20 APR 2017

RM folder reference No:	C-ECTT-17/223
Division/HHS:	CED
File Ref No:	

Brief for Ministerial Correspondence

SUBJECT: Potential impact on occupational violence prevention training and staff safety of the Chief Psychiatrist's prone restraint policy position

Key Issues

1. On 2 March 2017, Mr Ian Tracy, Occupational Violence Prevention Nurse Educator, wrote to the Honourable Cameron Dick MP, Minister for Health and Minister for Ambulance Services, regarding the *Mental Health Act 2016* and occupational violence prevention (OVP) training and prone restraint.
2. Mr Tracy has raised concerns that the Chief Psychiatrist policy on physical restraint under the *Mental Health Act 2016* may effectively prevent authorised mental health service staff from using the prone restraint technique, in which the person restrained is lying chest-down on the floor, that this policy position was inconsistent with OVP training, that OVP training in the prone restraint technique would need to cease, and that this would negatively impact staff safety.
3. The Chief Psychiatrist policy allows prone restraint; however, requires authorised mental health service staff to be appropriately trained in restraint techniques, to avoid the use of prone restraint wherever possible, and where prone restraint is necessary, to limit use to a maximum of two minutes, and to maintain the safety of the patient.
4. The requirements of the Chief Psychiatrist policy are consistent with the recommendations contained in a patient safety communique released by the Department of Health's Patient Safety and Quality Improvement Service in June 2016, regarding physical restraint (Attachment 2), and are also consistent with best practice approaches in other jurisdictions internationally and interstate.
5. On 3 April 2017, Dr John Reilly, Acting Executive Director, Mental Health Alcohol and Other Drugs Branch, Department of Health, responded to Mr Tracy (Attachment 1).
6. The Mental Health Alcohol and Other Drugs Branch is working with the Patient Safety and Quality Improvement Service to communicate to Hospital and Health Services (HHS) the need to review local OVP training and update it where necessary to align with policy and best practice.
7. It is anticipated that OVP training will continue to include prone restraint techniques for use by staff when necessary, and that HHSs may need to ensure the training includes additional emphasis on:
   - 7.1. alternative restraint positions;
   - 7.2. maintaining the safety of the patient during all instances involving restraint;
   - 7.3. how to safely move a restrained person out of the prone position; and
   - 7.4. how to safely release a person who has been restrained in the prone position.
8. This approach is consistent with the Positive and safe violence reduction and management program (National Health Service, United Kingdom), which has been endorsed by the National Institute of Health and Care Excellence.
9. The Department of Health has been granted limited access to the content of the United Kingdom program manual. This will be used to assist HHSs to compare current OVP training with the best practice program and to highlight necessary changes to local practice.

Results of Consultation

10. Consultation with HHSs during finalisation of the Chief Psychiatrist policy identified the need for HHSs to review OVP training and update it where necessary to align with the policy.
11. Further consultation has occurred with relevant units within the Office of the Chief Psychiatrist, and with the Patient Safety and Quality Improvement Service.

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12. All consulted parties agree that OVP training in Queensland Health facilities should be consistent with best practice in order to improve outcomes for both patients and staff.

Resource Implications (including Financial)

13. There may be resourcing implications for HHSs, where it is identified that changes are required to local OVP training.

Background

14. OVP training modules delivered by HHSs include training in physical restraint as a last resort in safely managing behaviourally disturbed persons who pose a serious risk to their own safety and/or the safety of others. Techniques taught include restraint of a person in a prone position.
15. Physical restraint is associated with injuries to both patients and staff, and has been implicated in patient deaths. In particular, both the prone restraint position and also the flexion of the patient's head or trunk towards the knees can restrict the ability of the patient to breathe, potentially leading to positional asphyxia.
16. The Chief Psychiatrist policy on physical restraint places limitations on the use of restraint and strict requirements on staff to protect the safety of patients and staff. The policy is consistent with international and interstate guidelines and policy directives, which recommend that the use of prone restraint be avoided wherever possible, and that where it does occur, it should be:
    16.1. limited to the shortest possible duration; and
    16.2. managed by trained staff, preferably using a coordinated team response.
17. The patient safety communique on physical restraint recommended that HHSs review local policy and procedures relevant to restraint, and update where necessary (Attachment 2).

Attachments

18. Attachment 1: Copy of letter from Dr John Reilly – C-ECTF-17/223
    Attachment 2: Copy of patient safety communique

Department Contact Officer

Ms Janet Martin, Director, Clinical Governance Unit, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division, on telephone 3328 9546 or ([redacted] or by email at Janet.Martin@health.qld.gov.au

Enquiries to: Janet Martin
Director, Clinical Governance
Mental Health Alcohol and Other Drugs Branch
Telephone: 3328 9456
File Ref: CE002314/ C-ECTF-17/223

Mr Ian Tracy
Nurse Educator
West Moreton Hospital and Health Service
c/- ianjtracy@health.qld.gov.au

Dear Mr Tracy

Thank you for your email dated 2 March 2016 regarding the potential implications of the Chief Psychiatrist policy on physical restraint under the *Mental Health Act 2016* for occupational violence prevention (OVP) training and staff safety. The Minister has asked me to respond on his behalf.

I understand that you are concerned for the safety of both patients and staff. I would like to clarify that the Chief Psychiatrist policy places limitations on the use of physical restraint to protect the safety of patients and staff, and that within these limitations, the policy allows the use of prone restraint where it is necessary, and requires authorised mental health service staff to be appropriately trained in restraint techniques.

The requirements of the policy are consistent with the recommendations contained in a patient safety communique released by the Department of Health's Patient Safety and Quality Improvement Service in June 2016 regarding physical restraint (refer to attachment), and with approaches in other jurisdictions internationally and interstate.

The Mental Health Alcohol and Other Drugs Branch is working with the Patient Safety and Quality Improvement Service to ensure clarity for Hospital and Health Service (HHS) staff whom are responsible for ensuring that local OVP training is reviewed and where necessary updated to align with policy and best practice.

It is anticipated that OVP training will continue to include prone restraint techniques for use by staff when necessary, and that HHS may need to ensure the training includes additional emphasis on:

- alternative restraint positions
- maintaining the safety of the patient during all instances involving restraint
- how to safely move a restrained person out of the prone position, and
- how to safely release a person who has been restrained in the prone position.

This approach is consistent with the *Positive and safe violence reduction and management program* (National Health Service, United Kingdom), which has been endorsed by the National Institute of Health and Care Excellence (NICE).

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I am aware that the West Moreton Hospital and Health Service has been granted limited access to the content of the UK program manual for the purposes of comparing current OVP training with the best practice program and highlighting necessary changes to local practice.

Yours sincerely

Dr John Reilly
A/Executive Director
Mental Health Alcohol and Other Drugs Branch
03/04/2017

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Patient Safety and Quality Improvement Service
PATIENT SAFETY COMMUNIQUÉ

"A Patient Safety Communiqué disseminates safety and quality information to ensure lessons learned are shared across hospital and health services"

Distributed to:

- **Hospital and Health Service Chief Executives**
- **Chief Health Officer**
- **Queensland Ambulance Service**

We recommend you inform:

- Executive Directors Medical Services
- Executive Directors of Nursing and Midwifery
- Executive Directors Mental Health Services
- Directors of Clinical Governance
- Emergency Department Clinical Directors
- Mental Health Service Clinical Directors
- Clinical Educators
- Safety and quality staff
- All relevant clinical staff

Contact:
Office of the Chief Psychiatrist
Mental Health Alcohol and Other Drugs Branch

Phone:
3328 9374

Email:
OCP-MHAODB@health.qld.gov.au

Subject:	**Physical restraint safety risks**
Issued by:	Patient Safety and Quality Improvement Service
Issue Date:	7 June 2016
Approved by:	Associate Professor John Allan, Chief Psychiatrist Signature: SIGNED

Purpose

The purpose of this Patient Safety Communiqué is to:

- notify Hospital and Health Services (HHSs) of the safety risks associated with the physical restraint of a person.
- ensure that appropriate action is taken by HHSs to reduce the likelihood of preventable patient harm.

Background

Restraint of any type carries a risk of injury to both patients and staff. Physical restraint has been associated with sudden patient death, even in young, apparently healthy people. The physical restraint of a person in a prone (face down) position is a significant risk and can cause asphyxia. Prone restraint was a contributing factor to a Queensland patient death in 2015.

Risk factors that contribute to physical restraint-related injury or death include:

- the position a person is held in, particularly where breathing is restricted or pressure is exerted that prevents venous return.
- the duration of restraint.
- acute behavioural disturbance or 'excited delirium' – an extreme form of behavioural disturbance characterised by severe agitation, aggression, paranoia, unusual strength and numbness to pain.
  - patients exhibiting delirium and extreme hyperthermia
  - excited delirium which can result in sudden death
- stress related cardiomyopathy.
- the presence of alcohol and/or drugs in the person's system, including administered medications
- pre-existing medical conditions (in some cases), e.g. obesity, respiratory disease, heart disease, diabetes (especially hypoglycaemia), history of chronic alcoholism or cocaine dependence.

"Safety Information is a document that provides lessons learnt from statewide, national and international sources".

Recommendations

- Avoid physical restraint wherever possible.
- Ensure appropriate executive oversight of physical restraint practice.
- Ensure that the physical restraint process is a coordinated team effort with a suitably qualified professional leading the process.
- Do not maintain physical restraint for longer than 10 minutes.
    - Physical restraint of any type should be for the shortest possible time.
- Control the limbs and ensure the patient's airway is clear. Wherever possible avoid exerting pressure on the neck, chest, abdomen or hips.
    - In clinical health settings a registered nurse or medical practitioner should be placed at the patient's head to protect the airway, monitor vital signs and ensure the chest area is not compressed during restraint.
- Avoid (if possible) taking consumers to the floor during physical restraint.
    - If restraint on the floor is necessary, the supine (face up) position should be used rather than the prone (face down) position.
    - If in the course of a physical restraint a person is placed in a face down position, this must cease as soon as practicable and should not exceed 2 minutes.
    - A staff member should ensure that the person is not in the prone position for longer than 2 minutes.
- Use extra caution in the case of any of the following:
    - acute behavioural disturbance, 'excited delirium' or prolonged struggle.
    - intoxication or administration of acute sedation.
    - suspected underlying medical or neurological conditions.
- Monitor the patient physically for as long as clinically necessary following restraint.
- Educate all staff in the use of restraint and the risks associated with it.
- Ensure that all physical restraints are treated as incidents and appropriately documented, escalated and reviewed.
- Develop and update (if required) relevant HHS policy and procedure to minimise the use of restraint.

