved in appointing and changing an allied person**
- **allied persons who are appointed rather than selected are often not able to gain the patient’s trust**
- **the (default) adult guardian model does not work well in regional, rural and remote areas of Queensland due to the availability of suitable people, and**

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1. The order in the Act is – a parent or guardian of a minor, a personal guardian, attorney, an adult relative or close friend, an adult carer, or another adult.
2. Source: Department of Health data.
3. Source: Mental Health Review Tribunal data.
Review of the Mental Health Act 2000 – Background Paper

- when there is no allied person available, the AMHS administrator may be reluctant to appoint one where there are disputes with family members or friends.

The fact that only 35 percent of patients have an allied person and that patients are represented in Tribunal hearings by an allied person on 8.5 percent of occasions is strong evidence that the model is not working. This is a poor outcome for the protection of patient rights.

Given the deficiencies in the current approach, it is proposed to discontinue the ‘allied person’ provisions and develop a more comprehensive system that better protects patients’ interests. Three principles of patient support need to be strengthened in the proposed legislation, namely:

1. Family, carers and other support persons have an important role in supporting decision-making, particularly regarding treatment, care, rehabilitation and recovery

2. Understanding by the patient of his or her rights and responsibilities is essential for informed and supported decision-making; authorised mental health services have an obligation to assist patients in this regard, and

3. Advocates and legal representatives play an essential role in ensuring that patient’s rights are protected and that safeguards are maintained.

7.2.2 Family, carers and other support persons

The only express reference to family, carers and other support persons in the Act is in section 8(1)(b) which provides:

to the greatest extent practicable, in making a decision about a person, the person’s views and the effect on his or her family or carers are to be taken into account

There are many benefits that flow from involving family, carers and support persons in the patient’s treatment and care and, conversely, non-therapeutic impacts of excluding family and other support persons. Treating teams that consult and involve family, carers and other support persons:

- obtain more detailed and accurate information about the patient, enhancing treatment planning, delivery and outcomes

- strengthen patient support networks, particularly during the stress of involuntary in-patient treatment

- encourage family, carers and other support persons to support the recovery and rehabilitation of the person with mental illness, especially once discharged from hospital, and

- strengthen patient participation and engagement with the mental health service particularly in recovery.

While many doctors work well with family members and other support persons, some submissions to the Review have highlighted situations where support people have not been adequately informed or consulted, or their views have not been respected. Further, some submissions to the Review expressed concern that inadequate consideration may be given to how a patient is best treated outside of an in-patient environment, including taking into account the views of families and carers.

The Australian Mental Health Statement of Rights and Responsibilities (2012) promotes and values the role of families, carers and other support persons in the treatment and care of people with mental illness. The proposed legislation should include a statement of principles based on
these rights and responsibilities, namely that family, carers and other support persons be able to:

- contact the patient while the patient is undergoing treatment
- participate in treatment decisions and decisions about ongoing care
- seek and receive additional information about the patient’s support, care, treatment, rehabilitation and recovery
- be consulted by the treating team about treatment approaches being considered for the patient
- arrange support services for the patient, such as respite care, counselling and community care, and
- be provided with any information that the patient requests they should receive.

To ensure that these rights are used constructively, family, carers and other support persons have the responsibility to:

- respect the humanity and dignity of the patient
- consider the opinions and skills of professional and other staff who provide assessment, individualised care planning, support, care, treatment, recovery and rehabilitation services to patients, and
- cooperate, as far as is possible, with reasonable programs of assessment, individualised care planning, support, care, treatment, recovery and rehabilitation.

**Right to be consulted**

Submissions received for the Review highlighted that the knowledge and expertise developed by the patient’s family, carers and other support persons can provide valuable insight into treatment and support programs, identifying and managing triggers to changed behaviour, and successful risk mitigation strategies.

These issues are also addressed in Background Paper 5, which makes recommendations in relation to the involvement of family, carers and other support persons in planning patient treatment and care.

**Right to be informed**

Some stakeholders expressed concern during the Review that there are undue restrictions on the release of medical information to patients, family and support persons. This should not be the case, as section 145 of the *Hospital and Health Boards Act 2011* provides for the disclosure of confidential information if it is for the treatment and care of the person to whom the information relates. Section 146 also provides that confidential information can be provided to persons who have a sufficient interest in the person’s welfare, such as family, carers and other support persons.

To clarify this matter, the proposed legislation should note that, under the *Hospital and Health Boards Act 2011*, family, carers and other support persons may be provided information about a patient’s treatment and care if the information is for the purpose of treatment and care, or if the person has sufficient personal interest in the patient’s health and welfare.

The above proposals would not over-ride a patient’s right to privacy if the patient did not want to be contacted by a particular person or did not want information to be provided to family, carers
and other support persons. This could apply generally, or specifically in relation to particular information or a particular person.

- **Right to visit**

The Act provides powers for a legal or other advisor to visit an involuntary patient in an AMHS at any reasonable time of the day or night (section 347). The rights of family or other support persons are not referred to in the Act in this way.

Submissions received during the Review have highlighted instances where:
- patients have been denied visits from friends and family, even though the exclusion of visitors provision have not been invoked (Chapter 10, Part 4)
- patients have been denied access to make or receive telephone calls, even in circumstances where it is known that both the patient and the caller wish to speak to each other.

The exclusion of visitors should only be on the basis of an explicit decision by an AMHS that the exclusion is necessary for patient security or welfare.

To address this, the proposed legislation should include an express statement that involuntary patients in an AMHS have a right to:
- be visited by family, carers and other support persons at any reasonable time, unless expressly excluded under the Act, and
- send and receive correspondence, phone calls and electronic messages, unless expressly excluded under the Act.

### 7.2.3 Independent patient companion

The Mental Health Act is a complex piece of legislation, and the mental health system is difficult to navigate for people who have had no previous experience with it. Submissions received through consultation have clearly stated that the allied person role has not been successful in providing advice to patients on their rights and responsibilities under the Act.

In order to meet this need, authorised mental health services may engage social workers or case managers to provide patients with support and awareness of the mental health system and their rights. These people are often embedded within the service but not part of the treating team. In addition, some non-government organisations provide support services to involuntary patients and their support persons. This could include specialist services for Indigenous and Torres Strait Islander patients or people from non-English speaking backgrounds.

However, the Act does not recognise these roles, and resources allocated for this type of service vary from region to region.

A system is needed that ensures, as far as is practicable, that an involuntary patient has someone available to explain his or her rights and obligations under the Mental Health Act. Given the complexity of the legislation and the issues of involuntary treatment, it is proposed that each AMHS engage a dedicated person or persons for this role.

The proposed legislation should require each AMHS to employ or engage (e.g. from a non-government organisation) a person or persons as an ‘Independent Patient Companion’, who is to report directly to the AMHS administrator and must not be part of the treating team.
The role of the Independent Patient Companion would be to:

- advise involuntary patients, family, carers and other support persons, of the patient’s rights and obligations under the Act
- assist involuntary patients, family, carers and other support persons to constructively engage with the treating team about the patient’s treatment and care
- advise patients, family, carers and other support persons of pending Tribunal proceedings, the patient’s rights at Tribunal proceedings, and the need and appropriateness of engaging an advocate or legal representative for a hearing
- actively identify if the patient has a personal guardian or attorney and, if one exists, work cooperatively with the guardian or attorney to further the patient’s interests, and
- advise patients, where appropriate, of the benefits of having an advance health directive or enduring power of attorney to address future times when the patient does not have capacity.

It is recognised that this would result in a small cost increase for authorised mental health services. However, it is envisaged this cost would be balanced by savings identified elsewhere in the Review.  

### 7.2.4 Advocates and legal representatives

The Act outlines the persons who may appear and participate at a Tribunal hearing (Chapter 12, Part 4). Patients can be represented at the hearing by a lawyer or, with the leave of the Tribunal, an agent. In addition, the patient’s allied person, or another person granted leave by the Tribunal, may attend the hearing to help the patient present the patient’s views, wishes and interests.

Tribunal hearings are intended to be conducted with as little formality and technicality as possible and the Tribunal is not bound by the rules of evidence, while still observing natural justice (section 459).

Submissions to the Review have highlighted that, in spite of this informal approach, some patients feel a sense of futility regarding Tribunal hearings. Low patient participation rate has been attributed to patients feeling that there is no point in attending their hearing as they believe the Tribunal will simply listen to the treating team and confirm the order.

The Tribunal is charged with very important responsibilities. As the Tribunal is not subject to the rules of evidence, both advocates and legal representatives can play an important role in bringing the Tribunal’s attention to evidence that may be unsubstantiated or incorrect. In this way advocates and legal representatives help to protect people from being unjustly subject to involuntary treatment.

The proposed Independent Patient Companions will have a role of advising patients, family, carers and other support persons of pending Tribunal proceedings, the patient’s rights at Tribunal proceedings, and the need or appropriateness of engaging an advocate or legal

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4 See Background Paper 22 which summarises the impact of the Review recommendations.
5 See section 9.2.2 of Background Paper 9.
representative at a hearing. To support a patient in this regard, the Independent Patient Companion is to be advised of all pending hearings.

Further, the Independent Patient Companion and the patient would discuss any upcoming Tribunal hearings and any statement the patient would like to make. The Independent Patient Companion could attend the Tribunal hearings if the patient wished, to help the patient convey his or her views.

The proposed legislation needs to take a simplified approach to patient support at hearings, namely:

- a patient may be represented at a hearing by a lawyer or other person (e.g. an advocate) unless excluded by the Tribunal, and
- the patient may be accompanied by a support person at the hearing, unless excluded by the Tribunal.

The need for legal representation in hearings is covered further in Background Paper 9.

### 7.2.5 Stigma and recovery

Despite some progress in recent years, there remains a stigma attached to mental illness that is not present in relation to other illnesses. This makes accessing mental health services, whether for assessment or for ongoing treatment, difficult for many people who may prefer not to seek or fully participate in treatment and care.

A number of stakeholders suggested that this stigma can affect longer-term care and recovery, and that the reduction of stigma associated with mental illness should be stated as a principle in the proposed legislation.

Both Tasmania and Western Australia have referred to the need to provide services free from stigma in the principles of their mental health legislation and it would be beneficial to have a similar principle in Queensland’s mental health legislation.

Stakeholders also suggested that the Act should have more focus on recovery, with the goal of patients being able to fully integrate back into their community. While recovery-oriented services are an essential element of service delivery, it is inevitable that legislation that deals with involuntary assessment, detention and treatment, is more focussed on legal authorities and protections. However, several jurisdictions place an emphasis on recovery in the principles to their legislation. Queensland’s legislation refers to achieving ‘potential and self-reliance’, but reference to recovery-oriented services and a statement that recovery should be a primary objective of any intervention would be beneficial.
8. Support for Victims

8.1 Background

The Mental Health Act 2000 includes provisions to support victims of unlawful acts by persons who may have been of unsound mind at the time of an alleged offence or unfit for trial. Under the Act, a victim of an alleged offence means:

- a direct victim of the alleged offence (i.e. a person against whom the alleged offence was committed), or
- an immediate family member (as defined in the Schedule to the Act) of a direct victim of the alleged offence.

Section 5 of the Act outlines how the purpose of the Act is to be achieved. This includes that, when making a decision under the Act about a forensic patient, the protection of the community and the needs of a victim of the alleged offence must be taken into account.

The Act enables a person, including an ‘eligible person’ (as defined in section 318O(7) of the Act), to apply to the Mental Health Review Tribunal for a forensic information order, which enables the person to receive specified information about the forensic patient’s status under the Act.

The Act also enables an ‘eligible person’ (as defined in section 318C(6) of the Act) to apply to the Director of Mental Health (DMH) for a classified patient information order, which enables the person to receive specified information about the classified patient’s status under the Act.

There are also provisions in the Act that allow victims to make submissions to the Mental Health Court (MHC) on a reference, or the Tribunal on hearing forensic order reviews. There are provisions in the Act that allow victims to apply to make their submissions confidential.

In addition, the MHC may make a non-contact order in favour of a victim if a forensic order is not made, and the Tribunal may make a non-contact order in favour of a victim if the Tribunal revokes a forensic order.

The DMH may also notify a victim of a reference to the MHC (section 264). There is also a provision (section 349(3)) that allows a high security unit to intercept mail from a forensic patient to a person if requested, including a victim.

8.2 Issues

The Review has identified the following issues in relation to supporting victims of unlawful acts offences committed by people with a mental illness or intellectual disability:

1. Recognition of victims in the principles of the Act
2. Identifying and providing services to victims
3. Victims’ submissions to the Mental Health Court and the Mental Health Review Tribunal
4. Re-submission of victim submissions
5. Notice of hearing for revocation of forensic orders
6. Forensic information orders
7. Notifications to victims
8. Tribunal membership
9. Confidentiality orders, and
10. Non-contact with victims.

### 8.2.1 Recognition of victims in the principles of the Act

The Act provides a framework for balancing the protection of people with a mental illness with the rights and freedoms of other people. It also must take into account, when making a decision about a forensic patient, the needs of a victim. Submissions to the Review proposed that victims of unlawful acts committed by persons with a mental illness or intellectual disability should have rights equivalent to the rights of victims of offenders in the criminal justice system, such as timely and accurate information, early support, and specialist intervention to assist their recovery.

Principles supporting victims’ rights can be found in the *Victims of Crime Assistance Act 2009* and the *United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power*.

It is proposed to include a statement of principles in relation to victims of unlawful acts in the Act to provide clear guidance to those administering the Act on how to consider victims’ issues, namely:

A person involved in the administration of this Act is to:

- recognise with compassion the physical, psychological and emotional harm caused to a victim by an unlawful act of another person
- recognise the benefits to a victim of being advised in a timely way of the proceedings against the person under this Act.
- recognise the benefits to a victim of being given the opportunity to express his or her views on the impact of the unlawful act to decision-making entities under the Act
- recognise the benefits to a victim of a timely completion of proceedings against the person
- recognise the benefits to a victim of being advised in a timely way of decisions to allow the person to go into the community, and
- recognise the benefits of counselling, advice on the nature of proceedings under the Act and other support services, to a victim’s recovery from the harm caused by the unlawful act.

In these principles, a reference to an unlawful act, includes an alleged unlawful act.

### 8.2.2 Identifying and providing services to victims

The Queensland Health Victim Support Service (QHVSS) was established in 2008 as part of the reforms stemming from the review of the *Mental Health Act 2000* by Mr Brendan Butler SC. The purpose of the service is to assist victims to cope with the trauma they have experienced as a victim by providing advice on the forensic mental health system, supporting their right to information, and having input into certain decisions.

To locate and support victims, protocols have been established whereby the DMH provides information to QHVSS on persons who have committed alleged offences where there is a
victim, the details of the charges, the court at which a person appeared, when a person becomes a classified patient, and when a person is referred to the MHC. Progress of matters through the MHC and decisions by the Tribunal are also provided by the DMH to QHVSS.

Information sharing processes have also been developed with the Queensland Police Service, the Department of Justice and Attorney-General and the Director of Public Prosecutions (DPP) to offer victims assistance from QHVSS when their case is referred to the MHC.

Research generally on victims of crime suggests that early intervention assists in reducing the severity of impact of the crime. Research also indicates that victims require provision of emotional and practical support, provision of information, and support to participate and be represented in processes concerning the person who has committed the alleged offence. Submissions and consultations indicated that proactive referral systems should be regarded as best practice and would assist in increasing awareness and take up of services.

In 2012, Queensland Police Service referrals made up 69 percent of referrals to QHVSS. Without the ability to share information between government agencies it would be difficult to locate victims for QHVSS to offer their support and assistance, specifically early in the process. To ensure that the current arrangements have an appropriate legislative basis, the proposed legislation will enable the Department of Health, a Hospital and Health Service, the Queensland Police, the Department of Justice and Attorney-General and the DPP to use and disclose information to:

- assist the identification of a person who may be a victim, or
- to provide information to a person who may be, or is, a victim.

This provision would over-ride any confidentiality or privacy duties under the Hospital and Health Boards Act 2011, the Information Privacy Act 2009 or any Act. It should be noted that this process does not require clinical information about a patient (i.e. information about the specific treatment and care provided to the patient), and therefore access would only be granted for information for the purposes of identifying, contacting and supporting a victim.

The exemption provided for the Queensland Police, the Department of Justice and Attorney-General and the DPP to disclose information will provide future flexibility for more efficient information-sharing arrangements to be put in place over time if agreed between the agencies.

8.2.3 Victims’ submissions to the Mental Health Court or the Mental Health Review Tribunal

The MHC may take into account a submission from a victim or ‘concerned person’ in making a decision on a reference. The Act provides that this person does not have a right of appearance unless ordered by the Court (section 284).

Similarly, for the Tribunal, the victim’s submission may be taken into account to help the Tribunal make decisions regarding the forensic patient’s order and conditions of the order.

In both instances, the victim’s submission is treated as evidence.

The Act does not clearly state the purpose of these statements. There is a lack of clarity in the Act as to whether victims’ submissions are intended to be victim impact statements, such as statements that can be made under the Victims of Crime Assistance Act 2009. While stakeholders generally considered the statements to be a victim impact statement, this is not
supported by the Act, which treats them as evidence to assist the Court in making a determination.

For Tribunal hearings, the fact that the statement is treated as evidence requires complex provisions whereby a victim must apply for a confidentiality order if the victim does not want the forensic patient to see the submission. This requires a Tribunal hearing where the Tribunal must arrange for a lawyer to represent the patient.

To address these issues, it is proposed the Act provide that a victim submission to the MHC or Tribunal is equivalent to a victim impact statement under the *Victims of Crime Assistance Act 2009*. This would not prevent the Court from receiving evidence from any person, including a victim. Victim impacts statements are to remain confidential unless otherwise requested by the victim.

In addition, some submissions have sought a right of appearance before the MHC to verbally give a submission about the impact of the unlawful act on the victim. This is based on the approach under the *Victims of Crime Assistance Act 2009*, whereby a victim may read a victim impact statement during sentencing of someone convicted of a crime. That Act provides that the purpose of reading aloud the victim impact statement is to provide a therapeutic benefit to the person.

However, while reading out of the victim’s submission may be therapeutic for the victim, it may be detrimental to the patient. Therefore, the MHC should retain a discretionary power that determines whether a victim statement should be presented verbally or not.

Some submissions also believed that victims of crimes should be able to attend Tribunal hearings to better understand the reasoning behind decisions made by the Tribunal. Some submissions noted that the equivalent Tribunal in NSW allows victims to view forensic order hearings via a video link. However, many victims may not want to attend or view a Tribunal hearing, but wish to be provided with more information about the reasons for the Tribunal’s decision. This latter approach is supported. Enabling victims to better understand the reasoning behind decisions made by the Tribunal is addressed below (see section 8.2.6).

### 8.2.4 Re-submission of victim submissions

During the Review, stakeholders expressed concern that victims need to make a separate submission to the Tribunal for each forensic order review, which occurs every six months, for their views to be taken into account. This is not an express requirement in the Act, but has become the practice of the Tribunal since 2009.

Some victims stated that providing a submission to the Tribunal every six months for each forensic order hearing was traumatic and resulted in them re-living the unlawful act and prevented them moving forward in their recovery. Preparation of submissions can be time consuming and often the victim’s sense of risk or feelings toward the patient had not changed from the previous six months. However, victims were concerned that their views would not be taken into account if they did not make a submission at each hearing.

If a victim’s opinion remains unchanged there is no apparent reason why a new submission should be required at every forensic order review.
The Act should provide that the initial submission made by a victim to the MHC or the Tribunal must be automatically read into subsequent Tribunal proceedings on each occasion unless the victim wants to make a new submission.

8.2.5 Notice of hearing for revocation of forensic order

During the Review, stakeholders expressed concern that victims were not given notification that a forensic order may be revoked at an upcoming Tribunal hearing.

It would be beneficial to victims if they were given prior notice that a forensic order may be revoked at an upcoming Tribunal hearing. This would give the victim a chance to emotionally prepare for the change. Giving a victim prior knowledge that a forensic order may be revoked may also allow the victim to prepare a more targeted submission to the Tribunal addressing any concerns in relation to the revocation.

It should, however, be noted that the review powers of the Tribunal make it possible for a forensic order to be revoked without a specific application for revocation being made and it would be infrequent for an application to be made to revoke an order. The most beneficial approach would be for the QHVSS to speak to victims before hearings to discuss possible outcomes.

It should be noted that if the proposal for the MHC to set non-revokable periods for forensic orders is accepted (see section 4.2.2 of Background Paper 4), this problem will not occur during the non-revokable period.

8.2.6 Forensic information orders and classified patient information orders

The following issues were raised in relation to forensic information orders during the Review:

1. The time-frame for the consideration of forensic information orders was too long, and
2. Forensic information orders lack information about reasons decisions are made.

In 2012-13, there were 17 forensic information orders made\(^1\). As at 30 June 2013, there were 100 forensic information orders in force\(^2\).

In 2012-13, there were four classified patient information orders made. As at 30 June 2013, there was one classified patient information order in force\(^3\).

The Victims of Crime Assistance Act 2009 and the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power both have principles which pertain to victim’s rights to information and for that information to be timely and accurate.

However, consultations during the Review indicated that it may take several months for an application for a forensic information order to be considered by the Tribunal. Victims believe this time-frame is not acceptable, particularly given the unnecessary stress and anxiety it causes.

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\(^1\) Source: Mental Health Review Tribunal Annual Report 2012-13
\(^2\) Source: Director of Mental Health Annual Report 2012-13
\(^3\) Source: Director of Mental Health Annual Report 2012-13
To address these issues, it is proposed to modify the approach to making forensic information orders and classified patient information orders. Given the non-judicial nature of making an information order, there is no apparent reason why the DMH should not make forensic information orders. It should be noted that currently orders are made by the Tribunal chair, without the need for hearing, as is permitted under the Act (section 318R). Enabling the DMH to make forensic information orders would expedite the process and give victims a more timely assurance that their concerns are being addressed.

Given the very low number of classified patient information orders, providing information to relevant victims could be streamlined by replacing orders with the ability for the Department of Health and the QHVSS to disclose relevant information to a victim. This would remove the need for a person to apply for an order.

Victims would benefit from receiving more information about the reasons particular decisions are made, particularly when a forensic order is revoked or a patient is granted access to community treatment. Under existing orders, a person is only notified of the fact that an order has been revoked or that limited community treatment has been granted. It is proposed that forensic information orders should include a statement of reasons for Tribunal decisions and a summary of the risk assessment that led to any decision for a forensic patient to be granted access to the community or revocation of a forensic order.

8.2.7 Notifications to victims

There are gaps in the notification of information to victims that should be rectified, namely:

- victims who have a forensic information order where the person was found to be temporarily unfit for trial be notified of a review for fitness for trial and the outcome of that review, and
- victims who have a forensic information order to be notified that an appeal has been lodged in the MHC in relation to the patient’s forensic order and the outcome of the appeal.

8.2.8 Mental Health Review Tribunal membership

Some stakeholders expressed concerns that Tribunals lacked specific expertise in relation to victims.

However, the Act does provide for a balance of members. The composition for a Tribunal hearing usually includes at least three members - a lawyer (who has at least five years standing), a psychiatrist or other doctor, and a community member who has experience that is relevant to the decisions. For various hearings the Tribunal panel consists of up to five members. In recommending persons for appointment as Tribunal members, the Act requires the Minister must take into account a range of matters, including the need for the membership to reflect the social and cultural diversity of the general community.

There is an obligation on Tribunal members to take to into account submissions by victims and, for forensic patients, issues of risk to community safety. In addition, the President of the Tribunal must have regard to the current risk the patient represents to the safety of himself, herself or others in deciding the constitution of a Tribunal panel (section 447 (3)).

For these reasons, it is not proposed to extend Tribunal membership as it already includes community representatives who are required to take into account issues of community safety.
8.2.9 Confidentiality orders

A victim making a submission to the MHC may make application for the submission to be confidential if the victim does not wish the patient to know about the contents of the statement. The person who has committed the unlawful act knows that a confidentiality order is made but is not advised who has made the submission or its content.

This process is similar for the Tribunal, where the forensic patient is told that an application for a confidentiality order is made, but not given details about who made it or the content. A patient is not permitted to attend a Tribunal hearing which is considering a confidentiality order application, however, a lawyer must be appointed to represent the patient, as the statement is considered to be evidence for the hearing.

The proposals outlined above (section 8.2.3), would clarify that a statement is of the nature of a victim impact statement and is not to be treated as evidence. It is proposed that the statement be treated as confidential (i.e. not provided to the forensic patient) unless requested by the victim. As such, there is no need for the Tribunal to conduct a confidentiality order hearing.

8.2.10 Non-contact with victims

The MHC may, when making a forensic order, impose a condition on LCT that the patient not contact a stated person, such as a victim (section 289). The Court may also make a ‘non-contact order’ if the Court determines that a person was of unsound mind at the time of the alleged offence or is permanently unfit for, and the Court does not make a forensic order for the patient (section 313A).

On a review of a forensic order, the Tribunal may impose conditions on LCT. A condition may be that the patient not contact a stated person, such as a victim (section 203). The Tribunal may also make a ‘non-contact order’ if the Tribunal decides to revoke a forensic order (Chapter 6, part 5A).

The purpose of placing a non-contact condition on LCT is clear, as the MHC or Tribunal has decided that a forensic order is required to protect the community. However, it is not evident why the MHC or the Mental Health Review Tribunal would make a non-contact order in circumstances where a forensic order is not made or is revoked. The Act states strict criteria for the making and revoking of forensic orders that include community safety. The Tribunal may only revoke an order if satisfied that there is not an unacceptable risk to the safety of others.

As a consequence, ‘non-contact orders’ are very rarely used, with there being only one non-contact order made by the MHC in 2012-13 and none by the Tribunal. In fact, the Tribunal has only ever made two non-contact orders and the MHC has made only one. It is therefore proposed to discontinue these orders. It is envisaged that the improved provision of information to victims will better address any residual concerns a person may have about his or her safety.