Acknowledgements:

Caring Solutions UK. 'Review of the medical theories and research relating to restraint related deaths', University of Central Lancashire, United Kingdom (2011)

Chief Psychiatrist Clinical Practice Advisory Notice 'Practice of prone restraint', Department of Health, Victoria (2013)

Clinical Practice Guideline 'Emergency restraint and sedation – Code Grey', The Royal Children's Hospital Melbourne, Victoria (2013)

National Institute for Health and Care Excellence (NICE) guideline 'Violence and aggression: short term management in mental health, health and community settings' (NG10), United Kingdom (2015)

Policy Directive 'Aggression, seclusion and restraint in mental health facilities in NSW', Ministry of Health, New South Wales (2012)

24 APR 2017

DOH RTI 4812

RM folder reference No:	C-ECTT-17595
Division/HHS:	CED
File Ref No:	

Brief for Ministerial Correspondence

SUBJECT: Evaluation proposal – Suicide Risk Assessment and Management in Emergency Department training program

Key Issues

1. On 3 March 2017, Professor David Crompton, Director, Australian Institute for Suicide Research and Prevention (AISRAP), wrote to the Honourable Cameron Dick MP, Minister for Health and Minister for Ambulance Services, submitting an evaluation proposal for the Suicide Risk Assessment and Management in Emergency Department training program (SRAM-ED).
2. On 24 November 2016, the Minister met with Ms Kerrie Keepa, Founder, Survivors of Suicide – Fighting Against Suicide Toll, and Ms Jacinta Hawgood, Senior Lecturer/Clinical Psychologist, AISRAP, to discuss the progress and planned evaluation of SRAM-ED.
3. At this meeting, AISRAP was invited to submit a research proposal for evaluation of the SRAM-ED training with a specific focus on patient outcomes.
4. Located at Griffith University, AISRAP is a World Health Organization Collaborating Centre for Research and Training in Suicide Prevention. AISRAP also manages the Queensland Suicide Register and provides education and training programs.
5. Whilst it is acknowledged that AISRAP is well placed to undertake such research, AISRAP cannot be rationalised as a single source supplier of evaluation capability. Other organisations, including the Queensland Centre for Mental Health Research or the Black Dog Institute, may also be considered as potentially suitable suppliers.
6. The Clinical Excellence Division will undertake a transparent procurement process by going to market to seek offers for a more comprehensive evaluation of SRAM-ED, to be undertaken in the 2017/18 financial year.
7. The Queensland Centre for Mental Health Learning (Learning Centre), who developed the SRAM-ED training package in collaboration with the Clinical Skills Development Service, has been allocated $640,000 over three years (2016/17 to 2018/19) to continue implementation of the SRAM-ED training and undertake ongoing evaluation.
8. Specifications will be developed to expand on the current evaluation of SRAM-ED developed by the Learning Centre.
9. AISRAP will be invited to submit an offer against the new specifications as will other appropriate research providers.

Results of Consultation

10. The Learning Centre has developed an evaluation plan for SRAM-ED to measure the process of delivering a train-the-trainer model, the impact of SRAM-ED in terms of clinician knowledge, attitudes, confidence, and the outcome of the implementation of SRAM-ED within Hospital and Health Services.
11. The Learning Centre is currently exploring adding the evaluation of clinician behaviour change (following completion of SRAM-ED training, for example, via a medical chart audit) to its evaluation plan.
12. The AISRAP proposal extends on the evaluation currently being undertaken by the Learning Centre in terms of the evaluation of patient specific outcomes only.

Resource Implications (including Financial)

13. Funding is available as part of the budget allocation for the Suicide Prevention in Health Services Initiative (2016/17 to 2018/19).

RM folder reference No:	C-ECTF-17/595
Division/HHS:	CED
File Ref No:	

Background

14. The Minister made a well-publicised commitment to Ms Keepa to provide training to emergency department staff following the tabling on 5 May 2015 of a petition calling for the urgent implementation of specialised training for emergency department staff on how to recognise and respond to suicidal patients.

15. In 2015, funding of $382,000 was allocated from the 2015/16 Department of Health budget to enhance training and the development of other resources to support emergency department staff to recognise, assess, and manage people at risk of suicide (BR061589 – Attachment 2).

16. On 28 April 2016, the Minister approved the reallocation of $9.6 million over three years (2016/17 to 2018/19) for a Suicide Prevention in Health Services Initiative (the Initiative) announced in the State Budget (BR064036 – Attachment 3).

17. The Initiative comprises three major components including the continued implementation and evaluation of training for hospital ED staff and other frontline acute mental health care staff in recognising, responding to and providing care to people presenting to Hospital and Health Services with suicide risk.

Attachments

18. Attachment 1: Letter of response to Professor David Crompton – C-ECTF-17/595
Attachment 2: Copy of BR061589
Attachment 3: Copy of BR064036

Department Contact Officer

Ms Janet Martin, Director Clinical Governance, Mental Health Alcohol and Other Drugs Branch, on telephone 3328 9456

Minister for Health and
Minister for Ambulance Services
Member for Woodridge

C-ECTF-17/595

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Professor David Crompton
Director
Australian Institute for Suicide Research and Prevention
Griffith University
176 Messines Ridge Road
MOUNT GRAVATT QLD 4122

25 OCT 2017

Dear Professor ~~Crompton~~ David,

Thank you for your letter co-signed by Professor Analise O'Donovan, submitting an evaluation proposal for the Suicide Risk Assessment and Management in Emergency Department training program (SRAM-ED).

I appreciate the Australian Institute for Suicide Research and Prevention (AISRAP) taking the time to develop a detailed research proposal, following prior discussions and our meeting on 24 November 2016.

The Queensland Centre for Mental Health Learning (Learning Centre) has been allocated $640,000 over three years (2016/17 to 2018/19) to continue implementation of SRAM-ED and undertake ongoing evaluation. This is funded as a core component of the three-year Suicide Prevention in Health Services Initiative. The Learning Centre has developed an evaluation plan for SRAM-ED to measure the process of delivering a train-the-trainer model, the impact of SRAM-ED in terms of clinician knowledge, attitudes, confidence, and the outcome of the implementation of SRAM-ED within Hospital and Health Services.

I am advised that the Clinical Excellence Division, Department of Health, agrees that a more comprehensive evaluation of SRAM-ED focusing on patient experiences and outcomes would be beneficial. To expand on the evaluation plan developed by the Learning Centre, specifications for a broader evaluation will be considered. The Clinical Excellence Division will undertake a transparent procurement process and seek offers from all suitable suppliers with health service evaluation capability.

Thank you again for the evaluation proposal submitted by AISRAP as per our prior discussions. I welcome AISRAP submitting an evaluation proposal by way of an offer against the new specifications once released.

Should you require any further information in relation to this matter, I have arranged for Ms Janet Martin, Director, Clinical Governance, Mental Health Alcohol and Other Drugs Branch, Department of Health, on telephone 3328 9456, to be available to assist you.

Yours sincerely

CAMERON DICK MP
Minister for Health
Minister for Ambulance Services

2 JUL 2015

Department RecFind No:	BR061589
Division/HHS:	HSCI
File Ref No:	

Ministerial Brief for Noting

Requested by:

☐ Department ☒ Minister's office

SUBJECT: Enhancing suicide prevention within emergency departments (ED)

NOTED **PLEASE DISCUSS**

Cameron Dick MP
Minister for Health and Minister for Ambulance Services

Date: 15 July 2015

Key Issue(s)

1. There has been growing community concern regarding the rates of suicide in Queensland with a recent focus on the quality of care provided to people at risk of suicide who present to emergency departments (ED).
2. Evidence states patient demand on EDs is growing, becoming increasingly complex and highly variable. Strategies such as system re-design, enhancement to staffing levels, expansion of community-based services to reduce the demand on EDs, or comprehensive mental health assessment of all individuals who present at risk require substantial resources and funding.
3. A lower cost and more immediate option is the provision of training to ED staff to enhance clinical knowledge and skills, including when, to whom, and how to refer, and access to resources.
4. Skill enhancement will be developed through the delivery of a new training package with flexible modes of delivery using a train-the-trainer model. Training will target medical, nursing and allied health ED staff and cover recognition, assessment, management and appropriate referral of people at risk of suicide presenting to an ED. Using the Queensland Health Emergency Events Management, Mental Health Module as a base, the Queensland Centre for Mental Health Learning in collaboration with the Clinical Skills Development Service, will develop the package and train a minimum number of nominated 'trainer' staff at each site.
5. The Department of Health will further support ED staff through enhancements to existing educational resources by:
   - 5.1. amending the Queensland Health Guidelines for Suicide Risk Assessment and Management to include clinical best practice guidelines for ED and mental health triage and crisis assessment and treatment teams.
   - 5.2. reviewing the Queensland MIND (Mental Illness Nursing Documents) Essentials resource; a mental health resource for generalist nurses which includes caring for a person who is suicidal. This will assist in the early detection and management of patients at risk who enter hospital either through a planned admission or an ED; and
   - 5.3. the revision, development and implementation of these clinical resources will be undertaken by the Mental Health Alcohol and Other Drugs Clinical Network and the Queensland Emergency Department Strategic Advisory Panel.
   - 5.4. assigning a temporary full time project officer to support the revision and implementation of the educational resources.
6. Funding up to $382,000 will be allocated from the 2015-2016 Department budget to support this initiative (attachment 1).

Dr Jeannette Young
A/Director-General
2 / 7 /2015

Department RecFind No:	BR061589
Division/HHS:	HSCI
File Ref No:	

Background

7. Queensland's public mental health services and other acute health care settings such as EDs, play a crucial role in assessing and managing suicide risk.
8. The Australasian College for Emergency Medicine draft Quality Standards for Emergency Departments, to be released July 2015, recognises that ED clinicians require skills in the identification, assessment and treatment of mental health problems in presenting patients.
9. A recent collaboration between emergency medicine and mental health has identified opportunities to work together to provide optimal care for people at risk of suicide. This will be supported by the release of a patient safety communiqué in June 2015 to ED and mental health staff to promote resources, training opportunities and local level partnerships.

Sensitivities

10. Nil.

Consultation

11. Chair, Queensland Emergency Department Strategic Advisory Panel.
12. Chair, Mental Health Alcohol and Other Drugs Statewide Clinical Network.
13. Director, Queensland Centre for Mental Health Learning.
14. Business Manager, Mental Health Alcohol and Other Drugs Branch.

Attachments

15. Attachment 1: Development of training program and resource review costing.

Department Contact Officer

Associate Professor John Allan, Acting Executive Director, Mental Health Alcohol and Other Drugs Branch, Health Service and Clinical Innovation Division telephone 3328 9538 or

Department RecFind No:	**BR061589**
Division/HHS:	**HSCI**
File Ref No:	

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)	Content verified by: (CEO/DDG/Div Head)
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Office of the Chief Psychiatrist	Office of the Chief Psychiatrist	Mental Health Alcohol and Other Drugs Branch	Health Service and Clinical Innovation Division
3328 9547	3328 9456	3328 9061	3405 6181
26/05/2015	27/05/2015	27/05/2015	1 June 2015

Ministerial Brief for Approval

Department RecFind No:	BR064036
Division/HHS:	CED
File Ref No:	

Requested by:

☒ Department ☐ Minister's office

SUBJECT: Funding for the suicide prevention in health services initiative

Recommendations

It is recommended that the Minister:

1. **Approve** the allocation of $9.6 million over three years (2016/2017 to 2018/2019) for the suicide prevention in health services initiative.

APPROVED / NOT APPROVED PLEASE DISCUSS

Cameron Dick MP
Minister for Health and Minister for Ambulance Services

Date: 28/04/16

Ministerial Office comments

Issues

1. Data from the interim Queensland Suicide Register (iQSR) administered by the Australian Institute for Suicide Research and Prevention shows that 764 people died by suspected suicide in Queensland in the 2015 calendar year. This is a significant increase on previous years (634 deaths in 2013 and 620 deaths in 2014).
2. The 2015 suicide data analysis project indicates that almost 25% of people who died by suspected suicide had a contact with a Queensland Health service within seven days prior to their death. Research also indicates that a significant proportion of people who die by suicide have had recent contact with a primary healthcare provider prior to their death.
3. At the System Leadership Forum held on 8 February 2016, Hospital and Health Service (HHS) Chief Executives supported a proposal to establish a taskforce to strengthen health service actions aimed at preventing suicide.
4. The suicide prevention health service initiative will form an integral part of the Mental Health Drug and Alcohol Services Plan 2016-2021 and will include:
    5.1. The establishment and operation over three years of a suicide prevention health taskforce in partnership between Queensland Health and Primary Health Networks. The taskforce will identify and translate the evidence base for suicide prevention initiatives in a health service delivery context, support implementation of early intervention initiatives, and promote the strengthening of partnerships across HHSs and Primary Health Networks at a statewide and local level (budget $8 million over three years 2016-2017 to 2018-2019).

Michael Walsh
Director-General
20/04/2016

Department RecFind No:	BR064036
Division/HHS:	CED
File Ref No:	

5.2. A multi-incident analysis of sentinel events relating to deaths by suspected suicide of people that had a recent contact with a health service. The analysis will inform the work of the taskforce and HHS development initiatives across the state (budget $1.1 million over two years 2016-2017 to 2017-2018).

5.3. Implementation of sustainable training for emergency department staff and other front line acute mental health care staff in recognising, responding to and providing care for people presenting to HHS with suicide risk (budget $0.5 million over three years 2016-2017 to 2018-2019).

Results of Consultation

5. System Leadership Forum members are supportive of the proposal to establish a health service taskforce.
6. Patient Safety and Quality Improvement Service are supportive of an analysis of sentinel events relating to deaths by suspected suicide using a Quality Council framework.
7. Chief Finance Officer has confirmed the funding source.

Resource Implications (including Financial)

8. Funding has been provisionally re-allocated from the Department of Health's 2015-2016 surplus funds for this initiative across financial years 2016/2017 to 2018/2019.
9. Funding for a total of $9.6million has been built into the Clinical Excellence Division's control budget to develop and implement a health service targeted suicide prevention strategy. as follows:

10.1. 2016/2017 - $1.7 million;

10.2. 2017/2018 - $4.2 million; and

10.3. 2018/2019 - $3.7 million

Background

10. On 10 September 2015, the Minister for Health and Minister for Ambulance Services launched the Queensland Suicide Prevention Action Plan 2015-2017 which aims to reduce suicide and its impact on Queenslanders and is a step towards achieving a 50% reduction in suicides in Queensland within a decade.
11. Over the past decade, the overall trend of suicide rates in Queensland have remained relatively stable, however is consistently higher than the national average.
12. On 28 October 2015, the Queensland Mental Health Commissioner wrote to the Minister regarding iQSR data which indicated a rise in the number of suicides in Queensland in the first half of 2015, compared with the same period in 2013 and 2014.
13. On 2 November 2015, a project officer was appointed to undertake an in-depth analysis of the iQSR data linked to six Queensland Health databases.

Sensitivities

14. The 2015 iQSR data, which shows the increase in suspected suicides in Queensland in not publically available.

Department Contact Officer

Ms Janet Martin, Acting Director Clinical Governance, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division, on telephone 3328 9456 or [redacted]

Department RecFind No:	**BR064036**
Division/HHS:	**CED**
File Ref No:	

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
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A/Director, Clinical Governance	Executive Director	Deputy Director-General
Mental Health Alcohol and Other Drugs Branch	Mental Health Alcohol and Other Drugs Branch	Clinical Excellence Division
3328 9456	3328 9538	3405 6181
18 April 2016	20 April 2016	20 April 2016

Minister for Health and
Minister for Ambulance Servi
Member for Woodridge

Back from
D-G meeting
Bk 2/7
Find Findings?

C-ECTF-17/595

Professor David Crompton
Director
Australian Institute for Suicide Research and Prevention
Griffith University
176 Messines Ridge Road
MOUNT GRAVATT QLD 4122

Dear Professor Crompton

Thank you for your letter co-signed by Professor Analise O'Donovan, submitting an evaluation proposal for the Suicide Risk Assessment and Management in Emergency Department training program (SRAM-ED).

I appreciate the Australian Institute for Suicide Research and Prevention (AISRAP) taking the time to develop a detailed research proposal, following prior discussions and our meeting on 24 November 2016.

The Queensland Centre for Mental Health Learning (Learning Centre) has been allocated $640,000 over three years (2016/17 to 2018/19) to continue implementation of SRAM-ED and undertake ongoing evaluation. This is funded as a core component of the three-year Suicide Prevention in Health Services Initiative. The Learning Centre has developed an evaluation plan for SRAM-ED to measure the process of delivering a train-the-trainer model, the impact of SRAM-ED in terms of clinician knowledge, attitudes, confidence, and the outcome of the implementation of SRAM-ED within Hospital and Health Services.

I am advised that the Clinical Excellence Division, Department of Health, agrees that a more comprehensive evaluation of SRAM-ED focusing on patient experiences and outcomes would be beneficial. To expand on the evaluation plan developed by the Learning Centre, specifications for a broader evaluation will be considered. The Clinical Excellence Division will undertake a transparent procurement process and seek offers from all suitable suppliers with health service evaluation capability.

Thank you again for the evaluation proposal submitted by AISRAP as per our prior discussions. I welcome AISRAP submitting an evaluation proposal by way of an offer against the new specifications once released.

Should you require any further information in relation to this matter, I have arranged for Ms Janet Martin, Director, Clinical Governance, Mental Health Alcohol and Other Drugs Branch, Department of Health, on telephone 3328 9456, to be available to assist you.

Yours sincerely

CAMERON DICK MP
Minister for Health
Minister for Ambulance Services

Ministerial Brief for Approval

RM folder reference No:	C-ECTF-17/936
Division/HHS:	CED
File Ref No:	

SUBJECT: Treatment of people unfit to plead or found not guilty by reason of mental impairment

Recommendations

It is recommended the Minister:

1. **Endorse** the National Statement of Principles Relating to Persons Unfit to Plead or Not Guilty by Reason of Cognitive or Mental Impairment (the Principles).

APPROVED / NOT APPROVED **PLEASE DISCUSS**

2. **Sign** the letter to the Honourable Yvette D'Ath MP, Attorney-General, Minister for Justice and Minister for Training and Skills (Attachment 1), endorsing the Principles.

APPROVED / NOT APPROVED **PLEASE DISCUSS**

Cameron Dick MP **Date:** 11/05/17
Minister for Health and Minister for Ambulance Services

Ministerial Office comments

Issues

1. The Minister for Health and Minister for Ambulance Services' endorsement of the Principles is sought prior to 19 May 2017 when Attorneys-General from across Australia will meet to consider the Principles. .
2. The Principles are included in an attachment to the Law, Crime and Community Safety Council (LCCSC) paper (refer to Attachment 2A).The Principles were discussed at the National Justice and Policing Senior Officers Group (NJPSOG) meeting on 4 April 2017, attended by senior officers of the Department of Justice and Attorney-General (DJAG). These will be presented to LCCSC (Attorneys-General meeting) on 19 May 2017.
3. The LCCSC paper also includes data collected from all jurisdictions on people unfit to plead or found not guilty by reason of mental impairment (Attachment 2B) and interstate forensic transfers (Attachment 2C).
4. The principles and data sets have been developed by a cross-jurisdictional Working Group on the Treatment of People Unfit to Plead or Found Not Guilty by reason of Mental Impairment (the Working Group), established under the LCCSC in November 2015.
5. Given that matters pertaining to mental health mainly fall within the Queensland Health (QH) portfolio, Queensland is represented on the Working Group by officers from the Department of Health and DJAG.

Michael Walsh
Director-General
28/4/2017

Department RecFind No:	C-ECTF-17/936
Division/HHS:	CED
File Ref No:	

6. The Principles represent a high-level, non-binding set of best practice principles for jurisdictions to consider and adapt, as appropriate, in the development of legislation, policy and practice regarding the treatment of persons found unfit to plead or not guilty (of unsound mind in Queensland's legislation) by reasons of cognitive/mental health impairment in the criminal justice and mental health systems.
7. The Principles are sufficiently high-level to reflect the Queensland context and are consistent with the objectives and principles set out in the *Mental Health Act 2016*.
8. It is intended that the Principles, if endorsed by LCCSC, will be made available on the Department of Health website.
9. The LCCSC paper recommends that Attorneys-General:
   - 9.1 endorse the Principles which will be made available on the Commonwealth Attorney-General's Department (AGD) website for each jurisdiction to determine how to best use and implement this resource to encourage reform within their own jurisdiction;
   - 9.2 agree that the AGD review the Principles in five years' time, in consultation with States and Territories, to ensure they remain relevant and in line with best practice in this area;
   - 9.3 note the work to analyse and identify gaps in existing data on people unfit to plead or found not guilty by reason of mental impairment and to share information and summarise interstate transfer arrangements; and
   - 9.4 agree that these papers form the basis of work that can now be progressed outside of the LCCSC process through the establishment of a standing inter-jurisdictional working group, to be chaired by the Commonwealth. The standing inter-jurisdictional working group will meet regularly to share information and continue projects, for example, on improving data and interstate transfer processes, as resources allow.
10. Queensland will continue to work with other jurisdictions as part of the proposed standing inter-jurisdictional working group to improve data collection methods in relation to the cohort in the criminal justice and mental health systems.

Vision

11. This brief aligns with the directions of Delivering healthcare and Pursuing innovation set out in Queensland Health's 10 year vision *My health, Queensland's future: Advancing health 2026*.

Results of Consultation

12. The Department of the Premier and Cabinet has been consulted and has confirmed Cabinet support is not required before Queensland endorses the Principles.

Resource Implications (including Financial)

13. There are no resource implications in relation to this matter.

Background

14. At the 21 October 2016 LCCSC meeting, Attorneys-General noted progress on the Principles and outcomes to date of the Working Group on collecting and collating existing data on fitness to stand trial, the defence of mental impairment and interstate forensic transfers and agreed to consider the Principles and data collection outcomes at their next meeting.

Sensitivities

15. There are no sensitivities in relation to this matter.

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Attachments

16. Attachment 1: Letter to the Honourable Yvette D'Ath MP, Attorney-General, Minister for Justice and Minister for Training and Skills;
    Attachment 2: LCCSC paper and attachments 2A, 2B and 2C

Department Contact Officer

Ms Jan Rodwell, Manger, Policy, Systems and Compliance, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division, on telephone 3328 9581

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Manager, Policy, Systems and Compliance	Executive Director Mental Health Alcohol and Other Drugs Branch	Deputy Director-General
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24 March 2017	27 March 2017	28 March 2017
	Dr John Reilly, A/ED MHAODB 13 April 2017	

Minister for Health and
Minister for Ambulance Services
Member for Woodridge

Queensland Government

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C-ECTF-17/936

12 MAY 2017

The Honourable Yvette D'Ath MP
Attorney-General, Minister for Justice and
Minister for Training and Skills
Member for Redcliffe
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

I write to endorse the National Statement of Principles Relating to Persons Unfit to Plead or Not Guilty by Reason of Cognitive or Mental Impairment (the Principles), which will be presented in a paper to the Law, Crime and Community Safety Council (LCCSC) meeting, which you will be attending on 19 May 2017. The paper also includes data collected from all jurisdictions on people unfit to plead or found not guilty by reason of mental impairment and interstate forensic transfers.

As you will be aware, the principles and data sets have been developed by a cross-jurisdictional Working Group on the Treatment of People Unfit to Plead or Found Not Guilty by reason of Mental Impairment (the Working Group) with representation by our respective Departments, established under the LCCSC in November 2015.

I note that the Principles represent a high-level, non-binding set of best practice principles for jurisdictions to consider and adapt, as appropriate, in the development of legislation, policy and practice regarding the treatment of persons found unfit to plead or found not guilty (of unsound mind in Queensland's legislation) by reasons of cognitive / mental health impairment in the criminal justice and mental health systems.

I am supportive of the Principles as they reflect the Queensland context and are broadly consistent with the objectives and principles set out in the *Mental Health Act 2016*. However, I note there is no mention of recognising the rights and interests of victims and the safety of the community, which is an important aspect of Queensland's mental health system. I recommend the inclusion of victim and community safety recognition in the Principles, and suggest that this is raised for consideration at the upcoming LCCSC meeting.