In addition, some submissions to the Review expressed concern that forensic patients may make attempts to contact victims via emails, letter, social media, by phone or by proxy while an in-patient. There is no legal authority for an authorised mental health service (AMHS) to prevent an in-patient from attempting to contact a victim by phone, email or other means while an in-

\[\text{Source: Mental Health Review Tribunal and Mental Health Court.}\]
patient, other than in high security facilities, where the Act enables a person to request mail addressed to the person be withheld (section 349).
To remedy this, it is proposed that the Act provide a legislative mechanism to enable an AMHS to prevent contact, including intercepting mail, if requested by a person such as a victim. This will assist in reducing fear and anxiety for the victim.
Review of the Mental Health Act 2000

Background Paper

May 2014
9. Mental Health Review Tribunal

9.1 Background

The Mental Health Review Tribunal is an independent statutory body established under the Mental Health Act 2000 (Chapter 12). Its primary purpose is to review the involuntary status of a person with a mental illness. It also has other functions under the Act, such as reviewing fitness for trial, and hearing various appeals (section 437). The Tribunal consists of the President and other members, including lawyers, psychiatrists and other persons with relevant qualifications or experience.

9.2 Issues

The following issues in relation to the Tribunal have been identified during the Review:

1. Appointment of a Deputy President
2. Low rate of legal representation for patients
3. Greater clarity on the purpose, initiation and decisions on hearings
4. Providing statements of reasons
5. Evidence in Tribunal hearings
6. Review timeframes for involuntary treatment orders
7. Reviews for missing people
8. Hearings on the papers and teleconferencing, and
9. Detention of minors in high security facilities.

9.2.1 Appointment of a Deputy President

The President of the Tribunal is appointed by the Governor-in-Council on a full time basis. For a person to be eligible for appointment, he or she must have at least seven years standing as a lawyer (section 440).

The Act provides that a person may be appointed by the Governor-in-Council to act for the President for any period the office of President is vacant or for any periods that the President is absent from duty or cannot, for another reason, perform the role (section 445). To be appointed to act for the President, the person must meet the eligibility criteria to be President.

There is, however, no provision in the Act for the appointment of a Deputy President for the Tribunal, who would provide high-level support for the President and automatically act for the President in the President’s absence. The case for a Deputy President is strengthened by the increased workload of the Tribunal, where 11978 matters were listed for hearing during 2012-13.

It is proposed that the Act provide for the position of Deputy President, to have the same minimum qualifications as the President and who would act as President in the President’s absence.

9.2.2 Low rate of legal representation for patients

Various sections of the Act provide for the right of patients to attend Tribunal hearings. In 2012-13, attendance at Tribunal hearings was 28 percent for patients on involuntary treatment orders and 40 percent for forensic patients\(^2\). Consultation during the Review indicated that patients are more likely to attend a hearing if the patient believed it may result in a change in the patient’s status (i.e. the revoking of an involuntary treatment order (ITO)) or conditions of the patient’s order (e.g. increased community treatment). Conversely, patients may not wish to attend if the patient believed there was little prospect of change. It should also be noted that patients may not be well enough to attend a hearing.

In addition, patients have the right to be represented by a lawyer or, with the leave of the Tribunal, an agent. There is, however, a very low rate of legal representation at Tribunal hearings. In 2012-13, only two percent of patients were legally represented before the Tribunal.\(^3\)

Particular concern was expressed during the Review of the fairness of hearings when the Attorney-General is represented and the patient has no representation. In 2012-13, the Attorney-General attended 856 hearings to represent the interests of the community.\(^4\) Legal representation for forensic patients is important in these hearings as a patient cannot be expected to advocate for themselves with the same skill and knowledge as a lawyer. Such an experience would significantly disempower the patient.

The right to legal representation is a fundamental right under Principle 1(6) of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care:

> the person whose capacity is at issue shall be entitled to be represented by counsel (defined as legal or other qualified representative). If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment to that person to the extent that he or she does not have sufficient means to pay for it.

Given the large number of hearings that occur each year it would not be feasible to require legal representation at each of these hearings, nor would all patients need or wish for this representation. However, certain groups of patients would significantly benefit from legal representation.

Submissions to the Review suggested a number of circumstances where there should be legal representation, at no cost to the patient, namely:

- where the patient was a child/minor
- ECT applications
- psychosurgery applications

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\(^2\) Source: Mental Health Review Tribunal.

\(^3\) Source: Mental Health Review Tribunal.

\(^4\) Source: Mental Health Review Tribunal.
• when the Attorney-General is a party
• forensic order or fitness for trial reviews
• matters concerning a patient who at the time of the hearing is held in seclusion
• matters concerning Chapter 7, part 2 patients in detention (either in a corrective services facility or an authorised mental health service (AMHS))
• people with vulnerabilities such as people under personal guardianship, people with intellectual disabilities, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and
• patients who have been in in-patient care for over 12 months.

Having considered the possible scenarios, it is proposed to require legal representation at Tribunal hearings, at no cost to the patient, for:
• hearings involving minors
• fitness for trial reviews, and
• reviews where the State is legally represented by the Attorney-General.

Based on 2012-13 hearings, this proposal would result in legal representation in approximately 900 hearings. It would be the responsibility of the Tribunal to provide legal representation in these cases if the patient is unable to do so. It is acknowledged that this would have cost implications for the Tribunal, however, there are other proposals in the Review that would significantly reduce costs for the Tribunal.

9.2.3 Tribunal hearings – purpose, initiation and decisions

The Act provides for various Tribunal hearings (section 437), namely:
• reviewing persons on involuntary treatment orders
• reviewing persons on forensic orders
• reviewing fitness for trial
• deciding applications for forensic information orders
• deciding treatment applications (ECT and psychosurgery)
• deciding applications for particular patients to move out of Queensland
• reviewing the detention of young patients in high security units, and
• deciding various appeals.

It is essential for proper hearings, and for transparency, that the Act provides clear statements as to the purpose of Tribunal hearings, how they are initiated (including who can apply and what can be applied for), the criteria for decisions, and what decisions can be made. The Addendum to this Background Paper summarises these considerations for each matter the Tribunal can hear. It demonstrates that there are inconsistencies and inadequacies in the provisions.

To remedy this, the Act should clearly articulate the following as outlined in the Addendum to this Background Paper:

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5 Source: Mental Health Review Tribunal.
6 Background Paper 22 summarises the impacts of the proposals.
who may apply to the Tribunal for a matter to be heard
the purpose of the application
the decision the Tribunal may make, and
the criteria for the decision.

9.2.4 Statement of reasons

There are a number of provisions of the Act that provide a party with the right to a statement of reasons for a Tribunal decision on request (e.g. sections 192(3) and 205(3)). The Act also requires the Tribunal to keep a register of matters, including reasons for decisions (section 486). Consultations during the Review indicate that a party to a hearing may request a Tribunal decision more than six months after the hearing. As the Tribunal does not record or transcribe all proceedings it is currently difficult to produce the reasons for decisions dating back to this time. One proposal to address this is to require the register to only contain reasons where requested, and to place a time limit (e.g. six months) on requests for reasons.

However, if the Tribunal recorded reasons for decisions at the time they were made, it would not be a difficult matter to produce a hard copy statement of reasons on request. In addition, there are no provisions in the Act for the Tribunal to publish decisions where such decisions involve precedential value, external interest or detailed legal or policy arguments. One legal stakeholder submitted that publishing (de-identified) decisions of precedent value would:

- improve the ability of patients, their representatives and their treating teams to understand the legal tests concerning the patient’s health status, treatment and decisions about that treatment
- increase Tribunal accountability
- provide more certainty of outcomes
- improve patient and public understanding and confidence in the system, and
- encourage public scrutiny, informed debate and discussion.

It would be beneficial for the Tribunal to publish de-identified decisions of precedential value. To achieve this, the Act should state that the Tribunal has this function, although which matters are published would need to be at the discretion of the Tribunal.

9.2.5 Inability of Tribunal to hear other evidence

The Act provides that Tribunal hearings may be attended by various persons, such as the patient, the Director of Mental Health (DMH), the Attorney-General, and a lawyer or agent representing the patient. However, the Act does not allow other persons to provide information or evidence to the Tribunal which would be beneficial in the decision-making process. Particular people can attend a hearing if the Tribunal grants leave for that person to attend but only to represent the views or wishes of the patient. Should the patient want another person to present a view about the patient, this can currently only occur through the treating team.

During consultations for the Review, examples were given where significant people in the patient’s life such as a carer, family member, support worker, or in a role such as a manager of
a residence where the patient resides, hold information about the patient which could be informative to the decisions being made at the Tribunal.

The patient should have a right to enable information about himself or herself, separate to the view formed by the treating team, to be presented to the Tribunal.

To achieve this, it is proposed that other persons be able to provide evidence at the Tribunal at the patient’s request. The Tribunal would then decide how much weight to place on the person’s contribution.

The Queensland Civil and Administrative Tribunal has a similar mechanism where reports from various people who hold relevant information can be presented at the Tribunal to inform the Tribunal making a decision.

9.2.6 Review time-frames

The Act states that the Tribunal must review the application of the treatment criteria to a patient for whom an ITO is in force within six weeks after the order is made and afterwards at intervals of not more than six months (section 187). Reviews may also occur on application made by the patient, a person on behalf of the patient, or the DMH. The Tribunal may also conduct a review on its own initiative.

In 2012-13, the Tribunal heard 7581 ITO reviews. Of these reviews, 95 percent resulted in no change to the order. This indicates a mature system where the assessment of authorised doctors and the Tribunal are closely aligned. It raises the question of whether the review hearings are too frequent, creating unnecessary stress for the patient and not making the best use of the Tribunal and treating teams’ resources.

It is essential that any extension of automatic reviews not diminish patients’ rights. As an important safeguard, the initial six week review should be retained. Consistent with the delivery of recovery-oriented services, patients should be encouraged to apply for a review (to revoke an ITO, or allow or extend treatment in the community) at a time that best meets the person’s treatment and care needs, for example, where a patient believes that he or she has recovered sufficiently to have the ITO revoked. Exercising these rights will be greatly enhanced by the proposed Independent Patient Companion (see section 7.2.3 of Background Paper 7). The proposed legislation will also require an authorised doctor to review a patient if, at any time, the doctor believes the treatment criteria may no longer apply (see section 5.2.4 of Background Paper 5).

A re-prioritisation of Tribunal resources will also enable fairer hearings for patients, particularly by requiring legal representation in particular reviews (see section 9.2.2).

It should be noted that the majority of involuntary treatment orders are in place for a relatively short period of time. Of the orders revoked in 2012-13, 3839 orders (59.2 percent) were in place for less than one month, while 4954 orders (76.5 percent) were in place for less than six months. Of the orders in place as at 30 June 2013, 2519 orders were in place for six months or more.

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8 Source: Department of Health data.
It is proposed to provide for automatic ITO reviews 12 monthly, while retaining the initial review at six weeks and the ability for the patient, or someone acting on the patient’s behalf, to apply to the Tribunal for a review at any time.

9.2.7 Reviews for missing people

The Tribunal must review a forensic patient’s mental condition within six months of the forensic order being made and afterwards at intervals of not more than six months. These Reviews are still required even when the patient is absent without permission. In these cases, a meaningful review of the persons’ mental condition is not possible. Preparing for, and holding, a hearing requires a significant amount of time and resources which, in these instances, serve no purpose.

It would therefore be appropriate to put any forensic order review ‘on hold’ until the patient is located.

In addition, there have been a small number of forensic patients who have been absent without permission for years, one for almost 15 years, and a number of others for over five years. In some cases it appears the person has moved overseas or died.

To address this, it is proposed that the Tribunal be able to revoke a forensic order if a patient is absent without permission for over five years and the available information indicates that the person is unlikely to return to the State or is presumed to have died.

9.2.8 Hearings on the papers and teleconferencing

As indicated above, patient attendance at Tribunal hearings was only 28 percent for ITO reviews and 40 percent for reviews of forensic orders. While patient attendance should be encouraged, there will be many times that a review hearing for an ITO would proceed when a patient does not wish to attend and does not wish to be represented at the hearing. This may occur where there has been no significant change in the patient’s health status from the last review.

In these instances, it is proposed that the Tribunal may, if appropriate, conduct a hearing entirely on the basis of documents, without the patient, the patient’s representative or the treating team appearing at a hearing. This model is used under the *Queensland Civil and Administration Act 2009* (section 32). As a safeguard, the Act would limit this to ITO reviews, and only where the patient or a representative does not wish to attend a hearing.

The Tribunal currently permits hearings to be conducted via video-conferencing, where appropriate. To clarify this procedure, the Act should explicitly state that the Tribunal be able to conduct hearings by remote conferencing, including video-conferencing, teleconferencing or another form of communication that allows a person to take part in discussions as they happen.

9.2.9 Detention of minors in high secure facilities

The legislation currently provides for the Tribunal to review a young patient’s detention in a high security unit (sections 194-199). This provision has only been used once and is considered unnecessary given the DMH’s role in approving the admission of a young patient to a high security unit.
It is therefore proposed that the legislative requirement for reviews by the Tribunal for young patients detained in high security units be discontinued.
## Addendum: Tribunal Hearings

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Purpose</th>
<th>Who can apply</th>
<th>Decision</th>
<th>Criteria for Decision</th>
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</thead>
<tbody>
<tr>
<td>Involuntary treatment order reviews</td>
<td>To review the application of treatment criteria (s.187)</td>
<td>Automatic (6 weeks and 6 monthly) (s.187) &lt;br&gt; Patient, person on behalf of patient, DMH (s.188) &lt;br&gt; On initiative of Tribunal (s.187)</td>
<td>Confirm or revoke ITO (s.191) &lt;br&gt; Change of category, LCT, transfer to another AMHS, change to monitoring conditions (s.191)</td>
<td>If the decision is to confirm or revoke an ITO, it is implicit that this relates to the application of the treatment criteria. &lt;br&gt; The Act states that for all decisions, the Tribunal is to consider the following (s.191(4)): &lt;br&gt; - the patient’s mental state and psychiatric history &lt;br&gt; - the patient’s social circumstances &lt;br&gt; - the patient’s response to treatment and willingness to continue treatment &lt;br&gt; Comment: The general criteria are too broad on their own to be of value. They cannot relate to retaining or revoking an ITO, as the treatment criteria apply. &lt;br&gt; The Review has proposed revised criteria for revoking ITOs and approving community categories and LCT.</td>
</tr>
<tr>
<td>Detention of a young patient in a high security unit</td>
<td>Not stated, but addressed in decision (s.197)</td>
<td>Automatic (7 days and 3 monthly) (s.194) &lt;br&gt; Patient, person on behalf of patient (s.195) &lt;br&gt; On initiative of Tribunal (s.194)</td>
<td>Continue to be detained in a high security unit or be transferred to an AMHS that is not high secure</td>
<td>The patient’s best interests, having regard to: &lt;br&gt; - the patient’s mental state and psychiatric history &lt;br&gt; - the patient’s treatment, care and security requirements &lt;br&gt; - for classified and forensic patients,</td>
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<tr>
<td>Hearing</td>
<td>Purpose</td>
<td>Who can apply</td>
<td>Decision</td>
<td>Criteria for Decision</td>
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<tr>
<td><strong>Forensic Patients</strong></td>
<td>Review of patient’s mental condition</td>
<td>Automatic (6 monthly)</td>
<td>Confirm or revoke forensic order (s.203)</td>
<td>For forensic patients (not forensic order– Disability) (s.203(6))</td>
</tr>
<tr>
<td></td>
<td><em>Comment:</em> This purpose is imprecise. The Act needs to state a clearer purpose.</td>
<td>Patient, person on behalf of patient, DMH (s.188)</td>
<td></td>
<td>- the patient’s mental state and psychiatric history</td>
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<td></td>
<td></td>
<td>On initiative of Tribunal (s.200)</td>
<td></td>
<td>- each relevant offence</td>
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<td></td>
<td></td>
<td><em>Comment:</em> The Act does not state what a person is applying for. The Act should provide for this.</td>
<td></td>
<td>- the patient’s social circumstances</td>
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<td>- the patient’s response to treatment and willingness to continue treatment.</td>
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<td></td>
<td>To revoke a forensic order, approve LCT, or amend or revoke a monitoring condition – Tribunal needs to be satisfied the person does not represent an unacceptable risk to the safety of the patient or others (s.204(1))</td>
</tr>
<tr>
<td></td>
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<td></td>
<td><em>Comment:</em> The general criteria are too broad on their own to be of value. The Review has proposed revised criteria for revoking forensic orders and approving community categories and LCT.</td>
</tr>
<tr>
<td><strong>Fitness for trial</strong></td>
<td>Not stated, but addressed in decision (s.212)</td>
<td>Every 3 months for first year, and thereafter 6-monthly</td>
<td>Whether or not the person is fit for trial</td>
<td>Relates to definition of ‘fit for trial’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient, person on behalf of patient, DMH (s.210)</td>
<td></td>
<td><em>Comment:</em> The Review has proposed a revised definition of ‘fit for trial’.</td>
</tr>
<tr>
<td>Hearing</td>
<td>Purpose</td>
<td>Who can apply</td>
<td>Decision</td>
<td>Criteria for Decision</td>
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<tr>
<td>Making of non-contact order</td>
<td>Not stated</td>
<td>Decision can be made at the same time a forensic order is revoked</td>
<td>To make a non-contact order in favour of a person</td>
<td>Criteria for decision (section 228C)</td>
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<td></td>
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<td>- the views of stated persons</td>
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<td>- the viability of making the order (e.g. small remote community)</td>
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<td>- the person’s criminal history</td>
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<td>- the terms of any other order (e.g. domestic violence order)</td>
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<td>(Section 228C)</td>
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<td></td>
<td><strong>Comment</strong>: The review has concluded that these provisions should be discontinued.</td>
</tr>
<tr>
<td>Perform ECT</td>
<td>To obtain approval to perform ECT</td>
<td>A psychiatrist</td>
<td>To approve ECT</td>
<td>Criteria for decision (section 233)</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist must be satisfied it is the most clinically appropriate treatment and the patient cannot give informed consent (s.229)</td>
<td></td>
<td></td>
<td>- the person does not have capacity to consent</td>
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<td>- ECT is the most appropriate treatment</td>
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<td></td>
<td><strong>Comment</strong>: The purpose of applying to the Tribunal after emergency ECT is performed is not clear.</td>
</tr>
<tr>
<td>Perform psychosurgery</td>
<td>To obtain approval to perform psychosurgery</td>
<td>A psychiatrist</td>
<td>To approve psychosurgery</td>
<td>Criteria for decision (section 233)</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist must be satisfied that the patient has given informed consent (s.230)</td>
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<td>- the person has given informed consent</td>
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<td>- psychosurgery has clinical merit and is appropriate in the circumstances</td>
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<td>- alternative treatments has not resulted in a sufficient and lasting benefit</td>
</tr>
<tr>
<td>Hearing</td>
<td>Purpose</td>
<td>Who can apply</td>
<td>Decision</td>
<td>Criteria for Decision</td>
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<td>- psychosurgery is to be performed by a suitably qualified person</td>
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<td>- psychosurgery is to be performed at an AMHS</td>
</tr>
</tbody>
</table>
10. Interstate Transfers

10.1 Background

Chapter 5 of the Mental Health Act 2000 provides for the transfer of involuntary patients into, and out of, Queensland.

The Fourth National Mental Health Plan 2009-2014 aimed to clarify arrangements for the interstate transfer of people subject to mental health legislation, including to:

- review and where necessary amend mental health and related legislation to support cross-border agreements and transfer of people under civil and forensic orders ...

Such transfers can be beneficial for the treatment and care of the patient. A patient's transfer to a State in which the patient's family and other support persons reside may impact significantly on the patient's quality of life and rehabilitation outcomes, particularly for patients requiring longer term treatment. Further, a transfer back to a patient's community can increase the likelihood of being successfully discharged into the community. The ability to "return to country" is particularly significant to Indigenous people.

The Act provides for the transfer of patients into, and out of, Queensland in different ways.

A person who may be taken to an authorised mental health service (AMHS) for assessment under the Act may instead be taken to an interstate mental health service if this is allowed under the laws of the other State (section 180). Conversely, a person who may be taken to an interstate mental health service may instead be taken to an AMHS in Queensland for assessment (section 182).

An involuntary patient may be transferred to an interstate mental health service by the order of the Director of Mental Health (DMH) or an authorised doctor if:

- the transfer is in the patient’s best interests
- the transfer is permitted under the other State’s laws, and
- the relevant interstate authority agrees to the transfer (section 181).

An involuntary patient who is detained in an interstate mental health service may be transferred to an AMHS in Queensland if:

- the administrator of the AMHS agrees to the transfer, and
- the transfer is permitted under the other State’s laws (section 183).

These transfers can only take place if there is a Ministerial agreement in place between Queensland and the other State (see section 10.2.1).

The Act also enables an application to be made to the Mental Health Review Tribunal to apply for a patient to be ‘moved’ out of Queensland (section 171). The Tribunal may approve the move if it is satisfied that appropriate arrangements exist for the patient's treatment or care at the place where the patient is to move. The Tribunal may also place conditions on the move. Although the forensic order is not revoked, the Act provides that the order for the patient is in force only if the patient returns to Queensland (section 175). The Queensland AMHS retains some responsibilities for a
forensic patient who has been ‘moved’ interstate. For example, at the regular reviews of the forensic patient before the Tribunal the relevant AMHS is required to report on the patient’s status, notwithstanding that the service has no ongoing contact with the patient.

On a review of a forensic order, the Tribunal cannot revoke the order for a patient who has ‘moved’ out of Queensland unless two years has elapsed, and it is satisfied the patient is not likely to move back to Queensland (section 204).

The rationale for providing both ‘moving’ and ‘transferring’ provisions in the Act is not evident from the Act or the Explanatory Notes for the Bill’s introduction into the Parliament.

10.2 Issues

The following issues were identified during the Review in relation to interstate transfers:

1. Ministerial agreements
2. Transfer of forensic patients
3. Transfer of patients on involuntary treatment orders
4. Transfer of involuntary patients living in the community, and
5. The ‘move’ provisions

10.2.1 Ministerial Agreements

The Act provides that the Minister may enter into an agreement with another State about the transfer, detention and apprehension of persons in Queensland and the other State under mental health laws (section 176).

Currently, there are five (5) such agreements in place:

- three *Forensic Apprehension and Return Agreements* (NSW, ACT, Victoria), which provide that a person who absconds from an AMHS (or equivalent in another jurisdiction) and travels interstate may be apprehended by the interstate police and returned, and
- two *Civil Agreements* (NSW, ACT), which provide for the transfer of patients on involuntary treatment orders (or equivalent in another jurisdiction).

There are no agreements in place for the transfer of forensic patients (or equivalent in another jurisdiction).

Sections 181 and 183 of the Act provide that an involuntary patient may be transferred to, or from, an ‘interstate mental health service’. The definition of ‘interstate mental health service’ relies on a Ministerial Agreement being in place. As such, the transfer provisions are ineffective if there is no agreement in force with the relevant jurisdiction.

As a result, since the Mental Health Act was enacted, no forensic patients have been transferred interstate, although one patient was transferred to a mental health service in another jurisdiction using the ‘move’ provisions rather than the ‘transfer’ provisions.

For patients on involuntary treatment orders, the deficiencies in the Act have been circumvented by revoking the order and allowing a person to go interstate, at which time the destination jurisdiction would impose an involuntary order under the other State’s laws.
There is no need for legislation to require Ministerial agreements to be in place for interstate transfers to be effected. It is therefore proposed that the need for Ministerial agreements be discontinued. Memoranda of Understanding could be put in place between Chief Psychiatrists in each jurisdiction, if needed, to outline administrative arrangements for interstate transfers.

10.2.2 Transfer of forensic patients

To facilitate the interstate transfers of forensic patients, it is proposed to simplify the provisions in the Act, while ensuring appropriate safeguards remain.

It is proposed that the interstate transfer provisions for the transfer of forensic patients out of Queensland provide for the following:

- a patient or the patient’s representative may apply to the DMH for a transfer to a mental health service interstate
- in making the application, the patient or the patient’s representative is to provide information on why the transfer would be in the patient’s interests (e.g. closer proximity to family and support persons who would assist the patient’s recovery), and on the willingness of the interstate service to receive the patient
- the DMH may approve the application if:
  - the transfer is in the patient’s interests
  - suitable treatment and care is available for the person at the destination mental health service, and
  - the person in the destination jurisdiction that is legally authorised to agree to the transfer agrees to the transfer.

It should be noted that it is up to the law of the other State to determine whether an interstate transfer can take place. This includes the nature of the order the person is to be placed on interstate.

The Mental Health Review Tribunal is to be advised of the transfer.

When the patient leaves the State, the forensic order is suspended. As a safeguard against the possibility of an early revocation of an order interstate, it is proposed that the Act provide that the forensic order in Queensland is automatically reinstated if the patient returns to Queensland within three years.

The restrictions in the current Act that prevent a person being transferred interstate where criminal proceedings have not been finalised (e.g. a classified patient) should be retained.

It is proposed that the transfer of patients who are on the equivalent of a forensic order in another State into Queensland take place as follows:

- a request for a transfer to be made to the Tribunal by the patient or the patient’s representative
- in making the application, the patient or the patient’s representative is to provide information on why the transfer would be in the patient’s interests (e.g. closer proximity to family and support persons who would assist the patient’s recovery)
- the Tribunal may approve a transfer into Queensland of an equivalent forensic patient if:
- the transfer is in the patient’s interests (e.g. closer proximity to family and support persons who would assist the patient’s recovery)
- suitable treatment and care is available for the person at an AMHS
- the person in the destination jurisdiction that is legally authorised to agree to the transfer agrees to the transfer, and
- the forensic order will adequately protect the community from serious harm to other persons, serious property damage or repeat offending of the type that was the basis for the equivalent order interstate.

As with transfers out of Queensland, it is up to the law of the other State to determine whether an interstate transfer can take place into Queensland.

The Tribunal is to decide the category of the order and any conditions, having regard to the equivalent order and conditions that applied interstate.

The forensic order is effective immediately the patient enters Queensland.

10.2.3 Transfers of patients on involuntary treatment orders

The removal of the requirement to have Ministerial agreements in place will assist the interstate transfer of patients on involuntary treatment orders, or the interstate equivalent. The provisions of the Act which allow for the transfer of patients on involuntary treatment orders into, and out of, Queensland, should be continued, based the patient’s best interests. For consistency, these transfers should be approved by the administrator of the relevant AMHS.