I look forward to advice on the outcomes of the LCCSC meeting.

Should your officers require any further information in relation to this matter, I have arranged for Associate Professor John Allan, Executive Director, Mental Health Alcohol and Other Drugs Directorate, Department of Health, on telephone 3328 9581 to be available to assist.

Yours sincerely

CAMERON DICK MP
Minister for Health
Minister for Ambulance Services

Dear Attorney,
It is critical that the guidelines include and give priority to, community safety and the rights and interests of victims.

Law, Crime and Community Safety COUNCIL

Commonwealth Paper

NJPSOG Item No. 2

Melbourne, 19 May 2017

Treatment of people unfit to plead or found not guilty by reason of mental impairment

RECOMMENDATION

The Commonwealth recommends that Ministers:

(a) **endorse** the National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health Impairment (**Attachment A**) which will be made available on the Commonwealth Attorney-General's Department website for each jurisdiction to determine how to best use and implement this resource to encourage reform within their own jurisdiction.

(b) **agree** that the Attorney-General's Department review the Principles in five years' time, in consultation with states and territories, to ensure they remain relevant and in-line with best practice in this area.

(c) **note** the work to analyse and identify gaps in existing data on people unfit to plead or found not guilty by reason of mental impairment (**Attachment B**) and to share information and summarise interstate transfer arrangements (**Attachment C**).

(d) **agree** that these papers form the basis of work that can now be progressed outside of the LCCSC process through the establishment of a standing inter-jurisdictional working group, to be chaired by the Commonwealth, that will meet regularly to share information and continue projects (for example, on improving data and interstate transfer processes) as resources allow.

DECISION AND DOCUMENT/S TO BE MADE PUBLICLY AVAILABLE

Ministers:

(a) Ministers agreed that the *National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health Impairment* (Attachment A) be made available on the Commonwealth Attorney-General's Department website for each jurisdiction to determine how to best use and implement this resource to encourage reform within their own jurisdiction. The Principles will be reviewed in five years' time to ensure they remain relevant.

(b) Ministers noted work to analyse and identify gaps in existing data on people unfit to plead or found not guilty by reason of mental impairment and to share information and to summarise interstate transfer arrangements. Ministers agreed that this work is now best progressed outside of the LCCSC process through an inter-jurisdictional working group that will meet regularly to share information and continue projects as resources allow.

Version 0.1 Date: <<insert date document became final>>

CONSULTATION

- Commonwealth Attorney-General's Department
- State and territory Departments of Attorneys-General, Justice and Health

KEY ISSUES

- The National Principles are a best practice guide, informed by recent law reform reviews across jurisdictions. The Principles identify safeguards that may be applied through the justice process and during the period in which a person, who is found unfit to plead or not guilty by reason of cognitive disability or mental health impairment, is subject to orders. The Principles are a non-binding document, drafted at a sufficiently high-level, in order for each jurisdiction to consider in the context of their own legislation, policy and practices and implement at their own discretion.
- The Principles have been developed through extensive consultation with the Working Group. with each jurisdiction contributing to the structure and content of the Principles. Significant issues identified by jurisdictions have been addressed through various drafting iterations.
- Releasing the Principles publicly will be a proactive response to the recommendations of the recent inquiry into 'indefinite detention of people with cognitive and psychiatric impairment in Australia' by the Senate Community Affairs References Committee. The Attorney-General's Department will review the Principles five years' time, in consultation with states and territories, to ensure they remain relevant and in-line with best practice.
- The Commonwealth Attorney-General's Department collated existing data from all jurisdictions on people unfit to plead or found not guilty by reason of mental impairment and prepared a document identifying gaps and inconsistencies in data collection across jurisdictions. The existing gaps, or unavailability of data, have made it challenging to assess the current situation in Australia regarding the experience of people with cognitive disability or mental health impairment in the criminal justice system. The Victorian Department of Health and Human Services also prepared a document collating existing data from all jurisdictions on interstate forensic transfers.

BACKGROUND

Key issues

The treatment of people with cognitive disability and mental impairment in Australia's criminal justice system has been the subject of ongoing scrutiny—including through high profile human rights complaints against Australia through UN mechanism and a recent inquiry by the Senate Community Affairs References Committee.

At Australia's Universal Periodic Review appearance before the Human Rights Council in November 2015, Australia announced a commitment to improve the way the criminal justice system treats people with cognitive disability who are unfit to plead or found not guilty by reason of mental impairment, in light of the establishment of this Working Group.

LCCSC Working Group

On 5 November 2015, LCCSC agreed to establish a Working Group on the treatment of people unfit to plead or found not guilty by reason of mental impairment. The Working Group is chaired by the

Commonwealth Attorney-General's Department and consists of representatives from Departments of Justice and Attorneys-General from each state and territory, and representatives from some Departments of Health.

The Working Group was tasked to collate existing data across jurisdictions, consider the development of a data collection framework and develop resources on fitness to plead and the defence of mental impairment for national use. The Working Group was asked to report back to LCCSC by November 2016.

The Working Group has met by teleconference five times (15 December 2015, 22 March 2016, 26 April 2016, 17 May 2016 and 24 August 2016). Further work to finalise the wording of the National Principles and papers on data and interstate transfers was settled by email. Initially, the Working Group was co-chaired by the Commonwealth and Western Australia however after the second meeting, Western Australia confirmed that they were no longer in a position to co-chair the Working Group nor take forward and lead work on interstate transfers. Victoria subsequently offered to lead on the interstate transfer work.

October 2016 LCCSC meeting

At the October 2016 LCCSC meeting, Ministers noted progress on the *National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health Impairment* (National Principles) and agreed to consider the National Principles at their next meeting.

Ministers also noted the outcomes to date of the Working Group on the treatment of people unfit to plead or found not guilty by reason of mental impairment (Working Group) on collecting and collating existing data on fitness to stand trial, the defence of mental impairment and interstate forensic transfers. Ministers agreed that the Working Group continue to analyse that data and report back to LCCSC at its first meeting of 2017 with any subsequent proposals to improve data collection frameworks and forensic transfer processes.

Recent Reviews

Criminal justice and related issues are the primary responsibility of states and territories. Mental health and cognitive impairment in the criminal justice system is an area of ongoing review and reform at the state and territory level. Between 2012–2015, law reform reviews on these issues were undertaken in New South Wales, Victoria, Queensland, South Australia and Western Australia.

Attachments

A – National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health Impairment

B – Paper on data collation and results

C – Mapping of interstate forensic transfers

NATIONAL STATEMENT OF PRINCIPLES RELATING TO PERSONS UNFIT TO PLEAD OR NOT GUILTY BY REASON OF COGNITIVE OR MENTAL HEALTH IMPAIRMENT

CONTENTS

PREAMBLE

These principles have been developed by a cross-jurisdictional Working Group on the Treatment of People Unfit to Plead or Found Not Guilty by reason of Mental Impairment, established under the Law, Crime and Community Safety Council in November 2015.

The principles recognise the rights of persons with cognitive or mental health impairment and the importance of them preventing harm to others—and seek to identify safeguards throughout legal processes and during the period in which a person who is unfit to plead or not guilty by reason of cognitive or mental health impairment is subject to orders. The potential for the criminal justice system to assist persons with cognitive or mental health impairment *prior* to any finding the person is either unfit to plead, of unsound mind, or not guilty, such as through early intervention, prevention and diversionary programmes or referrals to health and community service providers, is acknowledged.

Recommendations and commentary of recent law reform reviews, conducted between 2012 and 2015, that analyse the issues of fitness to plead and the defence of mental impairment in Australian jurisdictions have informed the drafting of these principles. Each jurisdiction may determine how to best use and implement these guidance materials. While states and territories have responsibility for their respective criminal justice and mental health systems, this document identifies best practice principles to be considered as each jurisdiction continues to develop its own legislation, policy and practices, as necessary and appropriate.

These principles are to be understood and read together with other relevant principles, frameworks and documents collectively developed by Australian governments including, but not limited to, the National Framework for Recovery-oriented Mental Health Services, the National Forensic Mental Health Principles, and the National Framework for Reducing and Eliminating the Use of Restrictive Practices.

DEFINITIONS

Community based alternatives includes compulsory treatment in the community through a conditional release order, community order or approved leave for forensic patients in the community. For people with cognitive impairment, community based alternatives may include secure management pathways by disability services or working with non-government agencies who provide more restrictive options, managed by statutory bodies such as the MHRT, and funding for disability related matters from National Disability Insurance Scheme.

Detention includes detention in a secure mental health facility, secure disability facility or in a correctional facility as an option of last resort.

Order includes a supervision or detention order made by a decision-maker following a finding that a person has been found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment or of unsound mind.

Habilitation refers to the process of supplying a person with the means to develop maximum independence and involvement in all aspects of life through the acquisition and enhancement of abilities and skills related to communication and activities of daily living including supported accommodation.

Relevant agencies include police, justice, corrections, parole boards, health, ageing, disability and housing departments, National Disability Insurance Agency, and any other agencies, both government and non-government, involved in supervising and caring for persons found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment.

Reviewing authority includes a court, mental health tribunal or relevant board.

OVERARCHING PRINCIPLES

- Policies, procedures and services should aim to recognise and reflect the distinction and interaction between the concepts of cognitive impairment and mental health impairment.
- The concepts of cognitive impairment and mental health impairment should be defined broadly, focusing in general on the effect of the impairment rather than on the inclusion or exclusion of particular conditions.
- Decision making should be guided by the least restriction of the rights of a person with cognitive or mental health impairment taking into account the risk of harm they may pose to themselves or others.
- The setting in which people are detained should aim to be inclusive and recovery-orientated, acknowledging that there will be individual differences in the meaning of recovery or habilitation and what it may entail.
- Information about the rights of persons detained under orders and how they may be exercised should be readily available to relevant persons and their families, guardians and carers in a format and mode by which this information may be understood.
- People who are detained following an order are entitled to receive health care (including mental health care) and support at an equivalent level to that available to people in the community.
- Duty of care should be a primary consideration when treating young people with cognitive or mental health impairment. Young people should be provided with care, protection and all necessary individual assistance in view of their age, sex and personality and, if detained, young people should be separated from adults.

TAILORED SERVICES AND CARE

- A personalised case management plan should be developed, where possible, for all persons found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment who are the subject of orders, soon after the original order is made.
- The plan should be inclusive and where relevant, recovery oriented, outlining clinical oversight, treatment and care, support services, and pathways towards less restrictive arrangements.
- Ongoing consideration and planning is required to facilitate the provision of appropriate supports, accommodation and community based alternatives to detention.
- Tailored programs should be available to support the individual needs of people with cognitive or mental health impairment who are released from detention to reintegrate into

the community taking account of ethnicity, cultural background and social factors. Particular consideration should be given to the needs of Aboriginal and Torres Strait Islander people.

- Young people should be provided with care, protection and all necessary individual assistance in view of their age, sex and personality and if detained, should be detained separate from adults.

COLLABORATION AND CONSULTATION

- Collaboration between government agencies and, where appropriate, relevant non-government service providers and professional associations, is necessary to develop and implement strategies to safeguard the rights of persons who are found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment.
- The individual management of persons who are the subject of orders should involve information sharing and collaboration amongst relevant agencies—including where such collaboration is required across jurisdictions.
- Relevant agencies should aim to develop and coordinate arrangements for ongoing treatment or care and support in the community when a person subject to a detention order is given leave or discharged.