The law of the other State will determine whether an interstate transfer can take place. For transfers out of Queensland, this includes the nature of the order, if any, the person is to be placed on interstate. For the transfer of patients on involuntary treatment orders, the jurisdictions may agree that the patient need not be placed on an order once transferred to the other jurisdiction.

10.2.4 Transfer of involuntary patients living in the community

The Act states (section 183) that “a person who is involuntarily detained in an interstate mental health service under a corresponding law may be transferred to an authorised mental health service …”

The effect of this provision is that an involuntary patient interstate can only be transferred into Queensland if the patient is detained in another State before being transferred to Queensland. This is not appropriate for patients on a community order, who could not be transferred or who would need to be detained for the sole reason of facilitating the transfer.

To remedy this, the proposed legislation will not include the requirement for a patient to be detained for a transfer to be effected.

10.2.5 ‘Move’ provisions

As indicated above, a forensic patient can be ‘moved’ out of Queensland on application to the Tribunal. During the period the patient is interstate (until such time as the
forensic order is revoked), the Tribunal must continue to review the order every six months. This is an unnecessary use of AMHS and Tribunal resources.

If effective transfer provisions were in place, there is no apparent purpose to be served by the ‘move’ provisions. Queensland has no jurisdiction in relation to a person living in another State, and no purpose can be usefully served by requiring regular Tribunal reviews of a patient who has no ongoing contact with a Queensland AMHS.

It is therefore proposed that these provisions be discontinued.

It should be noted that there is nothing preventing an AMHS approving that a person on a community category involuntary treatment order live in another State and return to Queensland for regular treatment. This may occur, for example, where a person lives in Northern NSW but receives treatment in South-East Queensland. This is a risk assessment issue for the relevant AMHS given that the assistance of police interstate would be required if the person does not return for treatment.

The Act also allows for temporary absences to be approved for certain patients. This could be used, for example, to authorise leave interstate on compassionate grounds.
Review of the Mental Health Act 2000

Background Paper

May 2014
11. Forensic Disability

11.1 Background

The Forensic Disability Act 2011 was passed by the Parliament on 10 May 2011 for the purpose of providing appropriate care and management to individuals with an intellectual disability who are placed on a forensic order by the Mental Health Court (MHC)\(^1\). The Forensic Disability Act established the forensic disability service (FDS) which is a purpose built facility that is currently resourced to provide care for up to ten individuals who are detained under a forensic order (disability). The Department of Communities, Child Safety and Disability Services (DCCSDS) is responsible for the FDS.

To support the operation of the FDS, the Forensic Disability Act made a range of amendments to the forensic provisions of the Mental Health Act 2000. Most significantly, the Mental Health Act was amended to provide the MHC with the authority to make a forensic order (disability), which authorises involuntary care for a person and, if required, detention in the FDS or an authorised mental health service (AMHS), which are the responsibility of the Health portfolio. As is the case with forensic orders generally, a person on a forensic order (disability) may be granted limited community treatment (LCT) which enables the person to go into the community for varying periods of time, including living in the community full-time. In these cases, the FDS or the relevant AMHS is accountable for the management of the order while the person is in the community.

A forensic order (disability) is distinct from forensic orders made for persons with a mental illness. Persons with an intellectual disability on a forensic order (disability) may be provided with involuntary care for the disability, while persons with a mental illness on a forensic order may be provided with involuntarily treatment and care for the mental illness. (‘Care’ is defined in the Mental Health Act to include the provision of rehabilitation, habilitation, support and other services).

For individuals with a mental illness on forensic orders, their treatment and care is coordinated through the mental health system, with regular reports provided by the treating psychiatrist to the Mental Health Review Tribunal outlining the ongoing treatment and care provided.

This is in contrast to care for individuals with an intellectual disability on forensic orders (disability) which takes place across the disability and mental health systems, depending on which service is accountable for the management of the order. If an AMHS is accountable for the management of the order, it is the treating psychiatrist who provides regular reports outlining the ongoing care and management of the person to the Tribunal. If the FDS is accountable for the management of the order, these reports are provided to the Tribunal by the senior practitioner (appointed under the Forensic Disability Act).

In addition, the care of persons with an intellectual disability within the forensic system takes place in the context of the provision of disability support and services more

\(^1\) An intellectual disability includes a cognitive disability.
broadly. Assessments under the *Disability Services Act 2006* about a person’s disability support needs are considered by the MHC when considering placing a person on a forensic order (disability) with approval to live in the community full-time. Determinations about eligibility, prioritisation, funding and disability support under the Disability Services Act are the responsibility of DCCSDS. These services are funded by DCCSDS with most being delivered by the non-government sector.

Any future proposals for the management of persons on forensic orders (disability) need to be cognisant of the scheduled review of the Forensic Disability Act from mid-2014 and the introduction of the National Disability Insurance Scheme (NDIS), where the care and support of forensic clients to be provided under the scheme is still to be determined at a national level.

### 11.2 Issues

The following issues in relation to forensic disability matters have been identified during the Review:

1. Greater clarity is required regarding the treatment and care that can be provided to persons with a dual diagnosis (i.e. mental illness and intellectual disability)
2. Enhanced accountability and consistency is required in relation to the management of individuals on forensic orders (disability)
3. The legislation should extend the expertise of clinicians assisting the MHC in hearings for an individual with intellectual disability, and
4. A need to ensure the co-existing application of an involuntary treatment order (ITO) and a forensic order (disability)

It should also be noted that there are a number of provisions in the Forensic Disability Act that are based on provisions in the Mental Health Act. As such, the proposed mental health legislation may result in consequential amendments being required for the Forensic Disability Act.

#### 11.2.1 Forensic orders for persons with dual diagnosis

The Mental Health Act enables the MHC to make either a forensic order or a forensic order (disability) where there is a finding of unsoundness of mind or unfitness for trial (section 288). Decisions about the type of forensic order are based on whether the finding of unsoundness or unfitness (whether temporary or permanent) is a consequence of an intellectual disability or a mental illness. If the Court considers the unsoundness or unfitness is due to an intellectual disability, the Court must make a forensic order (disability). If the Court considers the unsoundness or unfitness is not due to an intellectual disability, the Court must make a ‘standard’ forensic order.

A forensic order authorises involuntary treatment and care for a mental illness, while a forensic order (disability) authorises involuntary care for the disability.

Limiting the authority under a forensic order (disability) to the provision of care, ensures that individuals who have a finding of unsoundness or unfitness relating to an intellectual disability have the same rights as other members of the community to give consent to treatment for mental illness or, if consent is not possible, to have the treatment provided under the involuntary treatment provisions of the Mental Health Act, or the *Guardianship and Administration Act 2000*. 
However, numerous stakeholders have raised concerns about which forensic order is most appropriate for individuals with dual diagnosis of a mental illness and intellectual disability. In particular, stakeholders highlighted the complexities that can arise in attempting to clearly delineate between mental illness and intellectual disability in certain circumstances. This can add to complexities for the MHC in determining whether a person is unsound of mind or unfit for trial due to a mental illness or an intellectual disability. It may also not be possible for the MHC to definitively determine the basis for the unsoundness of mind at the time of the offence for persons with a dual diagnosis.

The MHC has commented on these issues in hearings following the introduction of the Forensic Disability Act. In *Re DKB* [2012] QMHC 6, Lyons J noted:

> Epilepsy is a mental disease and if DKB had been given a defence based on his epilepsy then he would have been placed on the normal forensic order… and the authorised psychiatrist could prescribe medication for his epilepsy. It would seem to me that if he is placed under a Mental Health Court – Disability forensic order then he is only detained for care… The authorised psychiatrist cannot therefore prescribe treatment for DKB’s epilepsy, depression or other mental illness but it would seem that the Adult Guardian could provide consent to this health care for at least his epilepsy. This would seem to be an anomaly.

Stakeholders presented varying views on how these complexities should best be addressed. In respect of the making of forensic orders, three options were considered by the Review:

1. Making it explicit that a forensic order (disability) and an ITO (for a mental illness) can apply at the same time
2. Broadening the factors the MHC may take into account when deciding the type of forensic order to make to include the person’s overall treatment or care needs, or
3. Removing the separate classifications of forensic orders, and have only one type of order that provides for both treatment and care.

Option 1 would require that the involuntary treatment of mental illness is only enforced under a forensic order where the unsoundness or unfitness is directly related to a mental illness. If this option is adopted, the pathways for individuals with intellectual disability to receive treatment and care for a co-existing mental illness will be clarified by making it explicit that a forensic order (disability) and ITO can co-exist. Under the proposed model, this would include the MHC having the authority to make an ITO for subsequent review by the Mental Health Review Tribunal.

However, this option is essentially the status quo and the complexities highlighted above in determining treatment needs, or where the basis of the unsoundness or unfitness decision is not clear, would continue to exist.

Option 2 would enable the MHC to decide the category of order based on the reasons for the unsoundness or unfitness, and the person’s treatment and care needs. For a person with a dual diagnosis, the Act would enable the MHC to make a ‘standard’ forensic order for the person if the Court believes the person requires involuntary treatment and care for a mental illness as well as care for the intellectual disability.

This option addresses the impracticality of the Court having to definitively decide the basis of the person’s unsoundness of mind or unfitness. This option would also ensure
there is a clear authority for individuals with dual disability to be provided with treatment and care for an intellectual disability and a mental illness. However, this option extends the authority of forensic orders to include treatment that may not be related to the alleged offence.

To support this option, the Tribunal would be given authority, in a review of a forensic order for a person with a dual diagnosis, to amend a forensic order to a forensic order (disability) if the person no longer required involuntary treatment for the mental illness.

Option 3 would provide a single co-ordination point for individuals on forensic orders regardless of their management needs. However, this option would revert to the previous model whereby the different treatment and care needs of persons with a mental illness and an intellectual disability become blurred, which has previously been criticised in reviews of the forensic scheme.

For the reasons outlined above, Option 2 is the proposed approach.

### 11.2.2 Management of forensic orders (disability)

The amendments to the Mental Health Act made by the Forensic Disability Act provide that persons with an intellectual disability on a forensic order (disability) can be detained in an AMHS as an alternative to the FDS.

As at December 2013, the FDS was responsible for ten individuals on forensic orders (disability). One of these clients had limited community treatment under the Forensic Disability Act to reside full time in a supported accommodation residence outside of the FDS.

Throughout the course of the review of the Mental Health Act, stakeholders raised concerns about the appropriateness of detaining a person with an intellectual disability in an AMHS which is established to support people with a mental illness.

As at December 2013, there were no persons on forensic orders (disability) detained in an AMHS. However, an AMHS was responsible for the management of a forensic order (disability) for 21 individuals, all of whom had approval to reside full time in the community.

As at December 2013:

- nine were receiving 24/7 support from DCCSDS-funded non-government agencies
- three were receiving very high levels of specialist support from DCCSDS or DCCSDS-funded non-government agencies and living in accommodation with family, and
- nine were receiving varying levels of support from DCCSDS or DCCSDS funded non-government agencies, ranging from no support, as they did not meet the eligibility criteria under the Disability Services Act, to limited support with specific areas of their lives (e.g. education or employment skill development).

As stated above (section 11.1), assessments under the Disability Services Act are considered by the MHC when considering placing a person on a forensic order (disability) with approval to live in the community full-time.

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Under the current arrangements, when a person on a forensic order (disability) has approval to live in the community full-time, an AMHS is likely to be assigned accountability for managing the order. However, the AMHS has a limited role in providing care to the person. Prior to the order being made, DCCSDS may advise that the person is assessed as eligible for services under the Disability Services Act and recommend a specified level of care. While the MHC may make an order based on this advice, the services provided under the Disability Services Act are not binding under the forensic order.

For example, in a recent case that was appealed to the MHC, the care being delivered by a non-government disability service provider to a person on a forensic order (disability) was withdrawn, resulting in the Tribunal not being satisfied that the person was not an ‘unacceptable risk to the community’. This meant that an admission to an acute care unit of an AMHS was the only way this risk could be addressed until such time as alternative disability service care and support could be provided.

This situation, where responsibility for managing a forensic order (disability) for a person is not aligned with responsibility for the provision of disability support care and services, can be detrimental to the person’s care and compromise the protection of the community. This may be further complicated by Queensland’s commitment to commence transition to the NDIS from 2016, as the Queensland Government will no longer provide specialist disability services to those people whose needs are intended to be met by the NDIS.

This issue has been highlighted in reviews of forensic orders (disability) before the Tribunal, where an AMHS which has legislative responsibility for management of the order but no day-to-day involvement in a person’s care, is required to appear before the Tribunal to report on the person’s management and care plan. Currently, DCCSDS as funder or provider of the care to the person, is not required under the legislation to attend hearings or provide any information to the Tribunal. Information about the care being provided to forensic disability patients in the community is largely dependent on informal communication channels directly between the AMHS and the disability service provider.

Given the importance of the MHC and Tribunal in safeguarding persons on orders and protecting the community, legislative and administrative processes need to be revised and aligned to enable effective implementation and monitoring of forensic orders.

Stakeholders have expressed the strong view that the agency responsible for providing care to persons with a disability should also be accountable for the management of the person’s forensic order.

It is proposed that the legislative, administrative and operational arrangements for the management of forensic orders and the care of a person on a forensic order (disability) be aligned.

It is also proposed to simplify the processes for transfers between an AMHS and the FDS. Currently the provisions are unnecessarily complex and, in practice, transfers have been agreed to by the Director of Forensic Disability and the DMH on a case-by-case basis. A memorandum of understanding could be developed across the two statutory positions outlining the collaborative working arrangements for this client group.
11.2.3 Expertise of clinicians assisting the MHC in hearings for an individual with an intellectual disability

Under the Mental Health Act, the MHC judge must be assisted by two assisting psychiatrists (section 382).

The Act sets out the specific functions of the assisting psychiatrists, which is primarily to advise the MHC on clinical issues relevant to the proceedings. Any advice the assisting psychiatrists provided to the judge must also be provided to the parties to a proceeding. Assisting psychiatrists do not have an examining role, but provide advice by analysing and clarifying the meaning of the clinical evidence.

While experienced psychiatrists of the calibre of those who assist the MHC can be expected to have a general knowledge of all kinds of conditions that may affect the functioning of the brain, their primary professional expertise is in the field of mental illness. Stakeholders have highlighted that there may be other clinical specialists who would be of equal or greater assistance to the MHC in hearings where issues regarding intellectual disability are raised. This could include, for example, forensic psychologists specialising in intellectual disability.

It is proposed that the Act allow a person with this type of expertise to assist the MHC in hearings involving persons with an intellectual disability.

11.2.4 Co-existing application of an involuntary treatment order and forensic order (disability)

Under the Mental Health Act, when a forensic order of any type is made for a person, a pre-existing ITO that is in force before the making of the forensic order ends (section 290). This does not take into consideration that when a forensic order (disability) is made, an ITO may have previously been made for the person to address a person’s co-existing mental illness.

The unintended result of this is that a person for whom a forensic order (disability) is made, who also has a co-existing ITO for a mental illness, is no longer able to be treated involuntarily for a mental illness once the forensic order is made.

Regardless of the approach taken in section 11.2.1, the dual application of an ITO and a forensic order (disability) will need to be provided for in the Act. This is to ensure that a person on a forensic order (disability) is able to appropriately access involuntary treatment under the Mental Health Act at any stage if required, regardless of his or her forensic status.
Review of the Mental Health Act 2000

Background Paper

May 2014
12. Guardianship and Attorneys

12.1 Background

The Guardianship and Administration Act 2000 (the Guardianship Act) and the Powers of Attorney Act 1998 establish a legislative scheme that, among other things, authorises the provision of health care to adults with impaired capacity without the adult’s consent at the relevant time. Chapter 5 of the Guardianship Act deals specifically with health matters and special health matters.

Where an adult has impaired capacity such that the adult cannot consent to health care, the legislation outlines how health care is to be authorised. For this purpose, the Guardianship Act distinguishes between ‘health care’ and ‘special health care’.

‘Health care’ generally means care or treatment of, or a service or a procedure for, an adult:

a) to diagnose, maintain, or treat the adult’s physical or mental condition, and

b) carried out by, or under the direction or supervision of, a health provider.

‘Special health care’ means organ donation, sterilisation, pregnancy termination, participation in medical research, electroconvulsive therapy (ECT) and psychosurgery.

The Queensland Civil and Administrative Tribunal (QCAT) may give consent for special health care other than ECT or psychosurgery.

Chapter 5 (section 63) of the Guardianship Act also deals with the provision of health care, other than special health care, in urgent circumstances. Under this chapter, a health provider may provide health care, other than special health care, to an adult with impaired capacity in urgent circumstances if:

• the provider believes the health care should be carried out urgently to meet imminent risk to the adult’s life or health (section 63(1)(b)(i)), or

• the provider believes the health care should be carried out urgently to prevent significant pain or distress to the adult and it is not reasonably practical to get consent from a substitute decision-maker, such as a personal guardian (section 63(1)(b)(ii)).

The legislation places restrictions in the exercise of this authority, namely:

• for health care to meet imminent risk to the adult’s life or health – that the health care may not be provided if the health provider knows that the person objects to the health care in an advance health directive, and

• for health care to prevent significant pain or distress to the adult - that the health care may not be provided if the person objects to the health care unless the adult has minimal or no understanding of the health care to be provided and the health care is likely to cause the adult no distress of temporary distress.

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1 See the Guardianship and Administration Act 2000, Schedule 2, section 5.
2 See the Guardianship and Administration Act 2000, Schedule 2, section 7.
3 See the Guardianship and Administration act 2000, section 68.
The Guardianship Act (section 79) establishes an offence for a person to carry out health care of an adult with impaired capacity unless:

- the Guardianship Act or another Act provides that the health care may be carried out without consent
- consent is given under an Act, or
- the health care is authorised by a court in its parens patriae jurisdiction.

Section 38 of the Powers of Attorney Act specifically deals with the situation where an involuntary patient has given a direction about the person’s health care (or special health care) in an advance health directive or otherwise. The section provides that an interpretation of the Mental Health Act 2000 that is consistent with the Powers of Attorney Act and the direction is to be preferred to any other meaning. However, the Mental Health Act prevails in the case of an inconsistency.

This means, for example, that involuntary treatment may be provided to a patient if permitted under the Mental Health Act, even if the person's advance health directive does not consent to the treatment.

12.2 Issues

The Guardianship Act and the Mental Health Act work effectively together, particularly as section 79 of the Guardianship Act expressly permits health care to be provided without consent if authorised under another Act.

However, some stakeholders identified some confusion in having to consider the two Acts together in emergency circumstances – i.e. where a person is brought into an emergency department under an emergency examination order (under the Mental Health Act), and is then treated under the ‘urgent healthcare’ provisions (section 63) of the Guardianship Act.

To clarify this, it is proposed to include a note in the relevant sections of the proposed mental health legislation stating that the emergency transport and examination provisions of the Act do not affect the operation of the Guardianship Act, particularly section 63 (Urgent health care).

In addition, the Mental Health Act provides that ECT may be performed on a person if the person has given informed consent to the treatment or the Mental Health Review Tribunal approves the treatment (sections 138 and 139). In addition, the Mental Health Act authorises ECT to be performed in emergency circumstances where it is necessary to save a person’s life or prevent the patient from suffering irreparable harm. The doctor must then apply to the Tribunal to continue the treatment.

The Guardianship Act deals with urgent health care in general terms, while the Mental Health Act deals with the performance of ECT in an emergency. However, the urgent health care provisions in the Guardianship Act do not apply to special health care (such as ECT), so no legislative conflict arises.

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4 ‘Parens patriae’ refers to the inherent power of a court to make decisions concerning people who are not able to take care of themselves (e.g. children, impaired persons).
Review of the Mental Health Act 2000

Background Paper

May 2014
13. **Restraint and Seclusion**

13.1 **Background**

13.1.1 **Restraint**

The *Mental Health Act 2000* regulates the use of mechanical restraints on involuntary patients in an authorised mental health service (AMHS). A mechanical restraint is an appliance that prevents the free movement of a person’s body or a limb. The term ‘mechanical restraint’ is the nationally accepted term for these devices, notwithstanding that the devices are not, in fact, mechanical in nature.

The Act creates an offence for using a mechanical restraint on an involuntary patient in an AMHS unless it is used in accordance with the Act. The Director of Mental Health (DMH) approves mechanical appliances that may be used to restrain patients. Currently, the DMH has approved the use of a “wrist cuffs to waist belt”, which is a band fastened around the waist linking to bands fastened around the wrists.

Under the Act, a doctor may authorise the use of a mechanical restraint if the doctor is satisfied it is the most clinically appropriate way of preventing injury to the patient or someone else. An authorisation lasts no longer than three hours. The administrator of an AMHS must give written notice to the DMH about the use of the restraint as soon as practicable after it is applied.

The use of mechanical restraint is largely restricted to the high security unit at The Park. The 2012-13 Annual Report of the Director of Mental Health states (p.32) states:

> In the current reporting period, mechanical restraint was applied to 14 patients. Nine of the 14 patients were part of a specific program which aims to reduce the use and duration of seclusion for certain patients in The Park High Security AMHS. Mechanical restraints are used with these patients to increase access to the open ward, which in turn increases their opportunity for socialisation and access to activities. Mechanical restraints are applied when the patient leaves their room to enter the open ward environment. Of the 2197 instances of mechanical restraint in the reporting period, 2158 (98 percent) pertain to patients in this program.

13.1.2 **Seclusion**

The Act also regulates the use of seclusion of involuntary patients in an AMHS. Seclusion is the confinement of a patient at any time of the day or night in a room or area from which free exit is prevented. The Act creates an offence for secluding an involuntary patient in an AMHS other than as provided for under the Act.

Seclusion may be authorised by a doctor (by 'written order') or, in urgent circumstances, by the senior registered nurse on duty. Seclusion may only be authorised if it is necessary to protect the patient or other person from imminent physical harm and there is no less restrictive way of ensuring the safety of the patient or others. Seclusion may only be authorised for a period of up to three hours.
During this time, the patient must be continuously observed unless the doctor authorises that it is not clinically necessary to do so, in which case the patient must be observed at intervals of no longer than 15 minutes as determined by the doctor. The administrator of an AMHS must notify the DMH about the seclusion as soon as practicable after it occurs.

Data on seclusion events for 2012-13 is provided below:

<table>
<thead>
<tr>
<th>Table 13.1 State-wide Clinical Indicators of Seclusion - 2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute in-patient</strong></td>
</tr>
<tr>
<td>Seclusion events per 1000 accrued patient days</td>
</tr>
<tr>
<td>12.7</td>
</tr>
</tbody>
</table>

* ‘Episode’ refers to an episode of care, such as a total hospital stay from admission to discharge or, if the type of care changes (e.g. from acute care to rehabilitation), the part that relates to each type of care.

(Source: Director of Mental Health Annual Report, 2012-13)

### 13.2 Issues

#### 13.2.1 Restrictive practices

The use of restraint and seclusion needs to be viewed in the wider context of the use of restrictive practices by health service facilities when patients are displaying challenging behaviours such as aggression, destructiveness, self-injury or other behaviours where the safety of the person or others is placed at risk. In these circumstances, various forms of restrictive practices may be used, namely:

- **Seclusion** – the involuntary confinement of a person on his or her own in a room or area from which exit is prevented
- **Containment** – physically preventing a person from leaving premises
- **Chemical restraint** – the use of medication for the primary purpose of controlling a person's behaviour
- **Mechanical restraint** – the use of the device to restrict the free movement of a person
- **Physical intervention** – the use of physical force by one person on another person to restrict the free movement of the person.

The legal authority to undertake restrictive practices derives from many Acts and the common law and is, by virtue of that fact, complex. The use of restrictive practices may lawfully be undertaken under the *Guardianship and Administration Act 2000*, the Criminal Code, workplace health and safety laws, and the common law. Whether restricted practices may be used, and how they are used, is dependent on the circumstances at the particular time.
Some public sector hospitals have policies and procedures in place that outlines the rights and obligations of health practitioners and other health service employees in using restrictive practices.

13.2.2 Reduction or elimination of seclusion and restraint

The use of seclusion and mechanical restraint on involuntary patients is a restriction on a person's liberty and should only be used in tightly defined circumstances. The 2012 National Report Card on Mental Health and Suicide Prevention includes a recommendation to reduce the use of involuntary practices and work to eliminate seclusion and restraint. The report card includes an action for all jurisdictions to contribute to a national data collection to provide information on seclusion and restraint.

The Act currently provides tight safeguards in relation to the use of seclusion and mechanical restraint. This is an appropriate framework within which strategies to reduce or eliminate seclusion and mechanical restraint can be implemented.

The DMH is also empowered under the Act to issue policies and practice guidelines about the treatment and care of patients. This includes policies and practice guidelines about the use of restraint and seclusion.

13.2.3 Extension of seclusion and mechanical restraint

The Act provides that seclusion and mechanical restraint may only be put in place for a maximum period of three hours.

No other jurisdiction places a statutory time limit on seclusion or mechanical restraint. If the criteria for seclusion or restraint are still met after three hours, the treating clinician may make another order or authorisation. This safeguard ensures that the treating clinician makes an assessment of the criteria on at least a three hourly basis. However, the Act would be more transparent if it expressly stated that further consecutive orders or authorisations may be made, and the basis on which they can be made.

The DMH has put in place administrative arrangements to support the legislation in relation to seclusion and restraint. For seclusion, the administrative arrangements require an AMHS to notify the DMH if seclusion if used for a patient three times within a day. This policy effectively determines how seclusion may be notified, as is required under the Act. For patients in the high security unit, the DMH may approve an individual management plan for a patient – called a "seclusion/restraint use minimisation plan". The plan addresses current presentation, psychiatric history, risk assessment, and management strategies employed to date. The clinical director of the high security unit reports weekly against the plan.

13.2.4 Relationship with other laws

During the Review, some uncertainty was expressed about the use of mechanical restraints by police officers and security staff. The most common concern was whether police could use hand-cuffs on a person who was engaging in challenging behaviour when brought into an emergency department that was part of an AMHS.
From a legal perspective, the various laws that allow the use of force can be applied concurrently. For example, the Police Powers and Responsibilities Act 2000 may permit the use of hand-cuffs on a person in an emergency department notwithstanding that the Mental Health Act also authorises the use of mechanical restraints in an AMHS.

It is however important that this matter be clarified in the legislation by stating that the mechanical restraint and seclusion provisions under the Act do not prevent the use of a mechanical restraint or seclusion under other laws.

13.2.5 Approval of mechanical restraint

In practice, mechanical restraint is used almost exclusively in the high security unit at The Park. The Review provides the opportunity to better reflect existing practices by stating that mechanical restraint is only to be used in a high security unit or another service approved by the DMH.

As an additional safeguard, it is proposed that the use of mechanical restraint is only to be used with the prior approval of the DMH.

13.2.6 Notification to Director of Mental Health

Given the strict statutory restrictions on the use of mechanical restraint and seclusion, the value of requiring a service to report to the DMH on the use of mechanical restraint or seclusion ‘as soon as practicable’ is of limited value, particularly if the proposal for prior DMH approval of mechanical restraint is adopted. Requiring notification ‘as soon as practicable’ also suggests that the DMH will take some action on being notified, which is unlikely to be warranted.

As an alternative, it is proposed that the Act require the DMH to issue binding policies on the use of mechanical restraint and seclusion to minimise its use and its impact on patients. This could include more frequent reporting from a particular AMHS if the DMH had concerns about the use of seclusion in that service. The Act should also enable the DMH to direct that seclusion not be used in a specific AMHS or not be used for a specific patient.

13.2.7 Other areas for improvement

An analysis of the mechanical restraint and seclusion provisions in the Act has identified areas where improvements could be made to the provisions. It is proposed to:

- re-draft the definition and mechanical restraint offence, as the current offence, which relies on the definition of ‘mechanical restraint’ as being an approved mechanical restraint, is ineffective
- amend the definition of ‘seclusion’ to exclude circumstances where the person asks to be left in a room (e.g. for privacy) and to clarify the meaning of ‘overnight’ which is excluded from being seclusion in a high security unit
- clarify that a registered nurse may release a person from seclusion where the nurse placed the patient in seclusion in urgent circumstances
• improve consistency in the provisions dealing with mechanical restraint and the provisions dealing with seclusion, and
• simplify the recording and reporting of seclusion and restraint.
14. Regulated Treatments

14.1 Background

14.1.1 Psychosurgery

Psychosurgery is a regulated treatment under the Mental Health Act 2000. Psychosurgery is defined under the Act as:

- a neurological procedure to diagnose or treat mental illness, but does not include a surgical procedure for treating epilepsy, Parkinson’s disease or another neurological disorder.

Other neurological disorders excluded from the definition of psychosurgery include chronic tic disorder, tremor or dystonia.

Although not expressly stated in the Act, psychosurgery would include the more recently developed treatment of deep brain stimulation when used to treat a mental illness.

Psychosurgery involves serious risks and has potentially irreversible side effects. As such, this form of treatment must be considered as a treatment of last resort.

However, unlike other areas of the Act, psychosurgery can only be performed on a person with the person’s informed consent.

The Act provides that psychosurgery can only be performed under the Act if:

- the person has given informed consent to the treatment, and
- the Mental Health Review Tribunal has given approval for the treatment.

It is an offence to perform psychosurgery other than in accordance with the Act.

Psychosurgery is ‘special health care’ under the Guardianship and Administration Act 2000 (see Background Paper 12).

14.1.2 Electroconvulsive therapy

Electroconvulsive therapy (ECT) is also a regulated treatment under the Act.

ECT is defined under the Act as:

- the application of electric current to specific areas of the head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent.

ECT involves the activation of part of the brain with an electrical stimulus to produce a brief convulsion (fit) which is monitored and controlled within a medical setting. The treatment is delivered under anaesthetic.

ECT is primarily used as a treatment for major depression, mania, some forms of schizophrenia and may be used for some other mental disorders where the condition is causing serious distress.

ECT can only be performed under the Act if:

- the person has given informed consent to the treatment, or
- the Tribunal has given approval for the treatment, or
• a psychiatrist and medical superintendent authorise its use in an emergency situation (which requires the issuing of an emergency certificate).

During 2012-2013, there were 357 applications heard by the Tribunal for general ECT, and 105 emergency ECT applications\(^1\).

ECT is ‘special health care’ under the Guardianship and Administration Act 2000 (see Background Paper 12).

### 14.2 Issues

#### 14.2.1 Psychosurgery

To date, psychosurgery has not been authorised for use in Queensland under the Act. However, in other jurisdictions in Australia (for example, in Victoria) and internationally, psychosurgery, particularly deep brain stimulation, has become a recognised treatment for major depression and obsessive compulsive disorder.

Despite no authorisations under the Act occurring to date, a number of stakeholders have identified issues with the provisions of the Act that relate to psychosurgery including:

- a lack of clarity about what is encompassed by the term ‘psychosurgery’, including that the term is out-dated and has negative associations
- whether the definition of psychosurgery should include deep brain stimulation, and
- increased reporting requirements for the Tribunal.

The use of psychosurgery on persons under the age of 18 was also raised by some stakeholders - specifically, whether the procedure should be restricted to adults. However, these risks are effectively mitigated under the legislation by the requirement for informed consent to be given for psychosurgery and the requirement for Tribunal approval.

A number of stakeholder submissions expressed strong concerns about the use of psychosurgery as a treatment for mental illness under any circumstances. These submissions highlighted the prohibition of the treatment in other jurisdictions namely, New South Wales and the Northern Territory. Comparatively, however, psychosurgery is regulated in Western Australia, Victoria, Tasmania, South Australia and the Australian Capital Territory. These jurisdictions all have similar requirements to Queensland regarding informed consent and Tribunal or committee approval.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Position Statement on Neurosurgery for Mental Disorders (October 2009) provides that it is ‘an established treatment which is effective for a proportion of highly selected patients. … It is used to treat severe and incapacitating mental disorders when all other attempts at treatment have failed and the alternative is continuing suffering for the patient’.

Having regard to the divergent views among stakeholders regarding the treatment, it is important to retain a regulated approval process and relevant safeguards in the proposed Act.

\(^1\) Source: Mental Health Review Tribunal Annual Report 2012-13
• Definition and scope of ‘psychosurgery’

In relation to contemporary terms for the treatment, the RANZCP utilises the term ‘neurosurgery for mental disorders’ in its position statement on psychosurgery. An alternative term proposed by stakeholders is the term ‘neurosurgery for psychiatric conditions’. It is proposed to update the definition using this terminology.

Although there has not been an approval of psychosurgery under the Act to date, feedback from stakeholders presented differing views as to the types of procedures that should be captured under the Act.

The focus of these submissions has centred on differentiating between ‘ablative’ and ‘non-ablative’ procedures. Ablative procedures involve the creation of focal lesions in the brain, while non-ablative procedures involve the use of brain stimulation techniques. The primary difference between these procedures is that non-ablative procedures (such as deep brain stimulation) do not have the primary objective of producing an irreversible lesion in the brain, but rather the procedure aims to stimulate one or more regions of the brain.

These two categories of psychosurgery would both be captured under the Act, although the use of deep brain stimulation for mental illness would not have been envisaged when the Act came into force - that is, the initial intention of the provisions for psychosurgery was to ensure that irreversible procedures were not undertaken without an appropriate review occurring first. It should also be noted that non-ablative procedures such as deep brain stimulation are performed to treat other conditions such as Parkinson’s disease.

The RANZCP excludes non-ablative procedures from its Position Statement on Neurosurgery for Mental Disorders.

If non-ablative procedures were included in the definition, deep brain stimulation to treat mental illness for persons with capacity to consent could only be undertaken if approved by the Tribunal. This is different to circumstances where the procedure is performed for purposes other than a mental illness, where informed consent only is required. For persons without capacity, the procedure could not be performed under any circumstances for a mental illness, but could be performed for other purposes under an advance health directive only (as required under the Guardianship and Administration Act).

If non-ablative procedures were not included in the definition, the safeguards in the Guardianship and Administration Act would continue to apply to deep brain stimulation. This would mean that if the person had capacity, the person’s informed consent would be required. If the person did not have capacity, the procedure could only be performed under an advance health directive. This would apply regardless of whether the procedure was for a mental illness or another purpose.

It is considered that the safeguards under the Guardianship and Administration Act are adequate and, for consistency across this type of procedure for different conditions, it is proposed that non-ablative procedures be excluded from the definition of neurosurgery for psychiatric conditions.

• Reporting requirements to the Tribunal in respect of psychosurgery

Under the Victorian Mental Health Act 1986, a neurosurgeon who performs psychosurgery under the Act must provide a written report to the Psychosurgery.
Review Board on the efficacy of the procedure within three months after the completion of surgery. Additionally, the psychiatrist who has prescribed the treatment must report to the Review Board within three months after the procedure, and again within the following 12 months. During the consultation period, one stakeholder proposed that consideration be given to including similar provisions for Queensland.

It is not apparent that this type of provision is needed given that psychosurgery has never been authorised under the Mental Health Act in Queensland. There are also adequate safeguards in the Act, namely the requirement for clinical members to be included on the Tribunal (e.g. two psychiatrists and a neurosurgeon) that ensures there is significant clinical expertise for hearings about psychosurgery without the need to include a regulated reporting regime on specific patients. No other specific treatment in the Act requires reporting on its efficacy to be provided to the Tribunal and, given that any procedure needs to be tailored to an individual patient’s needs, the outcome to be achieved by the Tribunal reviewing the efficacy of a particular procedure is not evident.

14.2.2 Electroconvulsive therapy

The following issues were raised by stakeholders in respect of ECT:

- the need to clarify the definition
- possible restrictions on the number of procedures the Tribunal may approve at a hearing
- legislated timeframes for hearing notices by the Tribunal following an emergency ECT
- the timeliness of hearings for an appeal against a decision of the Tribunal to approve ECT, and
- improving processes after emergency ECT.

The use of ECT on persons under the age of 18 was also raised by some stakeholders - specifically, whether the procedure should be restricted to adults. However, these risks are effectively mitigated under the legislation as ECT may only be performed with informed consent or with Tribunal approval. In emergency circumstances, a review of the treatment is required by the Tribunal.

Some stakeholders voiced strong views on the use of ECT as a treatment for mental illness, including concerns that the treatment may be used excessively, rather than as a last resort treatment.

The RANZCP has issued a position statement on the use of ECT as a treatment for mental illness – Electroconvulsive Therapy (August 2013). This statement provides that ECT is a ‘highly effective treatment with a strong evidence base’. A number of clinical stakeholders expressed similar views during the consultation on the Review, with a number recommending that ECT should be viewed in a similar manner to involuntary medication.

Having regard to the divergent views across stakeholders in respect of ECT, it is appropriate that the treatment remain regulated as a distinct treatment under the proposed Act.
• **Definition of ECT**

The above definition of ECT (section 14.1.2) does not specifically refer to treatment for a mental illness. Submissions proposed that the definition clarify that the use of ECT is for the treatment of a mental illness, which is supported.

• **Restriction on the number of procedures the Tribunal may approve**

One stakeholder proposed that consideration be given to limiting the number of treatments that can be approved by the Tribunal to a maximum of 12 treatments over 90 days for ongoing ECT. The benefits of restricting the number of treatments were seen as a way of achieving greater consistency with recognised research, standards and practice. For example, the Queensland Health guidelines for ECT for consumers and carers provide that ‘typically, 6 to 12 treatments are administered (two to three times a week)’.

However, as the decision-maker, the Tribunal can implement practice guidelines or directions in respect of the number of ECT treatments that may be approved, and over what time period. It is therefore not proposed to include this matter in legislation.

• **Timeframes for hearing notices by the Tribunal following an emergency ECT**

When issuing an emergency certificate for ECT under the Act, the psychiatrist must also make an application to the Tribunal for approval to administer ECT. On receiving an application, the Tribunal must provide two days’ notice of a hearing date for the application (section 232).

Advice to the Review indicates that the requirement for two days’ notice to be provided prior to a hearing can result in up to three ECT procedures being completed prior to the Tribunal hearing the application. While there is a need to clearly ensure parties are given appropriate notice to participate in a hearing, the legislated requirement has raised concerns for some stakeholders in respect of being assured that there is no impediment to the Tribunal reviewing the application as soon as possible.

To remedy this, the proposed Act will allow the patient or the patient’s representative to waive the two days’ notice.

• **Timeliness of hearings for an appeal**

A decision of the Tribunal on an application for ECT may be appealed to the Mental Health Court (MHC). The MHC must give seven days’ notice of the hearing (section 322).

Similar to the issues raised above in respect of legislated timeframes for Tribunal hearings, if an appeal of ECT is lodged with the MHC, it is important that there are no barriers to the appeal being heard expeditiously, provided all parties are sufficiently made aware of the hearing.

To remedy this, the proposed Act will allow the patient or the patient’s representative to waive the seven days’ notice.

• **Emergency ECT**

In issuing an emergency certificate for ECT, the psychiatrist must also make an application to the Tribunal for approval to administer ECT (section 140).
The purpose of requiring a treatment application to be made to the Tribunal when emergency ECT is performed is to ensure that the treatment is reviewed and, if appropriate, ongoing treatment approved, as soon as practicable by the Tribunal. However, stakeholders have advised that, in some circumstances, an application has been made to the Tribunal for ECT under of the Act, and while waiting for this application to be heard, the person’s mental state deteriorates to an extent that emergency ECT is required. In these circumstances, a second application is required to be made to the Tribunal.

The provision of a second application in these circumstances is unnecessary and leads to multiple applications being made for the same patient. To remedy this, it is proposed that where an existing application for ECT has been made to the Tribunal, the psychiatrist be required to notify the Tribunal if emergency ECT is undertaken, rather than requiring a new application to be made.
Review of the Mental Health Act 2000

Background Paper

May 2014
15. Transport Issues

15.1 Background

Various provisions of the Mental Health Act 2000 provide for the transport of persons to, from, and within authorised mental health services. This may be required for a person’s examination or assessment, to take a person to or from court, to take a person to an authorised mental health service (AMHS) after a court order, or to return a patient to an AMHS under numerous circumstances.

15.2 Issues

Clear transport provisions within the Act are necessary to ensure that patients subject to the examination, assessment or treatment provisions of the Act can be safely conveyed to, from, or within an AMHS as required.

The Review identified the following issues in relation to the transport provisions in the Act:

1. Inconsistent powers in the Act for the transport of persons
2. Clarifying when police assistance is required
3. Using mechanical restraints for safely transporting patients of the high security unit
4. Clarifying the involuntary status of a patient who attends court by videoconference from an AMHS
5. Extending circumstances where an AMHS must be responsible for returning a person to the community if he or she has been involuntarily transported to an inpatient facility
6. Clarifying the provisions that authorise the return to an AMHS of an involuntary patient
7. Clarifying when a warrant is required to enter a place to detain a person, and
8. Whether intubation of patients on flights has adequate regard to clinical considerations.

15.2.1 Inconsistent powers to transport persons

An assessment of the transport provisions in the Act, and the powers that may be exercised under these provisions has found that the powers are inconsistent, unclear and deficient in their application.

For example, under section 26, a person subject to assessment documents may be administered medication to transport them to an AMHS in circumstances where it is necessary to ensure the safety of the patient or others. Where a doctor is satisfied that this is the case, the medication may be administered by a doctor or a registered nurse under the specific instructions of a doctor. There is, however, no equivalent provision enabling the administration of medication to a classified patient for the purpose of transporting the person from a place of custody to an AMHS.
In some cases, there are no relevant powers at all. For example, there is no provision for persons to be transported, with or without police assistance if they are approved for a temporary absence for a medical, legal or other stated purpose.

It is critical that the transport provisions within the Act be clear and transparent to safeguard patients’ rights and to ensure that persons responsible for patient movements have clear legal frameworks within which to operate.

The proposed legislation will therefore include one set of provisions that consistently authorises the transport of persons to, from, and within authorised mental health services (including while temporarily absent), who is authorised to transport the person, the use of reasonable force, and the authority to administer medication if required.

The consistent application of transport provisions will:

- provide for health service employees to transport involuntary patients on their own or with police assistance if requested
- provide an ability for police to act alone in all circumstances when transporting involuntary patients
- provide an ability for corrective services staff or detention centre officers to act alone in all circumstances when transporting patients who are moved between a correctional facility and an AMHS, and
- provide authority for medication and reasonable force to be authorised by an authorised doctor for the purposes of safely transporting a person to, from, or within, an AMHS, under any involuntary process.

The use of reasonable force and medication will be subject to safeguards within the legislation, including the requirement for an authorised doctor to approve the use of medication, and its administration overseen by an authorised doctor or a registered nurse.

The proposed legislation will also clarify that patients on involuntary treatment orders may be moved within an AMHS, or between services, without a requirement to be accompanied by a health practitioner (e.g. with family or other support persons) if it is not clinically required.

### 15.2.2 Police assistance

The Queensland Police Service is frequently called upon to provide assistance in transporting involuntary patients to and from an AMHS. This may be required where a patient has left an in-patient facility without permission, failed to return after unescorted leave, or failed to attend a scheduled appointment while living in the community. The circumstances in which police are required may be indicated by clinical need or risk to the person or the community.

However, it is important that requests for police assistance only be utilised when there is a clinical or risk-related need, and not simply as a matter of practice.

To ensure that police resources are used effectively, it is proposed that where police assistance for transport is requested, the requesting AMHS must advise police of the reason that the person requires transportation, why police assistance is required, and risk information about the individual. The risk information would need to include information on current behaviours that may give rise to concerns about risks to the person or the community. The information would be provided despite any issues about
patient confidentiality or privacy. This will enable police to respond with the appropriate degree of priority to the request and in the appropriate way.

In addition, the proposed Act will clarify that police are to provide assistance, of the nature and in the time, that is reasonable in the circumstances, having regard to the reason the person is to be transported, and the risk information provided by the AMHS.

15.2.3 Use of mechanical restraints

There are circumstances where patients of the high security unit need to be transported from the high security unit to another place. Reasons for this transportation include moving to another AMHS, needing to obtain specialist medical treatment, attending a court hearing or for a specified purpose for compassionate reasons (e.g. to attend a funeral).

In some circumstances, the use of mechanical restraints may be appropriate to facilitate the safe transportation of the patient outside of the high security unit. However, there is currently no provision under the Act for this to occur.

The proposed legislation will enable the use of mechanical restraints when transporting high security patients, if clinically required, to ensure the safety of the patient or others. The use of restraints for this purpose would be subject to the same safeguards and requirements that apply to the use of restraints in other circumstances under the legislation, as well as be subject to policy and procedural requirements issued by the Director of Mental Health (DMH).

15.2.4 Appearances before court

A number of provisions within the Act enable an involuntary patient, under certain circumstances, to be ‘brought before a court’ to enable decisions about an alleged offence, or a custodial status, to be made. For example, a classified patient under a court assessment order is to be brought before court within three days of the DMH notifying the Chief Executive for Justice that the patient no longer needs to be detained in an AMHS (section 87).

Where a person is required to appear before a court, it is often the practice for the person to appear via video-link from an AMHS. This is particularly the case for patients of the high security unit. Once the patient appears before the court, various provisions of the Act provide that the patient’s involuntary status under the Act ceases (see, for example, section 219). As a result, it is not clear how the patient can be detained in the AMHS following the hearing.

The legislation needs to clarify the arrangements for a patient to appear before a court via video-link, including clarifying the power to detain a patient if the patient’s status under the Mental Health Act changes as a result of court proceedings via video-link.

15.2.5 Returning persons to relevant place

Some provisions of the Act require the relevant AMHS to make arrangements for a person’s return to the place from which the person came, or another reasonable place, if the person was involuntarily detained and transported to the AMHS. This applies, for example, if assessment documents are not made for a person who is the subject of an emergency examination order (section 41).
However, the circumstances under the Act where an AMHS is responsible for ensuring a person is returned to a reasonable place do not apply in all situations where a person is taken to an AMHS involuntarily. For example, if a person is involuntary detained under an involuntary treatment order for 2-3 days, there is no requirement for the person to be safely returned from where the person was detained. This may be a significant distance in regional, rural and remote areas of Queensland.

Given that a person is involuntarily taken from a place (e.g. the person’s home) to an AMHS, it is reasonable for the legislation to provide for the person’s safe return to the community in all circumstances. It is therefore proposed that the Act provide that the administrator of the relevant AMHS be required to ensure that a person is reasonably returned to a place in all situations where a person has been admitted to an AMHS under any involuntary process of the Act.

15.2.6 Clarifying the authority to return an involuntary patient to an authorised mental health service

The Act establishes mechanisms to return involuntary patients who are absent without permission to an AMHS to facilitate their assessment, treatment or care.

Section 508 provides authority for a person to be involuntarily taken to an AMHS by a health practitioner or police as outlined below:

- if an authorised doctor requires the person’s return under the following circumstances:
  - to complete a person’s involuntary assessment
  - to give effect to a change in the patient’s treatment plan
  - to give effect to a decision or order of the Mental Health Review Tribunal or Mental Health Court, or
  - if the authorised doctor reasonably believes the patient has not complied with the patient’s treatment plan and it is necessary in the interests of the health and safety of the patient or others
- if a patient’s temporary absence is revoked by the DMH or if the patient does not return to the AMHS at the end of the temporary absence period
- if a patient under a court order unlawfully absents themselves from the AMHS, and
- if a patient is required to return to an AMHS due to a suspension of limited community treatment by the DMH.

The DMH has issued guidelines to clarify when patients are considered to be absent without permission. While these guidelines provide operational guidance to authorised mental health services, the Act itself provides inadequate clarity about when a person may be detained and returned to an AMHS. For example, the ability for a doctor to require a patient’s return to ‘give effect to a change in the patient’s treatment plan’ has no clear parameters for when this situation may be applied. Additionally, if a period of approved leave ends and the person does not return, it is not explicit within the Act that a health practitioner or police has authority to return the person involuntarily to an AMHS.

Where a patient is considered absent without permission, the person should be given the opportunity to return to the AMHS voluntarily if it is clinically appropriate and there
are no immediate concerns in regard to the safety of the patient or others. The Act should clearly provide for this process, as well as the legal authority for persons to be returned involuntarily.

15.2.7 Entry of places and warrants

The Act makes provision for the entry of places and for warrants to be issued under certain circumstances (Chapter 14, part 2).

In addition, police are authorised under the Police Powers and Responsibilities Act 2000:

- to enter premises to arrest or detain someone or enforce a warrant (section 21), and
- to enter a place if there is an imminent risk of injury to the person, damage to property or domestic violence (section 609).

Although not explicit in the Act, section 21 of the Police Powers and Responsibilities Act authorises police to enter a place without the consent of the occupier if any of the following categories of patients are required to be returned to an AMHS:

- classified patients
- forensic patients, or
- patients subject to a court order under sections 101(2), 273(1) or 337(5) of the Act.

To clarify this, the proposed legislation will state that a warrant is not required if a classified patient, forensic patient or patient under a court order is required to return to an AMHS due to the operation of section 21 of the Police Powers and Responsibilities Act.

Background Paper 1 also makes a recommendation to clarify the circumstances where section 609 of the Police Powers and Responsibilities Act may be utilised.

15.2.8 Intubation on flights for transporting patients

During the consultation for the Review, stakeholders expressed concern that in some circumstances patients are being intubated for the purpose of flying a person to an AMHS when it may not be clinically indicated. Intubation involves the insertion of a long breathing tube or artificial airway into the trachea (wind pipe) via the mouth or through the nose. A patient will require intubation if unable to breath for themselves, including for example, when administered certain anaesthetic medication.

Section 224(3) of the Civil Aviation Regulation 1988 (Commonwealth) provides that:

the pilot in command shall have final authority as to the disposition of the aircraft while he or she is in command and for the maintenance of discipline by all persons on board

The Royal Flying Doctor Service (RFDS) has issued guidelines for the ‘Transfer of disturbed patients including patients with a mental illness’. This guideline requires an assessment of risk be undertaken by the health professional who has assigned the patient to the aircraft for transportation and the clinical crew of the flight. The assessment determines the management processes that are to be followed by the RFDS based on the level of risk.

The guidelines issued by the RFDS provide that intubation and ventilation should be avoided unless there is no other viable alternative.
On 13 September 2013, the Minister for Police and Community Safety announced that Queensland Government’s emergency helicopters, police and fixed wing aircraft will be brought together and operated under one combined service by March 2014.

Having regard to the *Civil Aviation Regulation 1988* and the consolidation of emergency flight services across Queensland, it is proposed that this policy matter be explored collaboratively between the Department of Community Safety and the DMH. This may, for example, result in some joint practice guidelines being developed similar to those currently issued by the RFDS.
Review of the Mental Health Act 2000

Background Paper

May 2014
16. Regional, Rural and Remote Issues

16.1 Background

There are significant challenges in delivering health care in regional, rural and remote areas of Queensland. These differences mean that health care planning and service delivery models that are appropriate for metropolitan areas do not necessarily translate into regional, rural and remote settings.

Similarly, it is important to recognise that legislative models that may operate effectively in metropolitan areas may not operate as well in regional, rural and remote areas.

For the Mental Health Act, specific challenges identified during the Review relate to:

- the availability of appropriately trained clinicians who perform functions under the Act, especially psychiatrists
- the location of mental health services where persons may be examined, assessed and treated under the Act
- the large distances between some communities (and primary health care services) and secondary and tertiary mental health services, and the associated issues of transporting persons for examination, assessment and treatment under the Act, and
- the higher relative burden of compliance with the administrative, accountability and reporting requirements under the Act, as regional, rural and remote services are unlikely to enjoy the same economies of scale as metropolitan-based services.

16.2 Issues

In consultations for the Review, regional, rural and remote stakeholders identified many issues that were in common with stakeholders elsewhere in the State. However, the following issues had specific implications for regional, rural and remote areas:

1. Places where a person may be examined or assessed
2. The requirement for a second examination within three days
3. Places where involuntary treatment in the community may take place
4. Transport of patients
5. Streamlined processes, and

16.2.1 Places where a person may be examined or assessed

The Mental Health Act states that, for the purposes of Chapter 2 (Involuntary Assessment), an authorised mental health service (AMHS) includes a ‘public hospital if there is no AMHS readily accessible for a person’s examination or assessment’ (section 15).