CULTURALLY APPROPRIATE SERVICES

- The needs of particular population groups, including Aboriginal and Torres Strait Islander people, and their understanding and experience of impairment, disability, health and wellbeing, should inform policy and practice relating to persons who are found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment.
- Culturally appropriate approaches, which may include the participation of elders, family and relevant agencies, should be considered when making orders in relation to Aboriginal and Torres Strait Islander people who are found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment.
- Jurisdictions should aim to make programs available that provide tailored support to assist the individual needs of people with cognitive or mental health impairment who are released from detention to reintegrate into the community taking account of ethnicity, cultural background and social factors e.g. Aboriginal and Torres Strait Islander people and migrants.

REASONABLE ADJUSTMENTS

- People found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment should have access to tailored assistance, service pathways and reasonable adjustments, including those needed to facilitate their effective participation in the criminal justice system or forensic mental health system.
- Consideration should be given, where practical, to the implementation of specialist courts or specialist court lists to deal with proceedings relating to cognitive or mental health impairment.

- Consideration should be given to any reasonable adjustments or modifications to usual processes or assistance that may be necessary to facilitate the person's effective participation in the criminal justice system. This may include:
    - modifications to court procedures, such as shorter sessions, additional breaks, or reducing the formality of proceedings
    - the discretion to require independent advice, including expert advice, and to hear parties making best interest representations, where appropriate
    - providing access to specialist services, such as communication assistance schemes, to support a person with cognitive or mental health impairment to exercise their legal capacity with respect to proceedings while respecting their rights, will and preferences;
    - ensuring that information is accessible and communicated in a format and mode appropriate to the person with cognitive or mental health impairment, or
    - any culturally relevant adjustments, including interpreters or support persons, as deemed necessary.

REASONS FOR DECISIONS

- Any decision, order or condition relating to a person found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment should be accompanied by reasons and communicated in a format and mode appropriate to the person.

ORDERS

- When making orders, people should be detained for the minimum period necessary to address the risk they pose to themselves or others.
- Where time limits on orders apply, jurisdictions should avoid time limits that exceed the maximum term of imprisonment that could have been imposed if the person had been convicted of the offence charged.
- The purpose of the order is to provide support and intervention that addresses the individual needs of the person with cognitive or mental health impairment while managing and addressing the risk a person may pose to themselves and others. In particular:
    - Measures should be taken that aim to support the independence and participation of persons with cognitive or mental health impairment in all aspects of daily life in their place of detention;
    - Habilitation, rehabilitation or other appropriate programs should be tailored to reflect the individual needs of persons with cognitive or mental health impairment;
    - Order conditions and programs should take into account the particular needs and disadvantages that may be faced by particular population groups e.g. Aboriginal and Torres Strait Islander people; and
    - Mechanisms to monitor the use of restrictive practices should exist with a view to recording and minimising the use of these practices.
- Once the Court has found a person unfit to plead or not guilty by reason of cognitive or mental health impairment, decisions about the detention, care, treatment or release of the

person should be made by the relevant reviewing authority or court, informed by relevant experts, or referred to an independent body with relevant expertise, as appropriate.

- Detention of persons found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment should occur in facilities appropriate to the person's needs.
- All relevant parties should be given the opportunity to make submissions to the reviewing authority relevant to the care, treatment, conditions or release of a person the subject of an order.
- Relevant parties may include a person subject to an order or their representative, health practitioners, carers and support services (including accommodation providers), and any victim/s or their family (where appropriate).

REVIEWS

- Any decision, order or condition relating to a person found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment should be subject to mechanisms of review.
- A clinical review of persons found unfit to plead, of unsound mind, or not guilty for reason of cognitive or mental health impairment should be conducted by relevant experts at regular intervals, with individual case management plans updated accordingly.
- Orders relating to persons found unfit to plead, of unsound mind, or not guilty for reason of cognitive or mental health impairment should be reviewed by a reviewing authority at regular intervals, with a person having a right to apply for review outside of any review date set by the reviewing authority.

LEAVE, RELEASE AND DISCHARGE

- Persons subject to detention orders should be informed about ways in which they can secure their leave or release.
- Criteria for leave and release from detention should have regard to a person's recovery, program participation, treatment progression or habilitation, risk of harm the person poses to themselves or the community and not reflect punitive principles such as whether the person has spent sufficient time in detention.
- Decision makers should have flexibility in extending and suspending leave or release, and in imposing leave or release conditions.

ALTERNATIVE DETENTION OPTIONS

- A person should be entitled to treatment and/or support in the least restrictive environment that will protect against serious risk of significant harm to the person or to others.
- Detention of persons found unfit to plead, of unsound mind or not guilty by reason of cognitive or mental health impairment should occur as far as possible in facilities appropriate to the person's needs.

- Step down accommodation options should be available to facilitate transition to the community for persons with mental health or cognitive impairment who are discharged from detention.
- Forensic systems should build capacity across high, medium, low secure and community environments to ensure that people can recover and transition to life in the community. Forensic mental health and cognitive impairment systems should be continuously improving and offer evidence based interventions that address risk.

TRAINING AND RESOURCES

- Training and resources should be provided to build the skills and capacity of relevant agencies and reviewing authorities to work with people who are found unfit to plead, of unsound mind, or not guilty by reason of cognitive or mental health impairment. This should include specialist training in adolescent mental health for staff working with young people.
- Courts and the legal profession should have access to information about reasonable adjustments and the supports and services available to persons with cognitive or mental health impairment through appropriate means—such as practice notes or an equal treatment bench book.

WORKING GROUP ON THE TREATMENT OF PEOPLE UNFIT TO PLEAD OR FOUND NOT GUILTY BY REASON OF MENTAL IMPAIRMENT

PAPER ON DATA COLLATION AND RESULTS

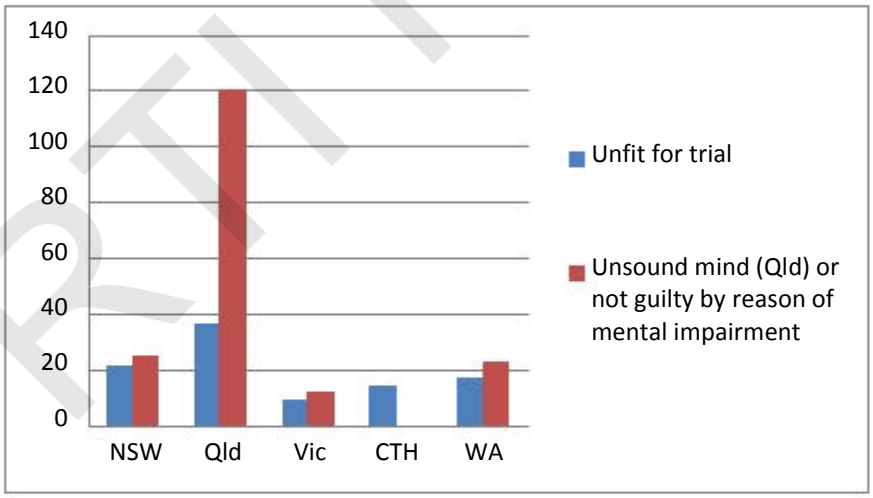
In accordance with the terms of reference of the Working Group, agreed by all Attorneys-General on 5 November 2015, the Working Group has been tasked with collating existing data on people unfit to plead or found not guilty by reason of mental impairment. If appropriate, the Working Group was given discretion to also consider developing a data collection framework for use by police and the courts, covering agreed data indicators to address any gaps in data uncovered.

The purpose of collating available data was to build a picture of the current situation in Australia, consider common issues affecting jurisdictions, discuss in the Working Group what the most relevant data indicators are for the purpose of informing policy development, and consider whether data collection processes could be refined to improve coverage across jurisdictions, including whether a national data collection framework could be developed. All jurisdictions on the working group contributed to an assessment of the type of data available within each jurisdiction but the data may not have been collected in a way which allowed for comparisons.

CURRENT SITUATION IN AUSTRALIA

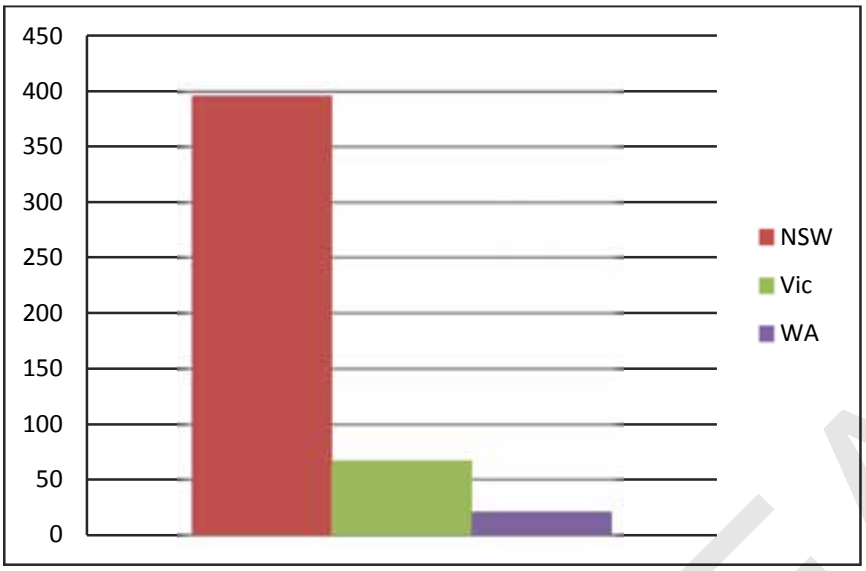
From the available data provided by jurisdictions, it is clear that there are gaps and inconsistencies in data collection and collation between jurisdictions, making graphical representation of the current situation in Australia challenging. Further, the availability and access to data is complex, particularly given the multi-agency nature of these issues, spreading across justice, corrections and health.

The graph below depicts total numbers of people found unfit for trial or not guilty by reason of mental impairment in the 2014/15 financial year, in jurisdictions where this information was accessible and could be provided.



The following graph aims to depict the total number of people who are found unfit to plead, or not guilty because of mental impairment (unsound mind in Queensland), who were in detention as at 30 June 2015. Western Australia is an outlier as persons subject to a forensic order may be approved for community treatment or leave, and therefore are not actually detained. Queensland had 770

patients on a forensic order who would have had approval for varying amounts of limited community treatment (or leave) of up to full community leave. It was not possible to extract data about the exact number in detention.



DATA GAPS IDENTIFIED

The existing data gaps, or unavailability of data, make it more challenging to be able to assess the full situation within jurisdictions and the extent of the commonality of these issues across Australia. The jurisdictional data collated shows that the main gaps in data collected and/or provided by jurisdictions include:

- Differentiating between whether the person has a cognitive disability or mental impairment
- What orders result from a finding of unfit to plead or not guilty by reason of mental impairment
- What type of facility a person is detained in
- Total lengths of any detention imposed

Jurisdictions were asked whether personal information was collected for people found unfit to plead or found not guilty by reason of mental impairment. Several jurisdictions reported that other agencies within their jurisdiction collect personal data, and as such, it was not available. Three jurisdictions (Queensland, Victoria and CDPP) were able to report whether an accused was Indigenous. Given the over-representation of Indigenous peoples in detention generally, it is important that the Working Group consider a consistent manner to collect data on the number of Indigenous accused who are mentally impaired.

The range of gaps in data, and difficulties in bringing together key data, as well as the definitional differences and how each system operates, makes it challenging to capture a holistic picture of an individual's interaction with the relevant processes in a jurisdiction, once found unfit to plead or not guilty by reason of mental impairment and given a relevant court order.

IMPORTANCE OF DATA CONSISTENCY AND KEY INDICATORS

Recent jurisdictional law reform reviews have indicated that issues, findings and outcomes in relation to findings of unfitness to plead and not guilty by reason of mental impairment, resulting

orders and any forms of detention, need to be recorded in a way capable of being analysed in a consistent way. Robust data collection will effectively inform evidence-based policy developments and any necessary corresponding legislative reforms. This will provide the opportunity to create more just outcomes for mentally impaired accused in the criminal justice system.

The recent jurisdictional reviews suggest that improvements be made to data collection processes, strategies for data collection be developed and changes be made to data recording practices across all agencies involved in the process. A suggested list of key indicators for which data should be collected includes:

- Total numbers of people found not guilty by reason of unsoundness or not fit to stand trial
- Personal information, including whether the person identifies as Indigenous or non-Indigenous, age, gender
- Type or classification of offence
- Type of order given
- Number of people who received a leave of absence or a conditional release order
- Number of people detained in a custodial setting
- Number of people detained in a hospital or other mental-health secure facility
- Number of people on conditional release orders, or equivalent
- Total length of any detention, including custodial or under a forensic order, or equivalent
- Total length of time detained until conditional release order or leave of absence
- Frequency of all and any reviews

POTENTIAL PROPOSALS GOING FORWARD

The Working Group has the opportunity to consider whether changes could be made to strengthen the coverage of data collection across jurisdictions—including through the development of a data collection framework, or other resources, to promote consistent data collection across Australia.

The Working Group may wish to consider the following proposals to take this work forward:

1. Develop a model for consistency in data collection across jurisdictions.

2. Agree on common group of core data indicators to ensure consistency across data from each jurisdiction— with each jurisdiction committing to work towards improving data collection processes and engaging with relevant agencies to progress this work.

LCCSC working group

Treatment of persons found unfit to plead or not guilty by reason of mental impairment

Mapping of interstate forensic transfers

Attachment C

About this document

This document is a summary of transfer arrangements for forensic patients and forensic residents, compiled from the survey responses of LCCSC Working Group members in June 2016. It is intended to promote discussion and inform decisions by the Working Group about forensic patient transfers.

It describes transfer arrangements current as at July 2016, with the exception of Queensland whose responses refer to the *Mental Health Act 2016 (Qld),* legislation that was passed by the Queensland Parliament on 18 February 2016 and commenced on 5 March 2017.

Explanation of terms used

The survey of Working Group members used 'forensic patient' and 'forensic resident' as umbrella terms to describe persons with mental illness or a cognitive impairment who are made subject to a custodial supervision orders. However the survey responses indicate it is common for one term to refer to all persons subject to supervision, irrespective of the cause of the person's impairment. See below. In this document the terms forensic patient and resident have been retained to distinguish between those with mental illness and those with cognitive impairment.

Terms used in different jurisdictions

ACT	NSW	NT	Qld	SA	Tas	Vic	WA
forensic patient	forensic patient	person subject to a supervision order	person subject to forensic order (MH) or (Disability)	defendant subject to a supervision order	forensic patient person subject to supervision order	forensic patient forensic resident	mentally impaired accused

Jurisdictions with interstate transfer legislation

Legislation in five jurisdictions expressly provides for interstate forensic transfers. See below:

Transfer	ACT	NSW	NT	Qld	SA	Tas	Vic	WA
IN	☑	☑	-	☑	-	☑	☑	-
OUT	☑	☑	-	☑	-	☑	☑	-
Relevant Legislation	Part 15.4 MHA 2015	Ch. 8 MHA 2007	Pt IIA Crim. Code (NT) 2007	Ch. 12 Pt 10 MHA 2016	Pt 8A Crim. Law Consolidation Act 1935	MHA 2013	Pt 7A CMIA[1] 1997	CLMIA[2] 1996

Jurisdictions that permit interstate forensic transfers

The mental health / criminal responsibility legislation in the Northern Territory, South Australia and Western Australia does not expressly provide for interstate forensic transfers, with the result that forensic patients and forensic residents have limited ability to enter and leave those jurisdictions.

In the absence of express provisions, the Northern Territory Supreme Court has the power to make orders permitting supervised persons to go interstate however, it is unclear if this power has been exercised to permit transfers. Also the Northern Territory, South Australia and Western Australia[3] have cross-border justice legislation that may permit a forensic patient who has a connection with the prescribed cross-border region to be detained in another state or territory that is part of the scheme.

The situation may change in South Australia with the likely introduction of a Bill to amend the South Australian *Criminal Law Consolidation Act 1935* to permit interstate transfers.

Who can be transferred

The jurisdictions with interstate transfer legislation (ACT, NSW, Queensland, Tasmania and Victoria) appear to permit adult and young people who are forensic patients or forensic residents to transfer interstate. However there are a number of legal and practical impediments that affect the application of these laws.

For example transfers can only proceed with the consent of the receiving jurisdiction and in the event of a conflict between the law of a sending and receiving jurisdiction, the transfer is governed by the most restrictive scheme.

There can also be resource and service system constraints that prevent transfers occurring. It is difficult to assess the impact of these issues on transfers into or out of the ACT as no transfers have occurred since the legislation commenced in 2016.

[1] Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)

[2] Criminal Law (Mentally Impaired Accused) Act 1996 (WA)

[3] Cross-border Justice Act (NT), Cross-border Justice Act 2009 (SA) and Cross-border Justice Act 2008 (WA)

The New South Wales scheme does not appear to support the interstate transfer of forensic residents with cognitive impairments because transfer provisions located in the *Mental Health Act 2007* only provide for the transfers between mental health facilities. Receiving detained forensic residents into NSW also appears to be problematic, with little secure accommodation in NSW for persons with a cognitive impairment.[4] Despite the existence of Forensic Community Treatment Orders in NSW, the orders are generally used for persons with mental illness who are leaving prison, not forensic patients. As a consequence persons subject to FCTOs are not transferred interstate.

It is unclear if service system issues will affect the operation of the Queensland *Mental Health Act 2016* when it commences, as the administrative arrangements for transfers under the new Act are yet to be settled.

The response from Tasmania did not identify any constraints on who can be transferred under the Tasmanian *Mental Health Act 2013*.

The Victorian scheme does not appear to support receiving detained forensic patients and forensic residents who are less than 18 years of age because the secure forensic and disability facilities in Victoria are for adults. There is also some uncertainty whether a forensic resident (irrespective of age) can be transferred into or out of Victoria when the legislation requires the Chief Psychiatrist a person with mental health expertise to certify the transfer.

Transferees[5]	ACT	NSW	Qld	Tas	Vic
supervised due to mental illness	☑	☑	☑	☑	☑
supervised due to cognitive impairment	☑	-	☑	☑	-
detained in a secure facility - adult	☑	☑	☑	☑	☑
detained in a secure facility - less than 18 years	☑	☑	☑	☑	-
supervised in the community - adult	☑	-	☑	☑	☑
supervised in the community - less than 18 years	☑	-	☑	☑	☑

Characteristics of persons able to transfer by jurisdiction

Where can people be transferred

The five jurisdictions with interstate transfer legislation restrict transfers to places they recognise as having 'corresponding' laws/orders or have an intergovernmental agreement. The law of the sending and receiving states

[4] NSW Law Reform Commission Report 138

[5] Theoretical with respect to ACT, Qld and Tasmania as there have been no transfers from those states under their current or soon to commence legislation being the MHA 2015(ACT), the MHA 2016 (Qld) or the MHA 2013 (Tas).

need not be compatible to be considered 'corresponding'. For example under section 243 of the *Mental Health Act 2015 (ACT)*, it is sufficient for the other law to make provision for the treatment and care of persons with mental illness or cognitive impairment.

The ACT does not require jurisdictions identified as having corresponding laws to be prescribed in the ACT regulations. Nor does the ACT require an intergovernmental agreement before a transfer can proceed.

Both NSW and Queensland nominate the jurisdictions they consider to have 'corresponding laws' in their regulations. NSW also requires an interstate agreement with the other jurisdiction.[6] Currently there are no agreements for the transfer of a forensic patient between NSW and other states (other than agreements for the return of forensic patients who have absconded). However people have been able to move interstate in circumstances where the NSW Mental Health Review Tribunal has granted forensic patients leave to reside in another state or a NSW patient has been discharged from their order on the basis they are subject to a supervision order in another state.

A regulation under the Queensland *Mental Health Act 2016* is proposed to declare the legislation of other jurisdictions as corresponding law and allow for the transition of existing interstate agreements between Queensland and other states.

Transfers to and from Victoria require the other jurisdiction to be recognised by Victoria as having either a 'corresponding law' or an 'interstate supervision order'. Recognition is achieved by order of the Victorian Governor in Council published in the Victorian Government Gazette.

Transfers to and from Tasmania require an 'intergovernmental agreement'. The requirement for an agreement is seen by some jurisdictions as a barrier to arranging transfers with Tasmania. However, the Tasmanian *Mental Health Act 2013* does not prescribe the nature of the agreement, presumably leaving it to the parties to determine.

	ACT	NSW	Qld*	Tas	Vic
ACT	N/A	-	☑	-	☑
NSW	☑	N/A	☑	-	-
Qld	☑	-	N/A	-	☑
Tas[7]	-	-	☑	N/A	-
Vic	☑	-	☑	-	N/A
Legislation	s.243 & s.244 MHA 2015	s.176 & s.178 MHA 2007 cl.21 & 23 MH Regs. 2013	* MH Regs 2002	Ch. 4 MHA 2013	s. 73A & s.73B CMIA 1997

Potential transfer destinations

Other threshold criteria for interstate transfers

The legal status of the person to be transferred and recognition of the other jurisdiction's law are only some of the threshold requirements for interstate transfers.

[6] The NSW Court of Appeal has suggested that the transfer of forensic patients does not require regulations or an interstate agreement. See *AG for NSW v XY [2014] NSWCA 466*

[7] Assumes no transfers can occur until intergovernmental agreements are in place.

The criteria in each jurisdiction are largely concerned with the therapeutic benefit for the person to be transferred. This may relate to their treatment and/or the support that can be provided by family or others at the destination.

Decision makers are also required to consider safety issues. This may be an express requirement to consider the safety of the person to be transferred or the receiving community more broadly. Alternatively it may be implied from a requirement to certify that suitable services are available for the person's custody and treatment.

In the ACT the transfer criteria are set out in sections 250-254 of the ACT *Mental Health Act 2015*. These include a requirement for the decision maker to consider the views and wishes of the person to be transferred and a requirement that they believe on reasonable grounds that the transfer is in the best interests of the 'safe' and effective treatment, care or support of the person. For transfers involving children, the decisions maker must also take into account the views of the persons with parental responsibility and the views of the Children and Young Persons Director General, if the person is subject to bail or sentencing orders.

In NSW the transfer criteria are set out in the NSW *Mental Health (Forensic Provisions) Act 1990.* Sections 40 and 74 of that Act provide for the criteria for transfers out of the state. These include the protection of the safety of members of the public and the provision of care, treatment and control of the person. The principles for care and treatment under section 68 of the *Mental Health Act 2007* are also applicable. No statutory criteria appear to be listed for transfers into NSW.

In Queensland the criteria for transfers out of the state are specified in s 523 and s 525 of the Queensland *Mental Health Act 2016*. These include the requirement that the transfer must be in the best interests of the person, appropriate treatment and care must be available for the person at the interstate service and there must be adequate arrangements to protect the safety of the community. Best interests can include the therapeutic benefit of being in closer proximity to the person's family or carer. Similar criteria in s 515 and s 517 apply to transfers into Queensland, with the additional requirement that a Queensland forensic order must be considered necessary because of the person's mental condition to protect the safety of the community.