The effect of this is that:

- a person may be taken to, and examined, under an emergency examination order at an AMHS or, if an AMHS is not accessible, a public hospital, and
• a person may be assessed (to determine whether an involuntary treatment order (ITO) may be made for the person) at an AMHS or, if an AMHS is not accessible, a public hospital.

The first issue identified during the Review is the uncertainty around the meaning of ‘public hospital, which is not defined in the Act. This can be addressed in the proposed legislation by referring to a public sector health service facility, as defined in the Hospitals and Health Boards Act 2011. This is addressed in Background Paper 1.

The second issue identified during the Review is that, in rural and remote areas, it is not always possible for an examination to be undertaken at a particular health service facility. In many rural and remote areas, health service facilities are primary healthcare facilities with no capacity for overnight admissions. The ability of a facility to examine a person will be dependent on the availability of suitably qualified clinicians or access to audio-visual facilities. It should be left up to local arrangements to decide whether a person should be taken to a public sector health service facility for examination under the Act, based on the capacity of the service to undertake the examination.

The third issue identified during the Review is the limitations on where clinicians in rural or remote settings may conduct assessments and short-term treatment and care. While the Act allows assessments to be made in places other than an AMHS, detention for involuntary treatment and care can only be provided in an AMHS. Therefore, it may be difficult for a clinician to undertake an assessment outside of an AMHS, unless an AMHS is readily available at a reasonably accessible location.

The key issue in this regard is the capacity for a health service to provide the type of treatment and care for a person that would be required if an ITO were made after the assessment. In a small rural hospital, this may be quite achievable if the patient is likely to only require detention and treatment for a few days or if the patient can be treated in the community.

To support this model, it is proposed that the Act clarify that the Director of Mental Health may approve specific facilities as authorised mental health services with conditions or limitations. This would enable a small rural hospital to provide a more limited range of detention and treatment as part of a larger AMHS.

16.2.2 Requirement for second examination within three days

The Act requires that, if an ITO is made by an authorised doctor who is not a psychiatrist or made using audio-visual facilities, the patient must be examined again by an authorised psychiatrist within 72 hours (section 112).

This results in the following scenarios:

1. Where an ITO is made by an authorised doctor who is not a psychiatrist after examining the patient in person – an authorised psychiatrist must do a second examination of the patient in person or by using audio-visual facilities within 72 hours

2. Where an ITO is made by an authorised doctor who is not a psychiatrist using audio-visual facilities – an authorised psychiatrist must do a second examination of the patient in person within 72 hours
3. Where an ITO is made by an authorised psychiatrist using audio-visual facilities – an authorised psychiatrist must do a second examination of the patient in person within 72 hours (this may be the same psychiatrist).

4. Where an ITO is made by an authorised psychiatrist after examining the patient in person – no second examination is required.

Consultation during the Review has indicated that requiring involuntary treatment orders to be subject to a second examination may result in patients being transported significant distances, while unwell, to have the order confirmed. One submission outlined the process of transporting a patient from Clermont to Mackay (a distance of about 300km) because the only psychiatrist in the Mackay region was based at the Mackay Base hospital. The return trip, including pick up and admission, took longer than 10 hours. The outcome of this process was that the patient’s order was confirmed and the patient’s treatment plan prescribed treatment in the community – Clermont. Similar examples were provided to the Review during consultation with mental health service providers in rural and remote areas.

Related to this issue are the restrictions in the Act on assessments undertaken using audio-visual facilities. The Review identified different views over the extent to which audio-visual facilities should be used to undertake assessments under the Act. Some stakeholders suggested that diagnosis and assessment may be difficult through video-conferencing, while others have believed that the technology has improved significantly in recent years and that the lesser status of diagnosis using audio-visual technology is not warranted in all circumstances.

To address this, the proposed legislation will not include restrictions on the use of audio-visual facilities for assessments, and leave it to the discretion of the relevant clinician to determine whether the use of audio-visual facilities is appropriate in each case.

The following approach is also proposed to the confirmation (or otherwise) of an ITO by a psychiatrist to apply in regional, rural and remote areas designated by the DMH. If the person is to be detained in an AMHS as an in-patient under the ITO, the second examination is to be required in seven days rather than three days. If the patient is not to be detained as an in-patient (i.e. a community order), the order is to be confirmed in 14 days.

### 16.2.3 Places where involuntary treatment in the community may take place

There is a lack of clarity in the Act as to where involuntary treatment in the community may take place. The treatment criteria specifically refer to treatment being available ‘at an authorised mental health service’. However, for a community category of an involuntary order (section 124), the Act suggests that treatment may be provided by a health service other than an AMHS. No equivalent provisions exist that clarify where forensic patients on limited community treatment may be treated in the community.

This issue is particularly important for rural and remote communities where the availability of health services is more limited. Submissions received during the Review have indicated that treatment that could be appropriately provided in the community is, in some cases, being only provided at an AMHS, requiring persons to travel long
distances for treatment. Any measure that unnecessarily removes a patient from his or her community should be avoided.

Clinicians should be able to decide where it is appropriate to provide community treatment under the Act. This may be an AMHS, a community mental health service, a primary healthcare centre or another place, such as a person’s home. The Act should not restrict this flexibility.

### 16.2.4 Transport of patients

The delivery of mental health services is challenging in rural and remote areas due to the distances that may need to be travelled to access facilities and clinical staff. The proposals outlined above will go some way to resolving these issues. However, it is clear that circumstances will exist where it is appropriate to transport a patient to another facility to receive treatment and care.

Where this is required, clear and consistent provisions in the Act are required for the transport of patients. Background Paper 15 outlines how this is to be achieved.

### 16.2.5 Streamlined processes

Smaller health services have a relatively higher burden of compliance with the administrative, accountability and reporting requirements under the Act. This is addressed to some extent by larger authorised mental health services being ‘hubs’ for some smaller health services in regional, rural and remote areas. There is, however, significant scope to improve the efficiency in the administration of the Act by rationalising the use of forms and other reporting requirements, and modifying authorised positions under the Act. Background Paper 19 outlines how this is to be achieved.

### 16.2.6 Extension of assessment timeframes

The Act provides for the period of time that a person may be detained for assessment as being a period of up to 72 hours.

In some circumstances in rural and remote areas, a person may be required to be transported in order to be assessed. Some stakeholders have advised that in these circumstances the assessment timeframes may not be sufficient. For example, where a person is required to be transported by the Royal Flying Doctor Service from a remote part of Queensland to a suitable place for assessment it may not be possible to arrange for flights within the 72 hour time period.

Detaining a person involuntarily for the purposes of assessment is a significant authority under the Act that should not be extended without a degree of oversight and scrutiny. It is therefore proposed that an authorised doctor may extend the time period for assessment past 72 hours to enable transportation to a suitable place, but only with the approval of the administrator of the AMHS where the person is located. This extension must not be for more than a further 72 hours and be specifically for the purpose of transportation to occur. This authority would be restricted to regional, rural and remote areas designated by the DMH.
Review of the Mental Health Act 2000

Background Paper

May 2014
17. **Indigenous and Multicultural Issues**

17.1 **Background**

Queensland is home to a large number of Aboriginal and Torres Strait Islander people who have unique cultural backgrounds. Unfortunately, these people are over-represented in the mental health system\(^1\). Queensland is also home to a significant population of persons from diverse cultural backgrounds, including refugees who have endured torture and other trauma before escaping from their homelands who experience elevated rates of mental illness\(^2\).

It is essential that these backgrounds and needs are taken into account by clinicians and others in providing health services. A person’s cultural context needs to be appreciated by clinicians if diagnoses are to be accurate and treatment appropriate. Research indicates that culturally appropriate services are significantly better services, which will produce better outcomes for patients and the community\(^3\).

This includes in the way that decisions, examinations, assessments and other actions are undertaken under the *Mental Health Act 2000*.

17.2 **Issues**

The following issues in relation to Aboriginal and Torres Strait Islander people and people with multicultural backgrounds have been identified during the Review:

1. The status of the principles in decision-making under the Act
2. Enhanced principles for culturally appropriate decision-making and services
3. Communication of information.

17.2.1 **Status of the principles in decision-making under the Act**

The Act outlines general principles for the administration of the Act in relation to a person who has a mental illness (section 8). These principles are grouped under the following headings:

- Same human rights
- Matters to be considered in making decisions
- Provision of support and information

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\(^1\) Pink, B. & Allbon, P.; *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*; ABS & AIHW, Canberra, 2008. For example, hospitalisations of Aboriginal and Torres Strait Islanders in 2005-06 for schizophrenia, schizotypal and delusional disorders were 2.7 times the non-Indigenous rate for males and 2.5 times for females.


\(^3\) Purdie, N, Dudgeon, P & Walker, R (Eds); *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*; Commonwealth of Australia, Canberra, 2010.
• Achievement of maximum potential and self-reliance
• Acknowledgement of needs
• Maintenance of supportive relationships and community participation
• Maintenance of environment and values, and
• Provision of treatment
• Confidentiality

There was not significant comment on the principles during the Review. However, Indigenous and multicultural stakeholders expressed significant concern that the principles were not always adequately considered by clinicians and administrators when making decisions and exercising powers under the Act. For example, stakeholders outlined cases where people from culturally and linguistically diverse backgrounds were examined, assessed and treated, or not treated, without the involvement of an interpreter or other culturally competent input, with inappropriate outcomes. It is difficult to see how the principles could be followed if communication between a person and the clinician assessing that person is not fully understood by each party – including all non-verbal communication, nuances, understandings of when a person might not be giving a complete answer, and other critical elements of communication that vary between cultures.

Inevitably, compliance with some principles underlying the administration of an Act would be expected every day, while other aspects will be more aspirational. However, failing to observe the principles may lead to the poor outcomes identified by stakeholders.

It is acknowledged that the need for culturally competent health service delivery is not unique to the mental health sphere – it is a challenge across the board; but it is an even more critical issue for vulnerable persons under the Act.

This issue is to a large extent a training and resourcing issue for Queensland Health, but the principles should articulate the need for culturally competent services.

The Act currently introduces the principles with the statement:

The following principles apply to the administration of this Act in relation to a person who has a mental illness

Enhanced introductory wording would be beneficial, as is in place in other jurisdictions, for example:

It is the Parliament’s intention that the principles for administering the Act and exercising powers under the Act be complied with unless it is impracticable to do so.

This revised wording is relevant to all of the principles under the Act and can be addressed during the drafting of the legislation.

17.2.2 Enhanced principles for culturally appropriate decision-making and services

The principles include that (section 8(1)(e)):

a person’s age-related, gender-related, religious, cultural, language, communication and other special needs must be taken into account
Some stakeholders proposed that this principle be strengthened by requiring culturally safe or culturally competent services. Achieving cultural potential was also suggested as an element of achieving a person’s overall potential.

It is proposed that the principles in the Act be strengthened by including the following principles:

- the cultural, communication, and other unique contexts and needs of Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds must be recognised and taken into account
- to the extent that is practicable and appropriate to do so, services provided to Aboriginal and Torres Strait Islander people are to have regard to the person’s cultural and spiritual beliefs and practices, and the views of families and significant members of the person’s community.

17.2.3 Communication of information

Many stakeholders identified that patients, carers and other support persons do not recall being given key information by clinicians, or do not understand the information given to them. This was particularly the case for Aboriginal and Torres Strait Islander people and people from non-English speaking backgrounds.

Some stakeholders also stated that information is not very accessible for some people who might want to access mental health services, either as a patient or a relative or friend of someone who might require treatment.

The Act deals with the provision of information in a number of places including, for example, in the principles (section 8(1)(c)) and in a more detailed provision in the body of the Act (section 541A).

Section 541A provides:

**Ensuring patient understands things told or explained to the patient**

(1) If a provision of this Act requires a person to tell or explain something to a patient, the person must do so—

(a) in the language or way the patient is most likely to understand; and

(b) in a way that has appropriate regard to the patient’s age, culture, mental illness, communication ability and any disability.

While this is a reasonable statutory provision, and is referred to in notes in various places throughout the Act, it is located in a chapter of ‘miscellaneous provisions’ towards the end of the Act. In re-drafting the legislation, it would be appropriate for this provision to be given more prominence in the Act.
Review of the Mental Health Act 2000

Background Paper

May 2014
18. Children and Adolescents

18.1 Background

The Mental Health Act 2000 refers interchangeably to a ‘child’, ‘minor’, ‘young person’ and ‘young patient’. The Act defines a ‘child’ by reference to the definition under the Juvenile Justice Act 1992, namely a person under the age of 17 years. The Act defines a ‘young person’ as an individual who is under the age of 17 years, while a ‘young patient’ means an involuntary in-patient under the age of 17 years. A ‘minor’ is defined in the Acts Interpretation Act 1954 as a person less than 18 years of age.

The purpose of the Act is to provide for the involuntary assessment, treatment and protection of persons, whether they are adults or children. Therefore, in most instances, the same provisions apply for children as for adults.

There are a small number of provisions in the Act that relate specifically to children and young persons, namely:

- the requirement for the Director of Mental Health (DMH) to authorise the assessment of a young person in a high security unit, and for the Mental Health Review Tribunal to review a young person’s detention in a high security unit
- specifying the way in which allied persons may be chosen or appointed for minors
- providing that the Mental Health Court is generally closed if it relates to a young person
- provisions requiring notices to be given to the Tribunal, the Chief Executive of Justice and others about a young person’s detention as a classified patient, and
- various other notification provisions that relate to children.

18.2 Issues

Although the Act does not generally distinguish children from adults, there are a number of issues pertaining to children that need consideration, particularly because this population is more vulnerable. The impact of mental illness on a child is often greater because children lack capacity, or a degree of capacity, to make good decisions for themselves and have limited ability to protect their own interests. The impact of involuntary treatment or admission can displace children from their primary attachments such as family and friends, and their school environment, which are critical in a child’s development. Poor mental health can expose children to further risks such as other behavioural and emotional problems and abuse.

The issues identified during the Review in relation to children and adolescents are:

1. Consistent use of terminology
2. Seclusion (‘locked time out’) 
3. Physical restraint
4. Emergency examination orders
5. Children held within adult facilities
6. Legal representation at Mental Health Review Tribunal hearings
7. Capacity to consent
8. Composition of Tribunals, and
9. Children of parents with a mental illness.

18.2.1 Consistent use of terminology

The Act refers interchangeably to a child, minor, young person and young patient. There is no apparent reason for this different use of terminology. Some stakeholders suggested that aligning the Act with the *Youth Justice Act 1992* was relevant given that forensic orders may be made for children charged with an offence who also have a mental illness. Some suggested that a child should be defined as someone under 18 years, which is consistent with other pieces of Queensland legislation regarding children, including the *Child Protection Act 1999* and the *Acts Interpretation Act 1954*. Other views suggested that the age of a child should be extended, as young adults (under 21 years of age) can be particularly vulnerable in an adult system.

For consistency, it is proposed that, throughout the Act, the term ‘minor’ replaces the words child, young person and young patient, with a minor meaning a person under the age of 18 years. This term is preferred to ‘child’ as this is frequently understood to mean a young child (e.g. under 12 years of age).

18.2.2 Seclusion (‘locked time out’)

Section 162L of the Act allows a doctor or registered nurse to order that an involuntary patient be secluded. The patient must be undergoing involuntary assessment or be on an involuntary treatment order or forensic order to be placed in seclusion. These provisions apply to both adults and minors. The specific issue for minors is that seclusion (also in practice referred to as ‘locked time out’) can be used to manage behaviour which is not related to a mental health issue, or to prevent the minor from leaving a facility. A minor may also have a mental illness but not to the extent that involuntary treatment is permitted under the Act through an involuntary treatment order (ITO).

It is evident that an adult or minor should only be placed on an ITO if the treatment criteria under the Act are met. If seclusion is used to manage the behaviour of a minor who is not on an involuntary order (an ITO or forensic order), then this issue is outside the scope of the Act. This is a broader issue of restrictive practices that needs to be considered within a wider legal framework, as discussed in Background Paper 13.

Some stakeholders proposed that seclusion for minors should be treated differently, as implementing seclusion for a child is often for a shorter period of time. For example, seclusion of a minor may be five-minute periods, four times in a day, while seclusion for adults may be for longer continuous periods of time. It was therefore suggested that there could be a provision specific to children such as ‘locked time out’ to make a difference between the practices. However, the Act allows the flexibility to vary the seclusion arrangements for individuals, including for minors, consistent with the least restrictive principle.

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1 This is discussed in more detail in Background Paper 13.
18.2.3 Physical restraint

The Act allows the use of minimum force that is necessary and reasonable in the circumstances to provide, or help provide, treatment to an involuntary patient (section 517). This includes a minor. However, physical restraint may also be used to manage a minor’s behaviour.

Some submissions to the Review expressed concern that restraint of children against their wishes could further traumatise children whose lives may have already been underpinned by significant trauma.

As discussed in Background Paper 13, this is a complex area due to the interactions with other laws such as guardianship legislation, workplace health and safety, the Criminal Code and the common law. It can be therefore be challenging for health services to establish if physically restraining a child to manage behaviour, prevent egress or to minimise harm to themselves or others is lawful conduct. As indicated in Background Paper 13, many Hospital and Health Services have established policies to address these issues. Using restraint when a minor is not an involuntary patient to manage behavioural issues or prevent the minor leaving a health facility is outside the scope of the Act and is best dealt with by way of such policies.

18.2.4 Emergency examination orders

Information provided to the Review indicates that emergency examination orders may be taken out on a minor inappropriately. This situation may arise, for example, if an adolescent is creating a behavioural disturbance, gains the attention of the police, and there are concerns about the minor’s welfare. Often these adolescents are intoxicated and may be at risk, but do not need to be placed on an emergency examination order for a psychiatric assessment.

As discussed in Background Paper 1, this is a difficult issue to resolve as police do not possess the expertise to assess the mental health of a person. Behavioural issues and intoxication, for example, can be interpreted by the officer as a mental health issue requiring assessment. Given the possible adverse consequences of a misinterpretation of the person’s state of mind, police understandably take a ‘no risk’ approach, by taking the persons to a health service facility under the Act, especially as there are no other legal authorities to move a person to a ‘safe place’.

Similar issues have been identified in the use of emergency examination orders generally, and proposed approaches are outlined in Background Paper 1.

18.2.5 Minors held within adult facilities

Some stakeholders indicated that it is not acceptable for minors to be held in an adult mental health facility under any circumstances, while others indicated that minors should be treated in a separate facility to adult patients where this is reasonably practicable. It was proposed by some stakeholders that the Act needs to state more explicitly that it is preferable that a minor be accommodated separately to an adult.

Some other jurisdictions have recognised this issue in their legislation. The Mental Health Act 2009 (SA) provides a principle in section 7(e) that children and young people should be cared for and treated separately from other patients as necessary to
enable the treatment and care to be tailored to their different developmental stages. The Mental Health Bill 2013 (Western Australia) and the Mental Health Act 2013 (Tasmania) also propose that children are treated separately from adults so as to better provide for their special needs.

It is acknowledged that minors should, wherever possible, be held in facilities separate to adults, although the significance of this will depend on the age and maturity of the minor.

To highlight this as an issue, it is proposed to insert a principle in the Act that states that, wherever practicable, minors should be held separately from adults in in-patients facilities. The DMH could issue policies on these issues if required.

18.2.6 Legal representation at Mental Health Review Tribunal hearings

Similar to adult patients, minors are under-represented at Tribunal hearings. However, minors are more vulnerable when placed under the Act, especially when they lack capacity, as they are limited in their ability to protect their own interests and decisions made about their treatment and care have greater impact on their development.

Submissions also noted the model of the Independent Child Lawyer (ICL) who is appointed by the Family Law Court. This role aims to preserve and represent the best interests of the child and helps the court to decide what arrangements are in the child’s best interests, for example, where the child lives and who the child spends time and communicates with. The independent lawyer must make sure that any views expressed by the child in relation to the case are put before the court.

Some stakeholders proposed that minors always have legal representation at Tribunal hearings. This proposal is supported (see section 9.2.2).

18.2.7 Capacity to consent

Under the Act, a person (an adult or a minor) is presumed to have capacity to make decisions about his or her assessment and treatment (section 8(1)(b)). However, under common law, a child does not have a presumed capacity to consent to medical treatment. The ‘Gillick competence’ test is used to determine circumstances where a minor may be found to have the capacity to consent to treatment. The child would need to be able to demonstrate that he or she has sufficient understanding, intelligence and maturity to appreciate the nature, consequences and risks of the proposed healthcare, and the alternatives, including the consequences of not receiving the healthcare.\(^2\) The law is quite flexible in this regard and is based on individual decisions within specific contexts.

It was proposed during the Review that the presumption about a child’s capacity should be made more explicit in the Act.

It was also noted that, where a child lacks capacity, the Act should be more explicit about the rights of the minor’s parents or guardians in decision-making about the minor’s treatment and care. This would need to be balanced with safeguards to ensure

the minor’s best interests are protected if the parents or guardians were not best placed to make decisions for the minor.

The Act should not affect the common law in relation to a parent or guardian consenting to a minor’s treatment. Notwithstanding this, a parent’s refusal to consent would not prevent a doctor from providing involuntary treatment under the Act if it was in the minor’s best interests.

To address these issues, it is proposed that the Act state that a minor is presumed to have capacity if the minor has the maturity and intelligence to fully understand the decisions being made.

The proposed legislation should also state that the Act does not affect the common law in relation to parents or guardians consenting to a minor’s treatment, noting that this would not prevent a doctor proceeding under the Act if the parents or guardians did not agree to treatment, but the doctor believed it was in the minor’s best interests.

18.2.8 Composition of Tribunals

During the Review, some stakeholders proposed that, where a minor was an involuntary patient, the panel for a Tribunal hearing should include an expert in child psychiatry.

Child and adolescent psychiatry is a sub-speciality focusing on the mental health of children and adolescents, and their families.

When a Tribunal hearing pertains to a minor, it would be in the best interests of that minor if the panel included a member with specific child psychiatry expertise.

It is proposed that the Act require this for involuntary patients who are minors.

18.2.9 Children of parents with a mental illness

Consultations during the Review indicated concern that children of parents or guardians with a mental illness who require admission to a mental health facility may be at risk of harm or neglect if these children are not identified. This is particularly problematic for single parents.

This issue should be dealt with by good practice and procedures, yet consultation highlighted that practices varied and there was a view that the issue warranted a provision in legislation to ensure that children of parents or guardians with mental illness are identified. However, it is not clear how legislation can effectively address this matter. It would be difficult to mandate what actions an authorised mental health service should take in each case and what would be the consequences of failing to do so.

It is therefore not considered appropriate for this to be addressed in legislation, but rather should be managed by policy (including DMHP Policies), training and good practice. The Independent Patient Companion (see Background Paper 7) will also assist in this regard.
Review of the Mental Health Act 2000

Background Paper

May 2014
19. Streamlined Processes

19.1 Background

19.1.1 Use of forms

The Mental Health Act 2000 provides powers for the Director of Mental Health (DMH) to approve forms for use under the Act (section 493), other than forms approved by the Mental Health Court or the Mental Health Review Tribunal. The DMH has developed a large number of forms for use under the Act, some of which are approved forms related to specific provisions under the Act.

The clinical information system, CIMHA (Consumer Integrated Mental Health Application), provides secure electronic clinical notes and care plans in a single State-wide system. It also provides users with a tool for the day-to-day management of legislative processes.

The DMH monitors compliance with the Act through the use of forms, CIMHA and audits.

The Act is a complex piece of legislation that requires service delivery accountabilities, particularly in ensuring that patient safeguards are maintained. In this environment it is understandable that policies, and supporting forms, may be introduced that increase the cost of statutory compliance in the pursuit of these accountabilities.

19.1.2 Statutory positions

The Act establishes a number of positions, namely:

- the Director of Mental Health
- administrators of authorised mental health services
- authorised doctors, including authorised psychiatrists
- authorised mental health practitioners
- health practitioners
- approved officers
- authorised officers (high security), and
- authorised persons.

Various sections of the Act outline the functions and powers of these positions.

19.2 Issues

19.2.1 Use of forms

Consultations during the Review have indicated that statutory reporting and the use of forms under the Act has increased significantly over recent years.

The Review has looked at opportunities to streamline this statutory compliance without compromising the level of accountability of authorised mental health services.
The suite of forms developed by the DMH do not clearly distinguish between forms that are approved forms under the Act, requirements to notify or document a matter in another way, and forms that are templates to assist authorised mental health services in complying with the Act.

Approved forms under legislation are usually only mandated in specific situations, for example:

- where standard information must be given to a decision-maker, such as the DMH, or
- where the document authorises the exercise of legal power, such as a statutory order to be given to a person.

Addendum A to this Background Paper lists all of the forms developed by the DMH with recommendations for change. It indicates that the number of approved forms could be substantially reduced.

It is proposed that the Act only include approved forms where stated in Addendum A. It is also proposed that, in implementing the proposed legislation, the DMH review all other forms taking into account the proposals in Addendum A.

### 19.2.2 Authorised positions

Addendum B to this Background Paper lists all authorised positions under the Act and looks at opportunities for streamlining responsibilities and powers to provide greater flexibility without compromising statutory objectives.

Significant proposals include:

- authorised mental health practitioners to be appointed by authorised mental health service administrators, rather than the DMH
- discontinue the appointment of ‘health practitioners’ and rely on the general use of health service employees.

It should also be noted that the Act contains a significant number of offences. It is usual practice for Acts to provide for the appointment of authorised persons with powers to investigate alleged offences. The Act does not include such provisions, which could seriously compromise the ability of the Department of Health to investigate and prosecute offences under the Act. This needs to be remedied in the proposed legislation.
**Addendum A: Use of Forms and Other Documents under the Mental Health Act 2000**

(Does not include forms made by the Mental Health Court or Mental Health Review Tribunal)

**Principles**

Approved forms should only be required when:

- Information must be given to a decision-maker (e.g. the Director of Mental Health (DMH)) for decision.
- A document authorises the exercise of a legal power.

All references to a matter being made ‘in writing’ includes in an electronic form. Where it is proposed that a matter may be dealt with ‘in writing’, the DMH may develop (discretionary) templates to assist authorised mental health services.

<table>
<thead>
<tr>
<th>Current Form</th>
<th>Proposal</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application to be an authorised mental health practitioner (AMHP)</td>
<td>Possible template</td>
<td>Appointment of AMHPs to be made by AMHS administrators.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Each AMHS can decide on form of appointment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AMHPs to operate anywhere in the State.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Register of AMHPs to be kept.</td>
</tr>
<tr>
<td>Renewal, transfer, dual/multiple and cessation of authorised mental health practitioner appointments</td>
<td>Not required</td>
<td>No need for annual renewal or transfer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Each AMHS can decide on form of appointment for transfers, and for cessation of appointments.</td>
</tr>
<tr>
<td>Application for appointment as an authorised doctor</td>
<td>Possible template</td>
<td>Each AMHS can decide on form of appointment.</td>
</tr>
<tr>
<td>Authorised doctor - renewal and cessation of appointment</td>
<td>Not required</td>
<td>No need for annual renewal.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Each AMHS can decide on form of cessation.</td>
</tr>
<tr>
<td>Request for assessment</td>
<td>Not required</td>
<td>Requirement to be discontinued.</td>
</tr>
<tr>
<td>Recommendation for assessment</td>
<td>Approved form</td>
<td></td>
</tr>
<tr>
<td>Request for police assistance</td>
<td>Approved form</td>
<td>One form to be developed for all forms of police assistance.</td>
</tr>
<tr>
<td>Current Form</td>
<td>Proposal</td>
<td>Comment</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Application for Justice Examination order</td>
<td>Approved form</td>
<td>To be re-named an ‘involuntary examination authority’.</td>
</tr>
<tr>
<td>Justice Examination Order</td>
<td>Approved form</td>
<td>To be re-named an ‘involuntary examination authority’.</td>
</tr>
<tr>
<td>EEO (Police or Ambulance Officer)</td>
<td>Not required</td>
<td>Legislation to provide legal authority to act in an emergency without</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the need for a form.</td>
</tr>
<tr>
<td></td>
<td>Possible template for</td>
<td>AMHS to record time of admission.</td>
</tr>
<tr>
<td></td>
<td>recording time of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>admission</td>
<td></td>
</tr>
<tr>
<td>EEO (Psychiatrist)</td>
<td>Not required</td>
<td>To be discontinued.</td>
</tr>
<tr>
<td>Extension of assessment period</td>
<td>Possible template</td>
<td>Extension to be made in writing.</td>
</tr>
<tr>
<td>Patient ceased to be an involuntary patient</td>
<td>Possible template</td>
<td>Cessation to be made in writing. (Administrator required to keep records</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of involuntary patients)</td>
</tr>
<tr>
<td>Involuntary treatment order</td>
<td>Approved form</td>
<td></td>
</tr>
<tr>
<td>Revocation of involuntary treatment order</td>
<td>Possible template</td>
<td>Revocation to be made in writing. (Administrator required to keep records</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of involuntary patients)</td>
</tr>
<tr>
<td>Involuntary treatment order ceased to have effect</td>
<td>Not required</td>
<td>To be discontinued.</td>
</tr>
<tr>
<td>Change of category</td>
<td>Possible template</td>
<td>Change of category to be made in writing. (Administrator required to kee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>p records of involuntary patients)</td>
</tr>
<tr>
<td>Treatment plan</td>
<td>Not required</td>
<td>To be discontinued.</td>
</tr>
<tr>
<td>ECT certificate</td>
<td>Approved form</td>
<td></td>
</tr>
<tr>
<td>LCT treatment plan</td>
<td>Not required</td>
<td>To be discontinued. However, authorised doctor required to document trea</td>
</tr>
<tr>
<td></td>
<td>Possible template for</td>
<td>tment in the community and patient’s obligations while in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Form</td>
<td>Proposal</td>
<td>Comment</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Request for approval for LCT (classified patient)</td>
<td><strong>Approved form</strong></td>
<td>Required for decision-maker (DMH).</td>
</tr>
<tr>
<td>Limited Community Treatment Review Committee Recommendations</td>
<td>Possible template</td>
<td>No statutory basis for form.</td>
</tr>
<tr>
<td>Request for Temporary Absence (classified, forensic etc)</td>
<td><strong>Approved form</strong></td>
<td>Required for decision-maker (DMH)</td>
</tr>
<tr>
<td>Notification to DMH about LCT event</td>
<td>Possible template</td>
<td>No statutory basis for form.</td>
</tr>
<tr>
<td>Agreement for assessment (classified)</td>
<td>Not required for AMHS</td>
<td>Agreement to be made in writing</td>
</tr>
<tr>
<td></td>
<td><strong>Approved form</strong> for DMH</td>
<td>DMH approval retained to detain young persons in high security</td>
</tr>
<tr>
<td>Court assessment order</td>
<td>Not required</td>
<td>To be discontinued.</td>
</tr>
<tr>
<td>Custodian's assessment authority</td>
<td><strong>Approved form</strong></td>
<td>Form to contain information about the person’s custodial status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(‘Custodian’s transfer authority’).</td>
</tr>
<tr>
<td>Notification of classified patient status</td>
<td>Possible template</td>
<td>To be notified in writing.</td>
</tr>
<tr>
<td>Detention in AMHS (Justice Department)</td>
<td>Not required</td>
<td>To be notified in writing.</td>
</tr>
<tr>
<td>Patient does not need to be detained as classified patient</td>
<td><strong>Approved form</strong></td>
<td>Required for decision-maker (DMH).</td>
</tr>
<tr>
<td>Request for detention in high security</td>
<td>Not required</td>
<td>To be discontinued for most patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Combine with agreement for assessment (classified) for young patients in high secure.</td>
</tr>
<tr>
<td>Current Form</td>
<td>Proposal</td>
<td>Comment</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Classified patient asks not to be detained etc</td>
<td>Not required</td>
<td>Combine with “Patient does not need to be detained as classified patient”</td>
</tr>
<tr>
<td>Agreement for detention (young person in high security)</td>
<td>Not required</td>
<td>Combine with agreement for assessment (classified) for young patients in high secure.</td>
</tr>
<tr>
<td>End of period of detention etc</td>
<td>Not required</td>
<td>To be notified in writing.</td>
</tr>
<tr>
<td>Seclusion order</td>
<td>Possible template</td>
<td>To be authorised in writing.</td>
</tr>
<tr>
<td>Seclusion authorised by senior registered nurse</td>
<td>Possible template</td>
<td>To be authorised in writing.</td>
</tr>
<tr>
<td>Third authorisation in 24 hours for seclusion</td>
<td>Possible template</td>
<td>DMH may require information to be provided as required.</td>
</tr>
<tr>
<td>Authorisation of mechanical restraint</td>
<td>Approved form</td>
<td>To be approved by DMH.</td>
</tr>
<tr>
<td>Notification to DMH of travel outside of Qld</td>
<td>Possible template</td>
<td>Notify in writing.</td>
</tr>
<tr>
<td>Classified/forensic patient moved within AMHS</td>
<td>Not required</td>
<td>To be discontinued.</td>
</tr>
<tr>
<td>Request for transfer (classified, forensic, court order patients)</td>
<td>Not required</td>
<td>To be discontinued.</td>
</tr>
<tr>
<td>Transfer order</td>
<td>Possible template</td>
<td>For DMH order only</td>
</tr>
<tr>
<td>Request for police assistance (interstate)</td>
<td>Not required</td>
<td>One form to be developed for all police assistance</td>
</tr>
<tr>
<td>Involuntary patient charged with an offence</td>
<td>Not required</td>
<td>To be discontinued.</td>
</tr>
<tr>
<td>Confirmation – Application of Chapter 7, Part 2</td>
<td>Not required</td>
<td>To be discontinued.</td>
</tr>
<tr>
<td>Involuntary patient summary</td>
<td>Not required</td>
<td>No statutory basis for form.</td>
</tr>
<tr>
<td>Current Form</td>
<td>Proposal</td>
<td>Comment</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Section 238 Report</td>
<td>Possible template</td>
<td>-</td>
</tr>
<tr>
<td>Allied person nomination</td>
<td>Not required</td>
<td>To be discontinued</td>
</tr>
<tr>
<td>Allied person acceptance</td>
<td>Not required</td>
<td>To be discontinued</td>
</tr>
<tr>
<td>Change of patient details</td>
<td>Not required</td>
<td>No statutory basis for form</td>
</tr>
<tr>
<td>Requirement to return</td>
<td>Not required</td>
<td>To be discontinued</td>
</tr>
<tr>
<td>Authority to return</td>
<td>Not required</td>
<td>One form to be developed for all police assistance. Authority to return to be authorised by treating psychiatrist.</td>
</tr>
<tr>
<td>Recall Notice (cancellation of a Authority to return)</td>
<td>Possible template</td>
<td>Police to be advised in writing</td>
</tr>
<tr>
<td>Notification to DMH of unauthorised absence</td>
<td>Not required</td>
<td>To be notified in writing. There is no statutory basis for this form.</td>
</tr>
<tr>
<td>Return of patient from unauthorised absence</td>
<td>Not required</td>
<td>To be notified in writing</td>
</tr>
<tr>
<td>Application for warrant</td>
<td>Not required</td>
<td>-</td>
</tr>
<tr>
<td>Warrant form</td>
<td>Not required</td>
<td>-</td>
</tr>
</tbody>
</table>
### Addendum B: Authorised Positions

<table>
<thead>
<tr>
<th>Position</th>
<th>Powers (Section)</th>
<th>Proposals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Director of Mental Health (section 488)</strong>&lt;br&gt;Primary role of protecting the rights of involuntary patients</td>
<td><strong>Classified Patients</strong>&lt;br&gt;Agree to an assessment of a person in custody or before a court (ss.53 and s.55)</td>
<td>Retain provisions related to assessment of persons in custody.</td>
</tr>
<tr>
<td></td>
<td>Approves assessment for persons charged with simple offences, and for young persons, in a high security unit (s. 53)</td>
<td>Discontinue for simple offences</td>
</tr>
<tr>
<td></td>
<td>Approve continued detention when patient no longer classified (s.82), or to return to custody or court.</td>
<td>Chapter 3, parts 4 and 5 provisions to be simplified.</td>
</tr>
<tr>
<td></td>
<td>Decides that classified patient does need to be detained in an AMHS (s.83)</td>
<td>Retain provision</td>
</tr>
<tr>
<td></td>
<td>Agree to detention at an AMHS during a trial (s.104)</td>
<td>Retain provision</td>
</tr>
<tr>
<td><strong>Treatment and Care</strong></td>
<td>Revoke ITO (ss.118 and122)</td>
<td>Retain provision</td>
</tr>
<tr>
<td></td>
<td>Issues policy and practice guidelines – treatment and care (s.124)</td>
<td>Retain provision, but broaden scope of matters</td>
</tr>
<tr>
<td></td>
<td>Approve LCT for classified patients (s.129)</td>
<td>Retain provision</td>
</tr>
<tr>
<td></td>
<td>Require LCT monitoring conditions (s.131A)</td>
<td>Retain provision but expand to all involuntary patients</td>
</tr>
<tr>
<td><strong>Regulated and prohibited treatments</strong></td>
<td>Approval of mechanical appliances (s.162B)</td>
<td>Retain provisions but require prior DMH approval</td>
</tr>
<tr>
<td>Position</td>
<td>Powers (Section)</td>
<td>Proposals</td>
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</tr>
<tr>
<td>Removal of restraint before authorisation ends (s.162H)</td>
<td>Broaden powers for the DMH to direct</td>
<td></td>
</tr>
<tr>
<td>End seclusion order (s.162V)</td>
<td>Broaden powers for the DMH to direct</td>
<td></td>
</tr>
<tr>
<td><strong>Moving, transfer and temporary absence of patients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May order transfer of patients between AMHSs (s.165)</td>
<td>Retain provision</td>
<td></td>
</tr>
<tr>
<td>Must approve transfers to high security (s.167)</td>
<td>Retain for young persons only</td>
<td></td>
</tr>
<tr>
<td>Authorised to transfer a patient from an AMHS to Forensic Disability Service (s.169A)</td>
<td>Retain provision but simplify arrangements</td>
<td></td>
</tr>
<tr>
<td>Apply for interstate move (s.171)</td>
<td>Discontinue</td>
<td></td>
</tr>
<tr>
<td>Authorise to transfer patient interstate (s.181)</td>
<td>Retain for forensic patients transferring out of the State</td>
<td></td>
</tr>
<tr>
<td>Approves temporary absences (s.186)</td>
<td>Retain provision</td>
<td></td>
</tr>
<tr>
<td><strong>Administrator (section 497)</strong></td>
<td><strong>Classified</strong></td>
<td></td>
</tr>
<tr>
<td>Responsible for ensuring the effective administration of the Act at the service level.</td>
<td>Agree to an assessment of a person in custody or before a court (s.53)</td>
<td>Retain provision but simplify</td>
</tr>
<tr>
<td></td>
<td>Agree to detention at an AMHS during a trial (s103)</td>
<td>Retain provision</td>
</tr>
<tr>
<td></td>
<td><strong>Involuntary Treatment Orders</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Order the patient to attend the AMHS for treatment if non-compliant (s.117)</td>
<td>Retain provision but clarify basis of non-compliance</td>
</tr>
<tr>
<td></td>
<td><strong>Treatment Plans</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approves changes to LCT plans (ss.126, 127 and 130).</td>
<td>Discontinue</td>
</tr>
<tr>
<td></td>
<td><strong>Moving and Transfer of Patients</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approves moves of ITO patients within AMHS (s.163)</td>
<td>Retain provision</td>
</tr>
<tr>
<td>Position</td>
<td>Powers (Section)</td>
<td>Proposals</td>
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<tr>
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</tr>
<tr>
<td><strong>Authorised mental health practitioner (AMHP)</strong>&lt;br&gt;Appointed by DMH (section 499)</td>
<td><strong>Involuntary Assessments</strong>&lt;br&gt;May make a recommendation for assessment (s.19)&lt;br&gt;May examine a person under a JEO (section 30)&lt;br&gt;May examine a person under an EEO (section 40)&lt;br&gt;May make a recommendation for assessment – classified patients (s. 50)</td>
<td>Retain provisions but streamline appointment:&lt;br&gt;- to be appointed by AMHS administrators&lt;br&gt;- can exercise powers anywhere in Queensland without the need to be approved by another AMHS&lt;br&gt;- registers to be kept of all current AMHPs</td>
</tr>
<tr>
<td><strong>Authorised doctor (section 504)</strong>&lt;br&gt;Is appointed by an AMHS administrator, must be a registered medical practitioner</td>
<td><strong>Involuntary assessment and treatment</strong>&lt;br&gt;Initial assessment and making an ITO (ss. 46 and 108)</td>
<td>Retain provisions</td>
</tr>
<tr>
<td></td>
<td>Extension of assessment period (s. 47)</td>
<td>Retain provision; AMHS administrator in rural and remote areas having the power to extend for transport</td>
</tr>
<tr>
<td></td>
<td>Treatment plan (ss.110 and 111)</td>
<td>Discontinue. Duties to provide appropriate treatment and care to apply</td>
</tr>
<tr>
<td></td>
<td>Non-compliance with treatment (s.117)</td>
<td>Retain provision but clarify basis for non-compliance</td>
</tr>
<tr>
<td></td>
<td>Change of category of ITO (s.119)</td>
<td>Retain provision but state criteria for change</td>
</tr>
<tr>
<td></td>
<td>Revocation of ITO (s.121)</td>
<td>Only authorised psychiatrist can revoke.</td>
</tr>
<tr>
<td></td>
<td>Change of treatment plan (ss.125,127 and130)</td>
<td>Discontinue. Duties to provide appropriate treatment and care to apply</td>
</tr>
<tr>
<td></td>
<td>Authorising LCT (ss. 129 and131)</td>
<td>Retain provision but state criteria</td>
</tr>
<tr>
<td></td>
<td>Transfer orders (s.165)</td>
<td>To be authorised by the AMHS administrator</td>
</tr>
<tr>
<td><strong>Classified Patients</strong></td>
<td><strong>Initial assessment (s. 71)</strong></td>
<td>Retain but simplify provisions</td>
</tr>
<tr>
<td></td>
<td>Treatment plan (s. 72)</td>
<td>Discontinue (generic treatment provisions to apply)</td>
</tr>
<tr>
<td>Position</td>
<td>Powers (Section)</td>
<td>Proposals</td>
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<tr>
<td></td>
<td>To advise DMH that treatment in AMHS is no longer required (s.74)</td>
<td>Retain provision</td>
</tr>
<tr>
<td>Forensic Provisions</td>
<td>Treatment plan (ss.278 and 307)</td>
<td>Discontinue (generic treatment provisions to apply)</td>
</tr>
<tr>
<td>Return Provisions</td>
<td>Return of involuntary patient (s. 507)</td>
<td>To be authorised by authorised psychiatrist for strengthened accountability</td>
</tr>
<tr>
<td>Authorised psychiatrist</td>
<td>An authorised doctor, who is a psychiatrist</td>
<td>*See also powers of Authorised doctor above.</td>
</tr>
<tr>
<td></td>
<td>Classified</td>
<td>Retain provisions but simplify</td>
</tr>
<tr>
<td></td>
<td>Regular assessments as required by the treatment plan (s.73)</td>
<td>Retain provisions but simplify</td>
</tr>
<tr>
<td>Involuntary Treatment Order</td>
<td>Confirm or revoke ITO on second examination (s.112)</td>
<td>Retain provisions but simplify</td>
</tr>
<tr>
<td></td>
<td>Regular assessments of patient’s condition (s116)</td>
<td>Retain provisions but simplify</td>
</tr>
<tr>
<td>Forensic Provisions</td>
<td>Regular assessments (ss. 298 and 309)</td>
<td>Retain provisions but simplify</td>
</tr>
<tr>
<td>Health practitioner (section s505A)</td>
<td>Taking patient to AMHS (s. 508)</td>
<td>Streamline provision - replace with a health service employee (as defined in the Hospitals and Health Service Act 2011) and other persons approved by the AMHS administrator (e.g. a security officer)</td>
</tr>
<tr>
<td></td>
<td>Can take a patient to or from court (s. 541)</td>
<td></td>
</tr>
<tr>
<td>Position</td>
<td>Powers (Section)</td>
<td>Proposals</td>
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<tr>
<td>-------------------------------</td>
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<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>worker.</td>
<td></td>
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</tr>
<tr>
<td><strong>Approved officers (section 500)</strong></td>
<td>DMH may appoint a health practitioner, lawyer or other person to be an approved officer.</td>
<td>Retain, but rename as authorised persons</td>
</tr>
<tr>
<td></td>
<td>Approved officers investigate serious non-compliance with the Act</td>
<td></td>
</tr>
<tr>
<td><strong>Authorised officer (high security)</strong></td>
<td>A health practitioner providing mental health services at the unit or a security officer for the unit.</td>
<td>Retain provisions, with modifications</td>
</tr>
<tr>
<td></td>
<td>Authority to search patients/visitors and possessions (ss.355, 356 and 361) Authority to refuse entry to a visitor or direct to leave (s.362) Authorised to conduct a search under the provision of the Act (ss.357 and 359)</td>
<td></td>
</tr>
</tbody>
</table>
Review of the Mental Health Act 2000

Background Paper

May 2014
20. Other Legal Issues

20.1 Background

Various legal issues have been addressed as part of the analysis in the other Background Papers. The Review also identified other legal issues through consultation and research that are discussed in this Background Paper.

20.2 Issues

The following other legal issues have been identified during the Review:

1. Disclosure of section 238 reports to legal representatives
2. Disclosure of section 238 reports to youth justice officers
3. Presentation of an indictment within six months of a committal
4. Charges dealt with while proceedings suspended
5. Definition of ‘unfit for trial’
6. Intoxication and unsoundness of mind
7. Mental Health Court proceedings where the charge is disputed
8. Defences other than diminished responsibility
9. Disputed facts relevant to expert opinion (section 269)
10. Youth justice officers attending the Mental Health Court
11. Managing capacity, clinical needs, and forensic order admissions
12. Admissibility of Mental Health Court decisions in sentencing
13. Making of forensic orders on appeals from Mental Health Review Tribunal fitness for trial decisions
14. Monitoring of accused persons temporarily unfit for trial
15. Miscellaneous confidentiality issues, and
16. Accessing health records for private psychiatrist’s reports

20.2.1 Disclosure of section 238 reports to legal representatives

Under the Mental Health Act 2000, a ‘section 238 report’ is used by the Director of Mental Health (DMH) and the Director of Public Prosecutions (DPP) to decide how charges are to be dealt with. If a charge is referred to the Mental Health Court (MHC), a copy of the report is provided to the MHC and all parties.

However if the person is found of sound mind and fit for trial and the charge is returned to the regular courts, the report is not provided to the accused person or his or her legal representatives, as it was not prepared for that purpose and the DPP takes the view that it therefore cannot disclose the report in the absence of an express statutory authority to do so.

During consultations for the Review, prosecution and defence stakeholders indicated that section 238 reports should routinely be provided to the defence.
Background Paper 3 presents options for changing the processes for the preparation of psychiatric assessments. The preferred approach would involve discontinuing mandatory psychiatric reports, unless the DMH directed a report in the public interest, so the issue of providing reports to legal representatives would only arise if the report was directed by the DMH.

Where a report is directed by the DMH, a copy of the report should be provided to the patient's legal representatives.

20.2.2 Disclosure of section 238 reports to youth justice officers

In a similar issue, stakeholders consulted during the Review proposed that the youth justice department (i.e. the department administering the Youth Justice Act 1992) have access to section 238 reports if proceedings for the relevant offence are subsequently continued under the Youth Justice Act 1992 in the regular courts.

Section 74 of the Youth Justice Act 1992 provides that in a proceeding in which a child is charged with an offence, the youth justice department is entitled to be heard by the court on certain matters including adjournments, bail and sentencing, even though the department is not a party to the proceeding. In practice, in the Childrens Court, materials that are available to the prosecution and defence that are relevant to the above matters are also available to the department, except for victim information for sexual offences for which a specific court order is required. When requested, the department prepares a comprehensive pre-sentence report to assist the court with sentencing.

While it may be beneficial to the department to access relevant section 238 reports to assist in performing these roles, to protect the person’s rights, a report should only be provided with the consent of the person, or if the person cannot consent, the person’s representative.

20.2.3 Presentation of indictment within six months of a committal

Pursuant to the Criminal Code, an indictment must usually be presented no later than six months after a committal (section 590). However, under the Mental Health Act, legal proceedings must be suspended if one of three matters occurs – the accused becomes a classified patient (section 75), a Chapter 7, part 2 process commences (section 243), or a reference is made to the MHC (section 259).

The Act provides that, despite the suspension of proceedings, matters such as bail can still be heard and determined while proceedings are suspended (sections 77, 244 and 260). There is, however, no provision expressly stating that the presentation of an indictment may continue, making it unclear whether the Criminal Code requirement is overridden.

In the vast majority of cases, there is no committal hearing prior to a reference to the MHC. This issue therefore only arises in a small number of cases. When this does occur, the DPP’s approach is to present an indictment in accordance with the Criminal Code. This ensures the prosecution is ready to proceed in the event that the MHC finds that the person was of sound mind and is fit for trial.
To clarify this matter, the legislation should state that the presentation of an indictment under the Criminal Code can proceed, notwithstanding that proceedings have been suspended.

**20.2.4 Charges dealt with while proceedings suspended**

As indicated in section 20.2.3, the Act provides that proceedings against a person are suspended in the circumstances stated in the Act. Despite this, the Review has been advised that, on occasions, matters may incorrectly proceed to be heard by magistrates. This would occur where the parties to the proceeding and the court are unaware that the automatic suspension of charges has occurred.

The Review has been advised that this does not occur in other courts, probably because the DPP prosecutes in the higher courts and the error would quickly come to light. In the Magistrates Court however, prosecutions are done primarily by police and are dealt with much more quickly than in the higher courts.

Section 21 of the *Justices Act 1886* provides for the following:

> **21 Presumption**
> 
> Every act done or purporting to have been done by or before a justice shall be taken to have been done within the justice’s jurisdiction without an allegation to that effect unless and until the contrary is shown.

This means that a conviction, and any penalty imposed by a magistrate, is prima facie lawful and enforceable, even if it was made while proceedings were suspended under the Act.

The words ‘until the contrary is shown’ allow the accused person an opportunity to challenge the conviction, but the onus is on the accused. This means the accused must initiate an application for the matter to be re-opened, generally within 28 days of the conviction (section 147A of the *Justices Act 1886*), and attend on the day of the hearing of that application to explain why the matter should be re-opened and the conviction set aside. Although the police are unlikely to oppose the application, or an application for an extension of time beyond the 28 days if necessary, this may be an onerous process for a vulnerable person and in practice rarely, if ever, happens.

However, the recommendations of this review in relation to section 238 reports will mean that nearly all relevant proceedings will be managed by the DPP, with less opportunity for these errors to occur.

**20.2.5 Definition of ‘unfit for trial’**

The definition of ‘fit for trial’ in the Act is:

> 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.

This is generally taken to include the common law definition of fitness for trial, plus the ability to instruct a lawyer and to cope throughout the trial without the trial having to be adjourned because of a deterioration in the person’s health.

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1 See definition in the Schedule to the Act.
The common law on fitness for trial in Australia is principally the Presser test, from a 1958 Victorian Supreme Court case. The Presser test requires the ability to:

- understand the nature of the charge
- plead to the charge
- exercise the right of challenge in relation to a prospective juror
- understand the nature of the proceedings – that it is an inquiry as to whether the accused committed the offence charged
- follow the course of the proceedings, and understand what is happening in a general sense (not necessarily all the formalities)
- understand the substantial effect of the prosecution evidence, and
- make a defence to the charge.