The Tasmanian, the *Mental Health Act 2013* states that persons to be transferred out of the state must not be prisoners. The Act also requires there be an intergovernmental agreement.

In Victoria section 73D requires the Chief Psychiatrist to certify that transfers out are for the person's benefit and the person has given informed consent to the transfer (or if they are incapable of giving informed consent their guardian has given informed consent). Under section 73E the Chief Psychiatrist must certify transfers into Victoria are for the benefit of the person and that there are facilities or services available for the custody care or treatment of the person, the person/guardian has given informed consent and the minister has made an interim supervision order for the person. Requiring a certificate of available services seeks to address safety concerns by prescribing the circumstances in which the person is to be treated and or detained.

Authorisation of interstate transfers

Transfer decisions are made by statutory officers (i.e. Chief Psychiatrist) tribunals and government ministers. See the table below:

In the ACT the Chief Psychiatrist decides transfers into the jurisdiction, while transfers out are authorised by order of the ACT Civil and Administrative Tribunal (ACAT). The NSW and Tasmanian legislation are less clear about the decision maker. For example the NSW legislation does not specify who makes decisions about the transfer of forensic patients into NSW.

In Queensland the Mental Health Review Tribunal authorises transfers into and out of the state.

In Victoria transfers are determined by the joint decision of the Attorney General and the Minister for Housing, Disability, Ageing and Mental Health. The decision must be in the form of an order for transfers out of Victoria. Given the negative media that these cases can attract, the decision to transfer a forensic patient has the potential to be quite political. The Victorian Law Reform Commission has recommended that the decision making function be given to the relevant departmental secretary. [8]

None of the jurisdictions with transfer legislation provide an appeal or review mechanism in the same legislation. Review of transfer decisions or delay in making a decision relies upon the forensic patient or forensic resident making use of informal or judicial and administrative review mechanisms.

Authorising interstate forensic transfers

	ACT	NSW	Qld	Tas	Vic
decision maker	Chief Psychiatrist (IN) ACAT (OUT)	Not specified (IN) MHRT (OUT)	MHRT	Not specified	Joint decision of AG & minister
form	agreement (IN) order (OUT)	order	order	intergovernmental agreement	agreement (IN) order (OUT)

Data

The number of transfers can't be determined from the survey responses. For example it wasn't clear if a NIL response meant no transfers had occurred or no data was available.

The numbers are difficult to interpret as the meaning of 'transfer' seems to vary between jurisdictions. Most of the cross border movement of adult forensic patients occurs on the Queensland NSW border. Queensland's current legislation does not provide for interstate transfers however, the Queensland Mental Health Review Tribunal can approve a patient to 'move' to another state while they remain on a Queensland order until that order is revoked by

[8] Victorian Law Reform Commission Review of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* Report June 2014 Recommendation 107 p 442

the Tribunal (not less than two years from the move). Generally the approval to move is made for high functioning patients who have existing leave to live in the community. The actual numbers of forensic patients leaving Queensland is not known however it appears as though approximately 16 patients moved to NSW and another two moved to Victoria since 2000.

The NSW survey response indicates no forensic patients have been received in the past two years. NSW also indicated they have granted one NSW forensic patient unconditional release to permit them to transfer to Queensland in circumstances where they were already a forensic patient in Queensland. This is consistent with Queensland's response that no forensic patients have transferred into their state because patients already on Queensland forensic orders are not considered to be from another jurisdiction.

No forensic patients less than 18 years of age appear to have been transferred. Nor have there been any interstate transfers of any forensic residents (adult or young persons).

It wasn't possible to assess the demand for interstate transfers among forensic patients and residents as incomplete information was provided about the number of transfer requests received in each jurisdiction.

	ACT	NSW	Qld	Tas	Vic
IN	NIL	NIL	NIL	NIL	2 (1 of whom is pending) both from Qld
OUT	NIL	NIL	E18 E16 to NSW 2 to Victoria	NIL	NIL

Transfers of adult forensic patients since 2000

Summary

Five states (ACT, NSW, Qld, Tas and Vic) have legislation that expressly provides for interstate forensic transfers.

Where transfer legislation exists, variations in statutory criteria could be a barrier to transfers occurring. For example the requirement for an intergovernmental agreement could be seen as a barrier in states that don't require an agreement. It is unclear if different interpretations of therapeutic benefit and community safety also impact on these decisions. In the absence of model legislation, a common understanding of each state's processes or agreement on 'best practice' may go some way to address these issues.

Young people and persons with cognitive impairment are not being transferred. This seems to be due to a lack of secure facilities able to provide appropriate treatment and care.

Ministers decide transfer applications in one state, which raises a concern that such decisions could be seen as political, particularly in cases where there has been negative media.

Data collection is variable across the states and there does not appear to be a common understanding of what constitutes an interstate transfer. A common data set could result in more reliable data that is able to be analysed to identify issues affecting the transfer of forensic patients and residents around Australia.

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RM folder reference No:	C-ECTF-17/1544
Division/HHS:	CED
File Ref No:	

Brief for Ministerial Correspondence

SUBJECT: Queensland Mental Health Commission (QMHC) Response to the Ed-LinQ Renewal Project Final Report

Key Issues

1. On 7 April 2017, Dr Lesley van Schoubroeck, Acting Mental Health Commissioner, wrote to the Honourable Cameron Dick MP, Minister for Health and Minister for Ambulance Services, providing a copy of the Queensland Mental Health Commission (QMHC) Response to the Ed-LinQ Renewal Project Final Report.
2. In November 2015, the QMHC funded Children's Health Queensland Hospital and Health Service (CHQHHS) to consult and develop a new model for Ed-LinQ, established in 2008.
3. The Final Report of the Ed-LinQ Renewal Project includes a draft renewed Ed-LinQ model and 16 recommendations. The QMHC's response to the Final Report conveys in-principle support for the proposed renewed Ed-LinQ model as a contemporary framework for strengthened integration of health and education sector.
4. The Department of Health is supporting implementation of the proposed Ed-LinQ Model across the State through funding provided to CHQHHS under *Connecting Care to Recovery 2016-2021: a plan for Queensland's state-funded mental health alcohol and other drug services (Connecting Care to Recovery 2016-2021).*
5. A proportion of this funding is also directed toward maintaining the Ed-LinQ Workforce Development Program for a further two years beyond its current expiry of end of 2017.
6. The proposed model is dependent on formal cross sectoral engagement, collaborative agreements and processes to support joint health and education planning, priority setting and implementation at the State, regional and service levels.
7. The Department is working with CHQHHS to establish an Ed-LinQ Steering Committee, which will include cross Departmental representation and will oversee implementation of the Ed-LinQ Renewal Project. A re-established Statewide Coordinator position (lost under the previous Government) has just been recruited and will work with the Department and CHQHHS to drive the renewed model for Ed-LinQ across the State.

Results of Consultation

8. As part of the Renewal Project, CHQHHS undertook consultation with relevant health and education stakeholders to refine the model.

Resource Implications (including Financial)

9. $5.2 million over five years for the expansion of the Ed-LinQ Program across the State has been allocated under *Connecting Care to Recovery 2016-2021.*

Background

10. Ed-LinQ was established under the *Queensland Plan for Mental Health 2007-2017.* In 2013, oversight transferred to the QMHC. Since that time, the QMHC has supported Ed-LinQ through funding the Ed-LinQ Workforce Development Program, commissioning an independent evaluation in 2014 and funding the Ed-LinQ Renewal Project in 2015-16.

Attachments

11. Attachment 1: Letter of response to Dr Lesley Van Shoubroeck - C-ECTF-17/1544

Department Contact Officer

Ms Anna Davis, Acting Director, Mental Health Strategy Planning and Partnerships Unit, Mental Health Alcohol and Other Drugs Branch, on telephone 3328 9561

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C-ECTF-17/1544

RECEIVED
6 JUN 2017

Dr Lesley van Schoubroeck
Acting Mental Health Commissioner
Queensland Mental Health Commission
PO Box 13027 George Street
BRISBANE QLD 4003

Email: info@qmhc.qld.gov.au

Dear Dr van Schoubroeck Lesley,

Thank you for your letter in relation to the Commission Response to the Ed-LinQ Renewal Project Final Report. I apologise for the delay in responding.

I appreciate you taking the time to share the Commission's ongoing commitment to the Ed-LinQ program. I understand that you have also written to the Department of Health in regard to this matter.

Like the Commission, the Government also recognises the valuable contribution the Ed-LinQ initiative has made towards improved integration and collaboration between the health and education sectors to support mental health outcomes for children and young people.

To that end, the Government has committed funding over the next five years through *Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health alcohol and other drug services* to expand and enhance the service. The effective implementation of the Ed-LinQ model across the State, refined as part of the Ed-LinQ Renewal Project funded by the Commission, is critical to the success of the program.

Thank you again for bringing this matter to my attention. Should you require any further information in relation to this matter, I have arranged for Ms Anna Davis, Acting Director, Mental Health Strategy Planning and Partnerships Unit, Department of Health, on telephone 3328 9561, to be available to assist you.

Yours sincerely

CAMERON DICK MP
Minister for Health
Minister for Ambulance Services

Brief for Ministerial Correspondence

RM folder reference No:	C-ECTF-17/4953 C-ECTF-17/2936
Division/HHS:	CED
File Ref No:	

SUBJECT: Commonwealth Government's $80 million for national psychosocial support measure

Key Issues

1. On 1 May 2017, the Honourable Greg Hunt MP, Commonwealth Minister for Health and Minister for Sport, wrote to the Honourable Cameron Dick MP, Minister for Health and Minister for Ambulance Services, requesting information on Community Mental Health (CMH) programs which Queensland Health will continue to provide outside the National Disability Insurance Scheme (NDIS) and Queensland Health program funding which will transition to the NDIS.
2. On 25 May 2017, Minister Hunt wrote to Minister Dick advising of the 9 May 2017 Commonwealth Budget announcement of the *Psychosocial Support Services* for people with mental illness and who are ineligible for the NDIS.
3. Minister Hunt is seeking in-principle agreement to this initiative which provides $80 million over four years from 2017-18 to jurisdictions which also contribute an appropriate and proportional level of funding. Minister Hunt is seeking an indication of Queensland's willingness to engage, with agreement to be formalised at the COAG Health Council (CHC) meeting on 4 August 2017.
4. The response to Minister Hunt welcomes discussions at the CHC meeting on 4 August 2017 (Attachment 1).
5. Since receiving Minister Hunt's correspondence, the Commonwealth's agenda paper for the upcoming CHC meeting (Attachment 2) states that the measure will reduce the service gap and leverage off national mental health reforms by directing the funding to Primary Health Networks (PHNs) to 'undertake the planning and commissioning of Community Mental Health (CMH) and clinical mental health services, improving coordination and 'wrap-around' care for individuals with psychosocial disability'.
6. The paper confirms that the measure is contingent on State and Territories contributing funding although there is no detail about the requisite level of this matched contribution.
7. By way of background, the Commonwealth has cashed out up to $300 million in CMH program funds to the NDIS with these programs due to cease by 30 June 2019.
8. This contrasts with Queensland, where the Department of Health cashed out about 20 per cent of its CMH program funding ($9.9 million out of existing $35 million). Despite this cash out, Queensland has maintained existing levels of investment and extended existing service agreements for one year to 30 June 2018, in order to more fully assess the impact of the NDIS, including those who are NDIS ineligible.
9. Discussions need to be cognisant of the significant gap that the Commonwealth has left in support for clients who experience psychosocial disability but are ineligible for the NDIS, as a result of it cashing out up to $300 million in CMH program funds.
10. Therefore, any participation in the national psychosocial support services measure should be on the basis of the negotiating parameter set out in Attachment 3.
11. While the Department of Health is supportive of collaborative planning with PHNs and supports the directions of the Draft 5th National Mental Health and Suicide Prevention Plan, directing State funds through PHNs is not supported.
12. PHNs are at an early stage of development and in Queensland they operate as seven independent bodies. The Department of Health has expertise both in mental health policy advice and commissioning and sees no advantage to directing program funding through seven independent commissioners, which risks diluting the benefit of the existing investment across seven commissioners.
13. The Department of Health is further concerned about the complexity associated with the governance and accountability arrangements if State funding were directed through PHNs.