The High Court and the Queensland Court of Appeal have also contributed to the common law on fitness since Presser, including that it is not necessary that the accused be capable, unaided, of understanding the proceedings so as to be able to make a proper defence, if the necessary assistance (such as a lawyer or an interpreter) is available; and that contemporary courts are sensitive to the varying needs of those who come before them. The High Court also said:

> There is simply no point in embarking on a lengthy trial with all the expense and inconvenience to jurors that it may entail if it is to be interrupted by reason of some manifestation or exacerbation of a debilitating condition which can affect the accused's fitness to be tried. Of course, that is not to exclude from the jury's consideration the question whether the condition is such that difficulties can be accommodated by an adjournment if and when they arise.

In light of these matters, it would be beneficial to update the definition of 'fit for trial' in the Act.

NSW is the only Australian jurisdiction not to have codified a definition of fitness for trial.

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3 Kesavarajah v. The Queen [1994] HCA 41.
5 Kesavarajah v. The Queen [1994] HCA 41 at par 35.
Most of the definitions in other jurisdictions are very similar, reflecting Presser, with several jurisdictions also clarifying that memory loss alone is not sufficient. The various elements have been adopted as follows:

<table>
<thead>
<tr>
<th>Element</th>
<th>Adopted by:</th>
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<tbody>
<tr>
<td>Understand the nature of the charge</td>
<td>All jurisdictions</td>
</tr>
<tr>
<td>Plead to the charge</td>
<td>All jurisdictions</td>
</tr>
<tr>
<td>SA has “respond rationally to the charge or the allegations on which the charge is based”</td>
<td></td>
</tr>
<tr>
<td>Exercise the right of challenge in relation to a prospective juror</td>
<td>All jurisdictions</td>
</tr>
<tr>
<td>Understand the nature of the proceedings – that it is an inquiry as to whether the accused committed the offence charged</td>
<td>All jurisdictions except WA, which has “understand the purpose of a trial”</td>
</tr>
<tr>
<td>Victoria, WA, NT and ACT; SA has “follow the evidence”</td>
<td></td>
</tr>
<tr>
<td>Follow the course of the proceedings, and understand what is happening in a general sense (not necessarily all the formalities)</td>
<td>All jurisdictions refer to following the course of the trial or proceedings; none adds the ‘formalities’ qualification</td>
</tr>
<tr>
<td>Understand the substantial effect of the prosecution evidence</td>
<td>Victoria, WA, NT and ACT; SA has “follow the evidence”</td>
</tr>
<tr>
<td>Make a defence to the charge</td>
<td>Tasmania and WA. SA has “respond rationally to the charge or the allegations on which the charge is based”</td>
</tr>
<tr>
<td>Victoria, NT and ACT have “give instructions to his or her legal practitioner” or similar</td>
<td></td>
</tr>
<tr>
<td>Memory loss of itself does not amount to unfitness</td>
<td>Victoria, Tasmania, NT and ACT.</td>
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</tbody>
</table>

The South Australian approach, introduced in 1995, is the most easily understood reflection of the common law and has merit for adoption in Queensland. Without changing the meaning, it groups the elements into three categories and is easy to conceptualise. However, the South Australian definition omits the clarification that memory loss alone is insufficient to amount to unfitness. Omitting this from the Queensland definition might imply that it was intentionally omitted to allow for memory loss alone to amount to unfitness in some circumstances. It would therefore be prudent to include the qualification.

None of the definitions includes a reference to the accused’s mental health not deteriorating during the trial. This should also be included.
20.2.6 Intoxication and unsoundness of mind

The Criminal Code (section 28) and the definition of ‘unsound mind’ in the predecessor to the Act were amended in 1997 to clarify that there is no defence for a person whose state of mind resulted, to any extent, from intentional intoxication.

However, the two provisions are worded slightly differently. For example, the Act includes a temporal element by reference to intoxication or stupefaction “at or about the time of the alleged offence”. This qualification is implied, but not stated, in the Criminal Code.

For certainty, it would be preferable to define unsoundness of mind wholly by reference to the Criminal Code, as is the case with the Act’s definition of diminished responsibility.

20.2.7 Mental Health Court proceedings where the charge is disputed

The Act precludes the MHC from deciding unsoundness or diminished responsibility if there is a reasonable doubt that the person committed the offence (section 268). The rationale for this is that a person should not be subjected to a forensic order if the person should have been acquitted of the charge for other reasons, and therefore does not represent a risk to the community. In these circumstances, the Court must decide if the person is fit for trial and, if so, refer the matter to trial, where the person may raise the unsoundness defence and other defences.

However, the effect of this provision is that a person who raises unsoundness as well as another defence is prevented from having the MHC hear the question of unsoundness. This is contrary to the purpose of establishing the MHC as a specialist court to decide matters of unsoundness of mind or fitness for trial, which it does much more efficiently than juries because of its accumulated knowledge and understanding of both mental illness and the law relating to mental illness.

If the version of events suggested by the accused person in support of the second defence would affect expert evidence about unsoundness, the MHC should not proceed (see section 20.2.9). However, where the dispute has no material effect on the question of unsoundness, it is proposed that the MHC should be able to make a determination of unsoundness.

There are at three possible options for facilitating this:

Option 1: Allow the MHC to continue its proceedings and decide unsoundness. If the person is found of unsound mind, the MHC may make any orders, in the usual way. The MHC would then decide fitness and, if the accused person is fit for trial, a trial can be held in the appropriate court if the accused still wishes to pursue the other issues. If the other defences are not upheld in that court, no conviction or penalty follows (as the accused has been found of unsound mind), but any MHC orders remain in force. If the defences are accepted, the person is acquitted and any MHC orders lapse.

Option 2: Require the MHC to proceed to decide fitness for trial (as occurs currently) and, if the person is fit, the matters in dispute are decided by a Mental Health Court judge sitting alone. If the non-mental health defences are accepted by the judge, the person is acquitted. If the defences are not
upheld, the MHC decides unsoundness. If the person is found of unsound mind, the MHC makes orders in the usual way. If the MHC finds the person of sound mind, the matter is referred to the appropriate criminal court for sentencing.

Option 3: As per option 2 but with the matters in dispute being referred to the appropriate criminal court for resolution. If the defences are upheld, the person is acquitted. If the defences are not upheld, the matter is returned to the MHC to decide unsoundness. If the person is found of unsound mind, the MHC makes orders in the usual way. If the MHC finds the person of sound mind, the matter is returned to the appropriate criminal court for sentencing.

Option 1 has the benefit of the MHC dealing with all mental health issues at the one time, while allowing juries to make determinations of other issues without the complications of having to deal with the question of unsoundness. Trials would therefore be shorter and simpler than is the case with the current requirement that juries hear all defences, including mental health defences. However, this option has the disadvantage of the MHC consideration of unsoundness becoming irrelevant if the accused is subsequently acquitted on the basis of another defence.

Options 2 and 3 have the advantage of avoiding a potentially unnecessary MHC consideration of unsoundness (and possibly the making of a forensic order), but would require the MHC proceedings to be adjourned while the other issues are determined. Option 2 would also deny the accused a jury trial on the matters in dispute which is currently available, although it is not proposed to remove an accused person’s right to a jury trial on all issues following the conclusion of the MHC process, as exists under the current Act.

Option 3 may result in a disjointed process in that the matter may be referred between the MHC and the other courts on three occasions.

### 20.2.8 Defences other than diminished responsibility

In the case of *Hansen*\(^6\), the MHC became aware that there may have been provocation, which may have reduced the charge of murder to manslaughter pursuant to section 304 of the *Criminal Code*. This triggered section 268 of the Act (see section 20.2.7) and precluded the MHC from deciding diminished responsibility.

The consensus, including from the Court of Appeal, is that it ‘may also be that [this] is not consistent with a general policy which might be thought to inform the Act, namely, that a person in the appellant’s position should not be exposed to the criminal trial process where mental abnormality impaired his capacities’\(^7\). The Court of Appeal also said:

> The consequence of the MHC not being permitted to decide the question of diminished responsibility is that the accused, whose mental capacity is seriously in question, is exposed to running a criminal trial to raise a defence of diminished responsibility which would be unnecessary were

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\(^7\) *Hansen v DPP & Anor* [2006] QCA 396, per Keane JA at par 24, with whom Douglas J agreed.
there some flexibility in the legislative structure. The circumstances of this case highlight the need for a review of these provisions of the Mental Health Act.\(^8\)

If the proposals in section 20.2.7 are adopted, this issue will not recur. If not, there would be merit in addressing this scenario by clarifying that if there is a reasonable doubt because of the operation of section 304 of the Code, the MHC may still make a finding under section 267. This may also apply to section 304B of the Criminal Code (Killing for preservation in an abusive relationship).

### 20.2.9 Disputed facts relevant to expert opinion (section 269)

Section 269 of the Act prevents the MHC from proceeding if a fact that is substantially material to the opinion of an expert witness is so in dispute it would be unsafe to make the decision.\(^9\) The rationale for section 269 is that psychiatrists often need to base their opinions on factors such as how the accused person was behaving at the time of the offence. Psychiatrists rely on the accounts of the accused and on sources such as witness statements for this information. If there is uncertainty about a particular fact and the psychiatric opinion would change if an alternative scenario were true, then it would be unsafe for the MHC to rely on the psychiatric evidence.

In these circumstances, the matter returns to the regular criminal courts, where a jury, among other considerations, will decide the facts in dispute and determine whether the accused has a mental health defence.

For similar reasons as set out in section 20.2.7, it is preferable to have the MHC make determinations in relation to mental health defences wherever possible.

Where the MHC forms the view that a fact that is substantially material to the opinion of an expert witness is so in dispute it would be unsafe to make a decision, a better process would be to allow the judge constituting the Mental Health Court to hear and determine the disputed facts, and then have the examining psychiatrists form opinions based on the facts as found by the judge.

This would retain the MHC’s role in determining mental health questions. The trial of facts will in most cases be simple and quick, with very discrete issues to resolve.

This would not preclude the accused person from seeking a jury trial on all issues following the conclusion of the MHC process, as is the case under the existing Act.

### 20.2.10 Youth justice officers attending the MHC

Under the Mental Health Act (section 412), the MHC is a closed court when hearing a matter relating to a young person (under 17 years). The MHC can permit a person to be present during the hearing if satisfied it is in the interests of justice.

As outlined in section 20.2.2, the youth justice department plays a very active role assisting courts in which a young person is charged with an offence. The *Youth Justice Act 1992*, provides that the chief executive of the youth justice department has the right to be heard in these courts, notwithstanding that the chief executive is not a party.

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\(^8\) *Hansen v DPP & Anor* [2006] QCA 396, per Jones J at par 30.
\(^9\) A matter related to this issue is currently before the Court of Appeal.
Stakeholders consulted during the Review proposed that the youth justice department have the same right to appear before the MHC. The same rationale for attendance in other courts would apply for the MHC. Young people would benefit from the knowledge and insight of departmental officers in being present in MHC hearings. In addition, if considering whether to make a forensic order, the MHC would benefit from information from the department about what supervision and support is being provided for the young person, which will be relevant to the young person’s treatment or care needs and the protection of the community.

It is therefore proposed that the youth justice department be entitled to be heard by the MHC in a similar way to proceedings before other courts.

20.2.11 Managing capacity, clinical needs, and forensic order admissions

Queensland’s high security unit at The Park is often full or close to full in the lead up to a MHC hearing at which a forensic order is expected to be made that would result in a patient being admitted to The Park. The current practice is to ensure a bed is available at the unit before the hearing. This may involve moving a patient to a medium secure unit, or if a bed is available, not accepting a transfer that would be accepted, based on clinical needs, if the forensic order were not anticipated.

There are times when the expected forensic order is not made, for a range of reasons, for example if the matter is adjourned. This means a bed has remained empty at the high security unit at The Park when it could have been providing treatment and care to a patient. Where more than one forensic order is expected, the problem can be accentuated.

A forensic order detaining a person as an in-patient in the high security unit at The Park will almost always be made for a person who is in custody on remand, without acute psychiatric needs. If the person's needs were acute, he or she would have been transferred to an authorised mental health service (AMHS) as a classified patient.

Given that the person is generally coming from custody without acute needs, and will have been awaiting the outcome of the MHC proceedings for a period of time, the transfer of the patient, once a forensic order is made, is not critically urgent.

Allowing a short period of time, perhaps a week, for the implementation of the order would be of great assistance in managing capacity and clinical needs more efficiently at The Park and at other facilities around the State.

There would, however, need to be an exception where a person’s mental health has deteriorated rapidly in the lead up to the MHC hearing, and the MHC believes the person needs urgent high secure in-patient treatment and care.

20.2.12 Admissibility of MHC decisions in sentencing

The Act deals with a person for whom a determination is made by the MHC and who then has a trial in the criminal courts (section 317). This section provides that, if the issue of the person’s mental condition is raised at the person’s trial, the Court’s decision is not admissible in evidence. Under the Criminal Code definitions, ‘trial’ includes ‘sentence’.
The apparent purpose of this section is to ensure a jury is not influenced by the MHC decision. However, the information in the MHC decision would be of great assistance in sentencing - for example, when a finding of diminished responsibility reduces a murder charge to manslaughter and the accused person is returned to the Supreme Court for sentencing, or where the finding is of sound mind and fit for trial, and the person returns to the regular courts and is found guilty of the offence.

In the past, MHC decisions have been considered by sentencing courts, but recently the question of whether this is within the meaning of the Act has emerged. It is proposed to clarify that MHC decisions are admissible in sentencing proceedings.

20.2.13 Making of forensic orders on appeals from Mental Health Review Tribunal fitness for trial decisions

Where a person has been found temporarily unfit for trial and, on a subsequent review, the Tribunal finds the person fit for trial, proceedings for the offence continue in the regular courts. The person must be brought before the relevant court within seven days and the forensic order for the person ends at that point (section 219).

However, the Tribunal decision may be appealed to the MHC. If on appeal the MHC declares the person unfit for trial there is some uncertainty as to whether the MHC has the power to reinstate the forensic order.

In these circumstances the MHC should be able to make a forensic order, or reinstate the previous forensic order. The MHC could also make an involuntary treatment order that can only be revoked by the Tribunal (see Background Paper 4).

20.2.14 Monitoring of accused people temporarily unfit for trial

There is an inconsistency between the management of people found temporarily unfit for trial by the MHC and by other courts (Supreme Court or District Court). Those found unfit by the MHC have a forensic order made, and are monitored by the Tribunal under Chapter 6, part 4 of the Act. Persons found by juries in the District or Supreme Court to be unfit are also monitored by the Tribunal (section 208(b)). However, where the prosecution and the defence in a District or Supreme Court trial agree that the accused is unfit for trial, the matter is adjourned and the person is monitored by the court hearing the matter, usually in a less methodical way. This can also lead to delays which disadvantage accused persons, victims, and other affected people.

Although this arises rarely, it would be preferable to have a consistent process in Queensland, whether the question of fitness is first raised in the MHC or in a regular court.

20.2.15 Miscellaneous confidentiality issues

There are several miscellaneous issues in relation to confidentiality that were identified during the Review.

- The meaning of ‘publish’

The Act prohibits the publication of certain information (sections 524 to 527), such as a report of a MHC decision, before a trial in the same matter is concluded. It is fairly clear
that the word ‘publish’ is intended to mean the relatively broad dissemination of the information. ‘Publish’ is defined in Chapter 14, part 5 as follows:

**publish** means publish to the public by way of television, newspaper, radio, the internet or other form of communication.

However, this definition may not achieve the level of protection that seems to be intended in Chapter 14, part 5. It would be beneficial to clarify the definition to ensure that communication such as distributing leaflets in letterboxes or announcing the information at a public meeting is covered.

- **The meaning of ‘report’**

The Act defines ‘report’ for Chapter 14, part 5 in a way that is not sufficiently clear (section 523). On one reading, it might be restricted to a transcript of a proceeding or the reasons for a decision, such as is found in law reports. Alternatively, it could mean something more like a media report – an account of what happened in the proceeding.

It is evident that ‘report’ should not be restricted to a written transcript, as the intent of the provisions would be undermined if it were. It would be beneficial if this were clarified.

- **Data for research**

The Act does not expressly deal with the use of information for research. There is a view that the MHC and the Tribunal can use their inherent powers under the Act (sections 384 and 439) to allow researchers to access information. It would be up to the MHC or Tribunal to determine how an application for access should be assessed, and what safeguards should be in place in each case. It would however be beneficial to be more explicit. Similar provisions are in place under the *Youth Justice Act 1992* (section 297) in relation to accessing information from the department administering that Act for research purposes.

Research into what processes and interventions are effective is important to the continuous improvement of mental health services and legal frameworks. For some research, de-identified, aggregated data will be sufficient - the Act does not prevent the release of such data. Other research will require qualitative analysis of individual cases, and it will not always be realistic for the MHC, Tribunal, or departmental staff to de-identify large volumes of this material. Specific provisions in the Act would allow this to be appropriately managed.

- **Identifying accused people subject to involuntary treatment orders or forensic orders**

As discussed in Background Paper 3, court liaison officers have a role in identifying persons who may have a mental illness for the purpose of diversion from the criminal justice system for treatment and care. To facilitate this, it would be prudent to include a provision authorising the exchange of information between the courts, police, other relevant government agencies and Health portfolio staff for the purpose of identifying persons who may have a mental health defence. This would also support automated arrangements which would result in a significant increase in productivity for court liaison officers.
20.2.16 Accessing health records for private psychiatrist’s reports

Patients to whom Chapter 7, part 2 does not apply must obtain their own psychiatric reports for the purpose of presenting a mental health defence. To enable these reports to be prepared, the patient’s records need to be accessed from the relevant AMHS.

Lawyers have advised the Review of difficulties and delays in accessing records from authorised mental health services and other health services.

There is no reason why all relevant information should not be accessed by a patient’s lawyer or private psychiatrist on request, consistent with administrative access policies. If the patient has capacity to consent, the records should be provided once the AMHS receives the consent. To address circumstances where the patient cannot consent, the Act should provide that records may be provided to a lawyer representing the patient. This provision would over-ride the confidentiality obligations of the Hospital and Health Boards Act 2011.
Review of the Mental Health Act 2000

Background Paper

May 2014
21. Other Issues

21.1 Background

Consultation and analysis during the Review identified a number of other potential improvements to the Mental Health Act 2000 that are not addressed in the other Background Papers.

21.2 Issues

The following other issues were identified during the Review:

1. The objectives of the Act
2. Inconsistent, inadequate and incorrect notifications under the Act
3. Enhancements to the Director of Mental Health Annual Report
4. Terminology used in the Act
5. Clarifying that involuntary patients may be treated at any authorised mental health service
6. Clarifying aspects of the search provisions
7. Terms for assisting psychiatrists, and
8. Automatic revocation of involuntary treatment orders

21.2.1 Objectives of Act

Section 4 of the Act provides that:

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:

(a) safeguarding their rights and freedoms, and

(b) balancing their rights and freedoms with the rights and freedoms of other persons.

The development of new mental health legislation in Queensland provides the opportunity to update the legislative objectives.

The focus of the proposed legislation relates to persons with a mental illness who are unable to consent to treatment and are at risk of causing harm to themselves or someone else, or suffering mental or physical deterioration. In the absence of legislation, there are inadequate legal authorities for people in this situation to receive treatment and care. One objective of the Act should therefore be to improve and maintain the health and well-being of persons with mental illnesses who do not have the capacity to consent to treatment.

The legislation also deals with persons who are charged with offences and are found to have been of unsound mind at the time of an unlawful act (which was the basis for the charge) or unfit for trial. This applies to persons with a mental illness or an intellectual disability. In these circumstances, the legislation aims to divert persons from the criminal justice system and, if necessary, protect the community from further unlawful...
acts by providing treatment and care. If it is necessary to protect the public, the person may also be detained in an authorised mental health service (AMHS) or the forensic disability service. As this treatment and care (or detention) occurs without the person's consent, legal authorities are required. It should be noted that this group of persons is much less significant than those who may receive involuntary treatment due to an inability to consent to treatment. In 2012-13, 6508 involuntary treatment orders were made, while 145 forensic orders were made.¹

It is also important that the objectives emphasise the importance of safeguarding the rights of involuntary patients, as is stated in the purpose for the current Act. The objectives should also indicate that, in achieving the Act’s objectives, a person’s liberty and rights are to be adversely affected only if there is no less restrictive way to protect the person’s health and safety or to protect others (see section 9 of Act).

It is also proposed that the objectives emphasise the importance of recovery orientation in the provision of services, as outlined in Background Paper 7 (section 7.2.5).

21.2.2 Notifications

The Act provides for notifications to certain people and bodies about certain events and changes in patients’ status. The Review identified a number of issues with the notification provisions in the Act, namely:

- notifications are inconsistent and not all of the people that should receive notifications are listed in the Act
- notifications are often not timely; in some cases there are no time-frames for the making of notifications
- some notifications should be discretionary to take into account where a notification may cause harm to the person’s health or put the safety of any person at risk
- some notifications would better serve their purpose if there was more information provided, and
- there are some omissions of notifications of significant events and errors in some provisions.

Where decisions are made under the Act or legal processes commenced (e.g. the commencement of a Mental Health Review Tribunal review), it is essential that the Act states who is to be notified, who is responsible for notifying, and the time-frame for the notification. The persons to be notified must be relevant to the matter and be applied consistently throughout the Act.

There are also circumstances in which a notification may result in a risk of harm to the patient or others, for instance if parents were notified of events relating to their child where the child had been subject to parental abuse. It is therefore proposed that all notifications within the Act be subject to a qualification taking into account situations where the notification may cause harm to a patient’s health or put the safety of any person at risk.

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¹ Source: Department of Health and Mental Health Court
21.2.3 Director of Mental Health annual report

The Act requires the Director of Mental Health (DMH) to give the Minister a report on the administration of the Act at the end of each financial year (section 494). The Minister must table a copy of the report in the Legislative Assembly within 14 sitting days after the Minister receives it.

The annual report provides the following type of information:

- data on the application of the involuntary provisions of the Act
- an update on significant reforms to the mental health system
- a list of authorised mental health services, administrators and the number of appointments made under the Act.

The Act would benefit from expanding on the content and timing of the annual report issued by the DMH.

In addition, the Act outlines the DMH’s responsibility to facilitate the proper and efficient administration of the Act, and to monitor and audit compliance with this Act (section 489). The recommendations of the Promoting balance in the forensic mental health system – Final Report – Review of the Queensland Mental Health Act 2000 (the Butler Report) proposed establishing a system of regular statutory audits of all authorised mental health services to monitor and ensure the involuntary admission, assessment, treatment and care of persons complies with relevant legislation.

As of July 2011, all authorised mental health services in Queensland had been audited using an audit process developed to meet these recommendations. When non-compliance is identified and deemed to be significant, the DMH appoints a panel of investigators under the Act. There have been 10 investigations since 2010, namely:

- three in 2010-11
- six in 2011-12
- none in 2012-13
- one in 2013-14

To ensure greater transparency and improve responsiveness to regulatory compliance, the annual report should report on statutory non-compliance by authorised mental health services. It would be appropriate that the Act expand the content of the annual report so the DMH must provide an overview of significant non-compliance with the Act, the recommendations provided to the AMHS and the actions taken by the AMHS in response to that recommendation.

21.2.4 Terminology

The following issues with defined terms in the Act have been raised:

- use of the terminology ‘Senior Registered Nurse on duty’ is out-dated
- the term ‘audio-visual link’ is not currently defined, and
- the use of the term ‘Chief Psychiatrist’ would be preferable to ‘Director of Mental Health’.

The Act contains a number of references to the functions and responsibilities of a ‘senior registered nurse on duty’. It was identified during the Review that the use of this term, and its definition in the Act, may be causing confusion in some clinical areas as it
does not fit with established positions within Hospital and Health Services. The term ‘registered nurse in charge of the shift’ is a more appropriate designation for use in the Act.

There is no definition of ‘audio-visual link’ in the dictionary to the Act, which has resulted in some confusion as to the appropriate technological medium that may be used for conducting an examination by audio-visual link. The Evidence Act 1977 defines audio visual links to mean - “facilities, including closed-circuit television, enabling reasonable contemporaneous, continuous audio and visual communication between persons at different places”. It is proposed that this definition be used in the Act.

It was also identified during the Review that the position of ‘Director of Mental Health’ may be more appropriately referred to as ‘Chief Psychiatrist’ within the Act. Chief Psychiatrist is the term most commonly used in other jurisdictions and would also minimise confusion with the role of the Executive Director, Mental Health Alcohol and Other Drugs Branch in the Health Department.

### 21.2.5 Clarifying that involuntary patients may be treated at any authorised mental health service

The Act requires that a nominated AMHS is responsible for the detention, treatment and care of a person on an involuntary treatment order (ITO) or forensic order (sections 108 and 288).

There are circumstances in which it is advantageous that a person may be treated and cared for in an AMHS other than the service responsible for the person’s involuntary status. These circumstances include where a person is being transitioned between services, where a person becomes unwell while temporarily residing in another region (e.g. while on holidays or working), or where an itinerant person lives across multiple regions. The Act should clarify that treatment and care can be provided by another AMHS in these circumstances.

### 21.2.6 Searches

The following issues with the ‘search provisions’ of the Act have been identified:

- Clarify that the ‘without consent’ search provisions do not apply to voluntary patients
- There is currently no authority within the Act to conduct searches on a person who is taken to a public hospital where there is no AMHS readily available for examination under an emergency examination order (EEO) or for involuntary assessment
- The threshold for a clinician to undertake a search without an involuntary patient’s consent requires more flexibility to allow for clinical judgement, and
- There is some uncertainty about how searches of visitors may be undertaken at places other than a high security unit.

Under the Act, health practitioners are authorised to conduct non-consensual searches on both voluntary and involuntary patients in AMHS (section 351). The purpose of the searches is to ensure the protection of patients and the security and good order of the AMHS. However, searches of voluntary patients without consent may be seen as a significant breach of individual rights as the patient’s treatment and care is entirely subject to the individual consenting to the provision of treatment and care. Searches of
voluntary patients should only be carried out with the consent of the patient, as occurs in other health settings.

There are instances in regional, rural and remote areas where a person under an EEO\(^2\) or involuntary assessment documents is taken to the nearest public hospital for examination or assessment. There is currently no authority under the Act to conduct searches on a person in these circumstances. Searches are restricted to facilities that have been declared to be authorised mental health services. It would be beneficial if the Act allowed non-consensual searches to include a public hospital in these circumstances. Any searches conducted in a public hospital would be subject to the existing safeguards in the Act that apply in relation to searches.

Under the Act, a search in an AMHS (other than a high security unit) can only be conducted if a doctor or the senior registered nurse on duty reasonably believes a patient in the health service has possession of a harmful thing (as defined) (section 353). There are risks associated with waiting for direct evidence to meet this reasonable belief. This restriction may prevent health practitioners from conducting a search considered necessary to ensure the safety of the patient or another person. Although providing for greater clinical discretion to conduct searches may be considered to impact on individual rights, the impact is justified to ensure the safe operation of the AMHS.

The Act provides for searches of visitors that may be undertaken at a high secure facility, but does not address whether and how visitors may be searched at other authorised mental health services. While the need for searching visitors generally is likely to be infrequent, it would be beneficial for the Act to state that the provisions that apply for the searches of visitors at a high security unit do not prevent other authorised mental health services undertaking reasonable searches of visitors if the service believed it necessary for the safety and welfare of patients, staff and others at the service. This would also allow the service to refuse entry if a person did not agree to be searched.

### 21.2.7 Assisting psychiatrists

It has been identified during the Review that it may be appropriate to limit the number of terms that assisting psychiatrists may be appointed to assist the Mental Health Court (MHC). The functions of the assisting psychiatrists include examining material for hearings and advising the MHC on the significance of clinical issues relevant to the proceedings (section 389).

Although not explicit in the Act, the practice for the appointment of the MHC justices has been that a judge will serve two consecutive terms only of six years in total. There is no equivalent practice that occurs for the assisting psychiatrists.

For consistency with the appointments of the MHC justices, it is proposed that a maximum limit of two consecutive terms be included in the Act for assisting psychiatrists.

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\(^2\) To be replaced by revised emergency transport provisions under the proposals in the Discussion Paper.
21.2.8 Automatic revocation of involuntary treatment orders

The Act provides that an ITO automatically ends if the patient does not receive treatment under the order for six months (section 118).

The Review has been advised that this provision may encourage a person to not engage with the service to facilitate ‘release’ from the ITO, including by moving interstate. However, the 2012-13 data for involuntary treatment orders indicates that only one percent of involuntary treatment orders were ceased through this process. Notwithstanding the limited application of this section, it is proposed to discontinue the automatic ending of an ITO after six months.

3 Source: Director of Mental Health Annual Report 2012-13
Review of the Mental Health Act 2000

Background Paper

May 2014
22. Impact of Proposals

The proposals in the Discussion Paper will achieve greater value in health services, strengthen support for patients, strengthen community protection, improve health service delivery, provide for a simpler and fairer Act, and improve legal processes. The proposals will also significantly reduce the cost of administering the legislation. However, the impacts will vary between different stakeholder groups, including:

- mental health consumers (including involuntary patients under the Act)
- family, carers and other support persons
- authorised mental health services (including administrators, authorised doctors and authorised mental health practitioners)
- the Queensland community (including victims)
- the Mental Health Court
- the criminal courts
- lawyers, including Legal Aid, the Director of Public Prosecutions and Crown Law
- the Mental Health Review Tribunal
- the Department of Health and the Director of Mental Health, and
- the Queensland Police Service.

The Addendum to this Background Paper summarises the impacts of the proposals on these stakeholders.

Impacts may include the following:

- strengthened alignment with legislative objectives (e.g. improved patient support, strengthened community protection)
- resource impacts for persons administering the legislation and other persons, including reduced paperwork or increased statutory obligations
- improved flexibility in legislative provisions, including improved alignment with good clinical practice
- enhanced clarity in the legislation, reducing compliance costs and creating certainty for users of the legislation, and
- simplified, quicker and fairer processes.

In making submissions to the Discussion Paper stakeholders are invited to provide comments on the impact of particular proposals.
### Addendum: Impact Assessment Matrix

<table>
<thead>
<tr>
<th>Major positive impact</th>
<th>Minor positive impact</th>
<th>Neutral – no impact</th>
<th>Minor negative impact</th>
<th>Major negative impact</th>
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#### Mental Health Consumers

- **Reduction in assessment documents**
  - *  
  - ++ Significantly reduced paperwork burden  
  - +  
  - Greater value in health services  

- **Involuntary Examination Authority (replaces Justices Examination Order)**
  - ++  
  - Same as for mental health consumers  
  - Improved support from authorised mental health services  
  - +  
  - Significantly reduced number of involuntary authorities (will offset extra support for applications)  
  - ++  
  - Significant reduction in incorrect use of authorities (including vexatious use)  

- **Emergency transport**
  - +  
  - Clarifies assistance in emergencies where person is  
  - Same as for mental health consumers  
  - +  
  - Authority to extend assessment period if cannot  
  - +  
  - Clarifies assistance in emergencies where person is

#### Family, Carers & Other Support Persons

- **Reduction in assessment documents**
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#### Authorised Mental Health Services

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#### Queensland Community (incl. victims)

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#### Mental Health Court

- **Reduction in assessment documents**
  - *  
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  - Same as for mental health consumers  
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#### Criminal Courts

- **Reduction in assessment documents**
  - *  
  - ++ Significantly reduced paperwork burden  
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#### Lawyers

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#### Mental Health Review Tribunal

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#### Department of Health (incl. DMH)

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#### Queensland Police Service

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<th>Queensland Community (incl. victims)</th>
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<th>Lawyers</th>
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2. Classified Patients

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<tr>
<th>Transfer to AMHS and admission of patients</th>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
<th>Authorised Mental Health Services</th>
<th>Queensland Community (incl. victims)</th>
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<tr>
<td>Greater clarity around transfer and admission of patients. Expedited process to transfer acutely unwell persons in prison.</td>
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<td>Reduced paperwork burden Greater clarity around powers and responsibilities</td>
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<td>More certainty about timing of DMH intervention.</td>
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<thead>
<tr>
<th>Treatment and care of classified patients</th>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
<th>Authorised Mental Health Services</th>
<th>Queensland Community (incl. victims)</th>
<th>Mental Health Court</th>
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<td>Greater clarity around rights to treatment.</td>
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<td>Better reflection of good clinical practice. Greater clarity around treatment obligations.</td>
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<table>
<thead>
<tr>
<th>Returning a person to lawful custody</th>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
<th>Authorised Mental Health Services</th>
<th>Queensland Community (incl. victims)</th>
<th>Mental Health Court</th>
<th>Criminal Courts</th>
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<td>Greater clarity around process of returning to custody</td>
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<td>Greater clarity around the powers and processes to return a person to custody.</td>
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</table>
### 3. Assessment of Persons Charged with an Offence

<table>
<thead>
<tr>
<th>Offences that can be heard summarily for persons on an ITO or forensic order</th>
<th>Same as for mental health consumers</th>
<th>Discontinuation of most mandatory psychiatrist reports; enables resources to be redirected to higher priority front line services.</th>
<th>Resources to be redirected to higher priority front line services.</th>
<th>An increase in cases in the Magistrates Court that would have been diverted due to unfitness or unsound of mind.</th>
<th>Quicker resolution for people who don’t wish to pursue a mental health defence.</th>
<th>Discontinuation of most mandatory psychiatrist reports; enables resources to be redirected to higher priority services.</th>
<th>An increase in cases in the Magistrates Court that would have been diverted due to unfitness or unsound of mind.</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Person has right to choose whether to seek assessment; quicker if person doesn’t wish to pursue a mental health defence.</td>
<td>Reduced publicly funded assessments for mental health defence, leading to increased potential for persons who may have a mental health defence to receive a criminal penalty.</td>
<td>Increased demand for court liaison support.</td>
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<td>+ Reduced publicly funded assessments for mental health defence, leading to increased potential for persons who may have a mental health defence to receive a criminal penalty.</td>
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<tr>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
<th>Authorised Mental Health Services</th>
<th>Queensland Community (incl. victims)</th>
<th>Mental Health Court</th>
<th>Criminal Courts</th>
<th>Lawyers</th>
<th>Mental Health Review Tribunal</th>
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<td>person to custody.</td>
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## Mental Health Court actions following a finding of unsoundness of mind or unfitness for trial

<table>
<thead>
<tr>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
<th>Authorised Mental Health Services</th>
<th>Queensland Community (incl. victims)</th>
<th>Mental Health Court</th>
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<th>Mental Health Review Tribunal</th>
<th>Department of Health (incl. DMH)</th>
<th>Queensland Police Service</th>
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</thead>
<tbody>
<tr>
<td>++ Person has right to choose whether to seek assessment Quicker reports and resolution of proceedings.</td>
<td>++ Same as for mental health consumers.</td>
<td>+ Significantly quicker assessments.</td>
<td>+ Quicker resolution of proceedings.</td>
<td>+ Reduced caseload, reducing time between reference and determination.</td>
<td>+ Quicker resolution of proceedings</td>
<td>+ Quicker resolution of proceedings</td>
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<td>+ Quicker resolution of proceedings</td>
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</table>

### Offences that must be heard on indictment

* For persons on an ITO or forensic order
  - + No change, unless the DMH directs an assessment.
  - * Same as for mental health consumers.
  - * Dependent on how many assessments are directed by DMH; likely to be limited in number.
  - * Greater certainty that these persons will be properly assessed.
  - * + Greater community protection through conditions on forensic orders (e.g. drug and alcohol program).
  - * * Tribunal ITO provides more flexibility to make orders appropriate to the circumstances.

* For persons not on an ITO or forensic order
  - * No change, unless DMH directs an assessment; likely to be limited in number.
  - * * No change, unless DMH directs an assessment; likely to be limited in number.

## 4. Orders and Other Actions Following Court Findings

+ MHC options include less onerous orders, more appropriate to circumstances.
+ Same as for mental health consumers.
++ Fewer forensic orders; AMHS will have more flexibility to redirect resources to higher priority front line services.
+ Resources to be redirected to higher priority front line services.
+ Greater community protection through conditions on forensic orders (e.g. drug and alcohol program).
+ Tribunal ITO provides more flexibility to make orders appropriate to the circumstances.
+ Tribunal ITO provides more flexibility to make orders appropriate to the circumstances.
+ *
<table>
<thead>
<tr>
<th>Duration and revocation of forensic orders</th>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
<th>Authorised Mental Health Services</th>
<th>Queensland Community (incl. victims)</th>
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<tr>
<td>Cannot apply for revocation during non-revoke period; although provides greater stability.</td>
<td>Same as for mental health consumers, but may receive greater benefit from greater stability.</td>
<td>Reduced workload in preparing for MHRT hearings during non-revoke period; clinicians can focus on care and treatment.</td>
<td>Period of stability during non-revoke period; victims can focus on their own recovery.</td>
<td>More flexibility to make orders appropriate to the circumstances</td>
<td>Reduced workload for patient's representative and Crown Law during non-revoke period</td>
<td>Reduced workload during non-revoke period</td>
<td>Reduced workload for patient's representative and Crown Law during non-revoke period</td>
<td>Reduced workload during non-revoke period</td>
<td>Reduced workload during non-revoke period</td>
<td>Reduced workload during non-revoke period</td>
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**Special hearings following finding of permanent unfitness for trial**

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<tr>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
<th>Authorised Mental Health Services</th>
<th>Queensland Community (incl. victims)</th>
<th>Mental Health Court</th>
<th>Criminal Courts</th>
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<tr>
<td>Substantial positive impact in the small number of relevant cases</td>
<td>Same as for mental health consumers</td>
<td>Marginal positive impact if inappropriate order is revoked</td>
<td>Minimal increase in resources for special hearings (approx. five hearings p.a.)</td>
<td>Minimal increase in DPP workload and applications for Legal Aid funding</td>
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**Magistrates Court powers on finding of unsoundness of mind or unfitness for trial**

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<thead>
<tr>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
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<tr>
<td>Person may be placed on an ITO, whereas the only option currently is to discharge.</td>
<td>Person may be placed on an ITO, whereas the only option currently is to discharge.</td>
<td>Person may be placed on an ITO, whereas the only option currently is to discharge.</td>
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<td>Person may be placed on an ITO, whereas the only option currently is to discharge.</td>
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**Increased likelihood of appropriate treatment and care when offending behaviour results from mental illness or intellectual disability, minimising the risk of recurrence.**

**Magistrates may have powers to deal with unsoundness and unfitness.**

**Magistrates may on occasions believe they do not have sufficient evidence on which to base decisions.**

**Police prosecutors may need to develop submissions for magistrates on which to base orders.**

**Potential for increased number of ITO’s; AMHS may not agree with decision of magistrate; reduced autonomy. Court liaison officers may be asked to provide more support for Magistrates’ decisions.**

**Increased likelihood of appropriate treatment and care when offending behaviour results from mental illness or intellectual disability, minimising the risk of recurrence.**

**Magistrates may have powers to deal with unsoundness and unfitness.**

**Magistrates may on occasions believe they do not have sufficient evidence on which to base decisions.**

**Police prosecutors may need to develop submissions for magistrates on which to base orders.**
5. Treatment and Care of Involuntary Patients

| Provision of treatment and care | ++ Better aligned with good clinical practice. Safeguards: auditable records; duty of administrator to ensure treatment. Ability to apply to Tribunal for review of treatment | ++ Same as for mental health consumers. As far as practicable, families to be consulted on treatment. | * Administrators: Additional duties (offset in part by removal of treatment plans) |
| Treatment in the community | + Patient to be provided with information on community treatment and responsibilities while in the community | + Same as for mental health consumers. As far as practicable, families to be consulted on treatment in the community | * Clearer statement of patient responsibilities while in the community |
| Authorisation processes for | + | + | + | + | + | + | + | + | + | + | + | + | + | + |

6. Treatment in the Community
<table>
<thead>
<tr>
<th>LCT (ITO)</th>
<th>Greater clarity around the use of LCT. Community treatment default category</th>
<th>Same as for mental health consumers</th>
<th>Greater clarity around criteria and use of LCT.</th>
<th>Greater clarity, consistency and transparency in use of LCT.</th>
<th>Greater clarity around criteria and use of LCT.</th>
<th>Greater clarity around criteria and use of LCT.</th>
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<tr>
<td>Authorisation processes for LCT (FO)</td>
<td>Greater clarity, consistency and transparency in use of LCT.</td>
<td>Greater clarity, consistency and transparency in use of LCT.</td>
<td>Greater clarity, consistency and transparency in use of LCT.</td>
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<td>Greater clarity, consistency and transparency in use of LCT.</td>
<td>Greater clarity, consistency and transparency in use of LCT.</td>
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<tr>
<td>Monitoring conditions</td>
<td>Extension of monitoring conditions to all involuntary patients, although likely to be used infrequently</td>
<td>Same as for mental health consumers</td>
<td>Extension of monitoring conditions to all involuntary patients, although likely to be used infrequently</td>
<td>Potentially improved perception of greater security for victims</td>
<td>Greater clarity about the role and options for MHC in setting conditions. May have increased workload if conditions are appealed</td>
<td>Greater clarity about the role and options for MHRT Increased workload in reviewing application of monitoring conditions</td>
</tr>
<tr>
<td>Treatment and care for patients in custody</td>
<td>Clarify custodial status and status under Act</td>
<td>Same as for mental health consumers</td>
<td>Clarify custodial status and status under Act</td>
<td>Clarify custodial status and status under Act</td>
<td>Clarify custodial status and status under Act</td>
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</table>
### Rights for family, carers and support persons

- **++** Greater recognition of patient’s right to be supported by family, carers and support persons, including greater support in decision making
- **++** Greater recognition of right to support patients, including greater support in decision making and access to information
- **+** Improved relationship with family, carers and support persons
- **+** Greater clarity around the patient’s rights and responsibilities.

### Independent Patient Companion

- **++** Significantly greater support for patients to understand rights. Improved interaction with MHRT, treating teams, guardians, advocates and legal representatives
- **++** Same as for mental health consumers
- **-** Increased resource commitment; balanced by improvements in consumer engagement in patient’s treatment and recovery, and removal of allied person requirements
- **+** Strengthened protection of consumer rights, including improved interaction with the MHRT, treating teams, guardians and advocates
- **+** More constructive input from patients and support persons
<table>
<thead>
<tr>
<th>Attendance at Mental Health Review Tribunal (MHRT) hearings</th>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
<th>Authorised Mental Health Services</th>
<th>Queensland Community (incl. victims)</th>
<th>Mental Health Court</th>
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<th>Mental Health Review Tribunal</th>
<th>Department of Health (incl. DMH)</th>
<th>Queensland Police Service</th>
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<tbody>
<tr>
<td>+ Simplifies and clarifies the role of advocacy and support persons in MHRT hearings.</td>
<td>+ Same as for mental health consumers</td>
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<td>*</td>
<td>+ Simplify and clarify the role of legal representation, advocacy and support persons in MHRT hearings.</td>
<td>+ More constructive input from legal representation, advocacy and support persons in MHRT hearings.</td>
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8. Support for Victims

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<tr>
<th>Identifying and providing services to victims</th>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
<th>Authorised Mental Health Services</th>
<th>Queensland Community (incl. victims)</th>
<th>Mental Health Court</th>
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<tr>
<td>++</td>
<td>Inclusion of principles to support victims</td>
<td>Removal of barriers to information exchange to identify and support victims</td>
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Victim Submissions

<table>
<thead>
<tr>
<th></th>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
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</thead>
<tbody>
<tr>
<td>+ Fairer process – distinguishes between evidence and impact statement</td>
<td>+ Same as for mental health consumers</td>
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</tr>
<tr>
<td>+ Clarify purpose of impact statement</td>
<td>+ Reduces re-traumatisation on victim of re-submission of statements</td>
<td>+ Clarify purpose of impact statement</td>
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<tr>
<td>+ Clarify purpose of impact statement</td>
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<tr>
<td>+ Clarify purpose of impact statement</td>
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</table>

Removal of barriers to information exchange to identify and support victims

Removal of barriers to information exchange to identify and support victims

Reduction of re-traumatisation for victims
<table>
<thead>
<tr>
<th>Mental Health Consumers</th>
<th>Family, Carers &amp; Other Support Persons</th>
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</thead>
<tbody>
<tr>
<td><strong>Forensic information orders</strong></td>
<td>*</td>
<td>*</td>
<td>- Minimal increased workload to provide summary of patient progress</td>
<td>+ Increased information with forensic information orders.</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>- Minimal increased workload to provide summary of patient progress</td>
<td>+ Reduced MHRT workload - no role in forensic information orders</td>
</tr>
<tr>
<td><strong>Tribunal hearings – purpose and decisions</strong></td>
<td>++</td>
<td>Greater clarity and consistency with regard to purpose of reviews, decisions and criteria for decisions</td>
<td>++</td>
<td>Same as for mental health consumers</td>
<td>++</td>
<td>For parties to hearings: Greater clarity and consistency with regard to purpose of reviews, decisions and criteria for decisions</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td><strong>Legal representation</strong></td>
<td>++</td>
<td>Greater legal representation to ensure rights are protected</td>
<td>++</td>
<td>Same as for mental health consumers</td>
<td>+</td>
<td>As a party to a hearing: Better consideration of issues in hearings</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

9. Mental Health Review Tribunal

<p>| <strong>Tribunal hearings – purpose and decisions</strong> | ++ | Greater clarity and consistency with regard to purpose of reviews, decisions and criteria for decisions | ++ | Same as for mental health consumers | ++ | For parties to hearings: Greater clarity and consistency with regard to purpose of reviews, decisions and criteria for decisions | * | * | * | ++ | For parties to hearings: Greater clarity and consistency with regard to purpose of reviews, decisions and criteria for decisions | ++ | For parties to hearings: Greater clarity and consistency with regard to purpose of reviews, decisions and criteria for decisions | * | As a party to a hearing: Better consideration of issues in hearings | * | As a party to a hearing: Better consideration of issues in hearings | * |</p>
<table>
<thead>
<tr>
<th>Mental Health Consumers</th>
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<td>(but minimal impact due to limited DMH involvement)</td>
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</tbody>
</table>

**Improved Tribunal processes**

- Fainer process – can present evidence
- Reduced delays due to use of Deputy President
- Same as for mental health consumers
- As a party to a hearing:
  - Streamlined processes:
    - less frequent
    - mandatory ITO reviews;
    - hearings on the papers;
    - no reviews for missing patients
- + Publication of de-identified decisions

**10. Interstate Transfers**

<table>
<thead>
<tr>
<th>Transfer of patients on forensic orders</th>
<th>+ + Removal of barriers to transfer of forensic patient – resulting in improved treatment, care and recovery</th>
<th>+ + Same as for mental health consumers</th>
<th>+ + Removal of barriers to transfer of forensic patient – resulting in improved treatment, care outcomes</th>
<th>*</th>
<th>+</th>
<th>*</th>
<th>*</th>
<th>+</th>
<th>- New role for approving transfers into Qld; balanced by improved patient outcomes</th>
<th>- New role for approving transfers out of Qld; balanced by improved patient outcomes</th>
</tr>
</thead>
</table>

**11. Forensic Disability**

<table>
<thead>
<tr>
<th>Forensic orders for</th>
<th>+</th>
<th>+</th>
<th>+</th>
<th>*</th>
<th>+</th>
<th>*</th>
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<tbody>
<tr>
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<tr>
<td>persons with dual diagnosis</td>
<td>Enables treatment and care under the one order</td>
<td>Same as for mental health consumers</td>
<td>Greater clarity; allows treatment and care under the one order</td>
<td>Greater clarity for deciding forensic orders</td>
<td></td>
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<td></td>
<td>Greater clarity; allows treatment and care under the one order.</td>
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<tr>
<td>Forensic orders (disability) managed by agency that provides care</td>
<td>+ Ensures appropriate care can be provided</td>
<td>+ Same as for mental health consumers</td>
<td>+ Ensures appropriate care can be provided</td>
<td>+ Ensures proper implementation of MHC orders</td>
<td>*</td>
<td>*</td>
<td>+ Better informed MHRT hearings</td>
<td>-</td>
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</tbody>
</table>

12. Guardianship and Attorneys

| Nil (no significant impacts) | * | * | * | * | * | * | * | * | * |

13. Restraint and Seclusions

<p>| Restraint and seclusion | + Clarification of provisions and increased transparency of restraint and seclusion extensions. Increased safeguards and oversight by DMH on the use of restraint. | + Same as for mental health consumers | - Administrators and authorised doctors: Some increased requirements under Act in relation to mechanical restraint (high security only) | + Greater clarity and transparency in provisions | * | * | * | * | − Some increased approvals required for mechanical restraint (high security only). | + Clarification that restraint offence does not prevent exercise of powers under PPRA |</p>
<table>
<thead>
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<tr>
<td><strong>14. Regulated Treatments</strong></td>
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<tr>
<td>Psycho-surgery</td>
<td>+ Greater clarity about what constitutes psychosurgery</td>
<td>+ Same as for mental health consumers</td>
<td>+ Greater clarity about what constitutes psychosurgery</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>+ Greater clarity about what constitutes psychosurgery</td>
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<tr>
<td>Electro-convulsive therapy (ECT)</td>
<td>+ Improved processes, including quicker MHRT hearings and appeals</td>
<td>+ Same as for mental health consumers</td>
<td>+ Improved MHRT processes</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>+ Reduced workload due to removal of dual applications</td>
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<td><strong>15. Transport Issues</strong></td>
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<tr>
<td>Inconsistent transport powers</td>
<td>+ Greater clarity around transport powers, including safeguards</td>
<td>+ Same as for mental health consumers</td>
<td>++ Greater clarity around transport powers</td>
<td>+ Greater clarity around transport powers</td>
<td>- Need to provide risk assessment to police</td>
<td>*</td>
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<tr>
<td>Return of patients to community</td>
<td>+ All persons involuntarily transported to an AMHS to be safely returned to community</td>
<td>+ Same as for mental health consumers</td>
<td>* Minor increased workload</td>
<td>*</td>
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<tr>
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16. Regional, Rural and Remote Issues

- Regional, Rural and Remote Issues
  - Greater flexibility in where and how treatment is provided; improved patient outcomes
  - Same as for mental health consumers
  - Greater flexibility in where and how treatment is provided; improved patient outcomes
  - Removal of barriers to the use of audio visual technology
  - Minor increased in approving rural and remote services

17. Indigenous and Multicultural Issues

- Indigenous and Multicultural Issues
  - Implementing principles will result in improved patient outcomes
  - Same as for mental health consumers
  - Implementing principles will result in improved patient outcomes
  - Improved outcomes; MHRT hearings to include child psychiatrist

18. Children and Adolescents

- Children and adolescents
  - Greater clarity around capacity to consent
  - Improved rights; MHRT hearings to include child psychiatrist
  - Same as for mental health consumers
  - Improved outcomes; MHRT hearings to include child psychiatrist
### 19. Streamlined Processes

| Forms under the Act | * | * | ++ Significantly less paperwork | * | + Greater value in health services | * | * | * | + Greater clarity about the use of approved forms, ways to provide information, and template forms | * |

| Powers and responsibilities of authorised positions | * | * | + Greater flexibility and clarity around statutory positions | * | + Ability to investigate and prosecute offences, resulting in improved community protection | * | * | * | + Removed requirement to approve and renew AMHP. Ability to investigate and prosecute offences resulting in better oversight | * |

### 20. Other Legal Issues
### Other Legal Issues

<table>
<thead>
<tr>
<th>Mental Health Consumers</th>
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<tr>
<td>Wrongful convictions reversed (where proceedings suspended)</td>
<td>Same as for mental health consumers</td>
<td>Better management of high security patients in anticipation of making of forensic orders</td>
<td>More matters determined by MHC – more reliable determinations</td>
<td>Clearer definition of ‘fitness for trial’ Increased opportunity for unsoundness to be determined by MHC</td>
<td>Greater consistency in role of courts v. MHC</td>
<td>Clarifies key legal matters and provides greater consistency in role of courts v. MHC</td>
<td>Minor increased workload in monitoring temporary unfitness for trial</td>
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<td>Faireer processes for monitoring temporary unfitness</td>
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### 21. Other Issues

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<th>Nil (no significant impacts)</th>
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Review of the Mental Health Act 2000 –Background Paper - 17 -