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14. It is noted that Queensland's share of the $7.8 million offered in 2017-18 is $1.55 million rising to $4.88 million by 2020-21.
15. If it is determined that Queensland should participate in the new psychosocial support services measure (Attachment 3), it is recommended:
    15.1. negotiate for the first year (2017-18), programs such as the Clubhouse model be identified – these programs do not fully align with Queensland's priorities for funding under *Connecting Care to Recovery 2016-21* as they are also maintenance Information, Linkages and Capacity type programs.
    15.2. in the absence of further detail, it is not possible to commit or identify further possible funds or programs that may be suitable.
    15.3. given past experiences with agreements with the Commonwealth (for example National Partnership Agreements), it is risky to identify service delivery, which requires a recurrent funding source to maintain. There needs to be a guarantee from the Commonwealth that the program of funding would continue beyond 2020-21.

Results of Consultation

16. A number of jurisdictions have indicated they require further information about the funding arrangements and the matched funding would need to align with current CMH planning priorities.

Resource Implications (including Financial)

17. Queensland's matched funding would be approximately $16 million over four years.
18. *Connecting Care to Recovery 2016-21* invests more than $350 million over five years from 2016-17 to 2020-21.
19. Currently, Queensland Health invests about $70 million per annum in CMH ($36 million CMH and $34 million for Housing and Support Program).
20. By 2019-20, the Queensland Government cash out to the NDIS of existing CMH funded through the Department will be $44.3 million.
21. Queensland Health has contributed additional new funds to CMH:
    21.1. $35.78 million (GST inclusive) to extend CMH service agreements in 2017-18;
    21.2. $7.15 million (GST inclusive) in 2016-17 and a further $8.89 million (GST inclusive) over 2017-18 and 2018-19 for 94 HASP clients funded under a NPA not extended beyond 30 June 2016 by the Commonwealth; and
    21.3. $2.25 million will be required from 1 July 2019 (GST exclusive) per annum for those people who are ineligible for the NDIS as they will be aged 65 or older.
22. The Department must also maintain funding to 82/166 Housing and Support Program clients who did not transition to the NDIS by mid-June 2017, requiring ongoing funding at an annual rate of $4.8 million.

Background

23. The decisions regarding cashing out of CMH programs to the NDIS were made prior to the defining of mental health cohorts who would be eligible for the NDIS. It is now apparent that approximately 90,000 only of the estimated 280,000 people with moderate to severe psychosocial disability will be eligible for the NDIS.
24. Of this group, 64,000 people are estimated to be NDIS eligible because of a primary psychosocial disability, with the remainder eligible because of dual or multiple disabilities that include psychosocial disability.

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25. CMH provides community based specialised mental health services to individuals experiencing a severe and persistent mental illness with complex needs that may be episodic in nature. The program aims to build more person-centred and recovery oriented care close to the person's community and their support networks. Individuals receiving this care experience better health, social and economic outcomes.

Attachments

26. Attachment 1: Letter of response to the Honourable Greg Hunt MP – C-ECTF-17/1953 / C-ECTF-17/2936
    Attachment 2: CHC Item 3 Agenda Paper
    Attachment 3: Queensland's preferred parameters to match the national psychosocial supports measure funding

Department Contact Officer

Ms Sandra Eyre, Director, Strategy Planning and Partnerships, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division, on telephone 3328 9531 or [redacted]

Hi Michael,
This letter was done in readiness for CHC, so would need to go by Thursday if it is to be sent.
Advice from South As Minister's office is that the Commonwealth may announce review of Mental Health supports, as no states support this proposal
Regards,
Stephen
ok me.

Queensland Government

Minister for Health and
Minister for Ambulance Services
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C-ECTF-17/1953 / C-ECTF-17/2936

E-MAILED
3 AUG 2017

The Honourable Greg Hunt MP
Minister for Health
Minister for Sport
PO Box 6022
House of Representatives
Parliament House
CANBERRA ACT 2601

Dear Minister

Thank you for your letters seeking in-principle agreement to a national psychosocial supports measure and an indication of Queensland's willingness to engage in the measure and formalise the agreement at the 4 August 2017 COAG Health Council meeting. I apologise for the delay in responding.

I understand that the 2017-18 Commonwealth Budget commitment of $80 million over four years from 2017-18 for psychosocial support services for people with mental illness who do not qualify for the National Disability Insurance Scheme (NDIS) is contingent on a matched commitment from the States and Territories, to secure a national approach to maintaining community mental health services outside the NDIS.

Queensland welcomes discussions regarding this Commonwealth Budget commitment at the COAG Health Council meeting on 4 August 2017.

Queensland notes that the Commonwealth preference is to leverage off national mental health reforms by funding Primary Health Networks to undertake the planning and commissioning of community mental health and clinical mental health services.

I note that the $80 million in Commonwealth funding that is contingent on matched State and Territory funding will not meet the gap left by the Commonwealth Government's cash out to the NDIS of approximately $300 million from its community mental health programs, for example, Partners in Recovery, Personal Helpers and Mentors, Day 2 Day Living and Mental Health Respite Carer Support.

Thank you again for bringing this matter to my attention. Should your officers require any further information in relation to this matter, I have arranged for Ms Sandra Eyre, Senior Director, Mental Health Alcohol and Other Drugs Branch, Department of Health, on telephone (07) 3328 9531, to be available to assist.

Yours sincerely

CAMERON DICK MP
Minister for Health
Minister for Ambulance Services

RM folder reference No:	C-ECTF-17/3826
Division:	Prevention
File Ref No:	

Brief for Ministerial Correspondence

SUBJECT: Advocating for amendment to mandatory reporting requirements

Key Issues

1. On 26 June 2017, Dr Shaun Rudd, Chair, Australian Medical Association (AMA) Queensland Council, wrote to the Honourable Cameron Dick MP, Minister for Health and Minister for Ambulance Services, requesting consideration of amendment to mandatory reporting requirements in the National Law so as not to dissuade medical practitioners from seeking necessary treatment.
2. A letter of response has been drafted and is provided at Attachment 1.
3. At the AMA National conference in May 2017, there was unanimous support for a motion calling for urgent removal of mandatory reporting across Australia.
4. The Honourable Brad Hazzard MP, New South Wales Minister for Health, has recently indicated an intention to review mandatory reporting laws in New South Wales (Attachment 2).
5. The Commonwealth Government has indicated its intention to work with State Governments on mandatory reporting laws to establish a common national standard (Attachment 3).
6. Other State and Territory ministers have not identified their jurisdiction's intentions with respect to the requirements.
7. Significant recent media attention has been given to issues related to doctors' wellbeing, including perceptions around the potential impact of mandatory reporting requirements on doctors' willingness to seek treatment.

Results of Consultation

8. The Legislative Policy Unit, Strategic Policy and Planning Division, has been previously consulted on potential legislative considerations of any future amendments to the National Law.

Resource Implications (including Financial)

9. Nil

Background

10. Since 2010, the AMA has advocated for removal of provisions in the Health Practitioner Regulation National Law which stipulate the mandatory requirement of health practitioners to report colleagues' medical conditions that could affect their performance.
11. The AMA *Health Vision*, released in 2015, outlines the organisation's advocacy and policy priorities. Part two of the *Health Vision*, 'Workforce and Training' includes initiatives to improve the health of doctors including, 'Ensuring doctors can safely seek medical treatment without fear of mandatory reporting'.
12. Queensland passed the original National Law in 2009. This legislation was then adopted by other States and Territories to constitute the National Registration and Assessment Scheme .
13. Legislation to effect change to the whole National Registration and Assessment Scheme must be passed by Queensland first and then adopted by other States and Territories. Individual States and Territories may seek an exemption (for example, Western Australia) or include an additional co-regulatory component (for example, Queensland Ombudsman, New South Wales Medical Council).

RM folder reference No:	C-ECTF-17/3826
Division:	Prevention
File Ref No:	

Attachments

14. Attachment 1: Letter of response to Dr Shaun Rudd – C-ECTF-17/3826
    Attachment 2: *Daily Telegraph* article dated 7 June 2017
    Attachment 3: Sydney *Morning Herald* article dated 27 June 2017

Department Contact Officer

Dr Jeannette Young, Chief Health Officer and Deputy Director-General, Prevention Division, on telephone 3708 5190

Minister for Health and
Minister for Ambulance Services
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C-ECTF-17/3826

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E-MAILED
6 SEP 2017

Dr Shaun Rudd
Chair
Australian Medical Association
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Email: amaq@amaq.com.au

Dear Dr ~~Rudd~~ Shaun,

Thank you for your letter in relation to mandatory reporting.

As you have stated in your letter, the Health Practitioner Regulation National Law defines the circumstances under which health practitioners are required to report other practitioners. These conditions mandate reporting if a doctor believes the health practitioner they are treating has an impairment that places the public at risk of substantial harm.

As presently constituted, the threshold for mandatory reporting under the National Law is appropriately high, and allows practitioners to exercise clinical discretion in determining if a report is required. I note that advice provided to practitioners by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency highlights the risk of substantial harm as a critical factor in assessing potentially notifiable conduct. As you may be aware at the COAG Health Council meeting on 4 August 2017, Ministers agreed that officials should prepare a recommendation for a national approach to mandatory reporting in consultation with consumer and practitioner groups. The proposal will be considered at our meeting in November.

As you may be aware, Queensland Health has recently allocated $2 million to implement a range of initiatives to support the wellbeing of the medical workforce, from interns to senior consultants. I look forward to the Australian Medical Association Queensland's involvement as a key stakeholder in the formulation of responses to this critical issue.

Thank you again for bringing this matter to my attention. If you require any further information in relation to this matter, I have arranged for Dr Jeannette Young, Chief Health Officer and Deputy Director-General, Prevention Division, Department of Health, on telephone 3708 5190, to be available to assist you.

Yours sincerely

CAMERON DICK MP
Minister for Health
Minister for Ambulance Services

Laws 'detrimental to doctors' mental health' to be changed

Sharon Verghis

Sydney Morning Herald, June 27 2017

The federal government will make changes to the controversial mandatory reporting laws which have been blamed for being "detrimental and even dangerous to doctors' health".

A spokesperson for Health Minister Greg Hunt said the federal government will be working with state governments to "establish a common national standard to protect the mental health of doctors".

Doctor suicides are on the radar after a spate of suicides nationally, including at least four junior doctors in NSW in recent months.

The 2013 Mental Health Survey of Doctors and Medical Students by beyondblue found that compared to the Australian population and other Australian professionals, doctors reported substantially higher rates of burnout, psychological distress and attempted suicide.

Mandatory reporting compels a medical practitioner to report doctors who may pose a public risk.

Who is at risk and how that is judged are often debated but there is a consensus among many in the medical profession and affected families that this is too rigid and punitive.

Proposals include amendments along the model adopted by Western Australia, which provides exemptions for medical professionals who treat doctors seeking medical help for mental health issues.

WA-style exemptions were strongly supported by the Australian Medical Association, mental health advocacy organisation beyondblue, families and international medical authorities who have long campaigned for greater understanding and less draconian red tape for doctors already at risk.

AMA president Michael Gannon said that changes to mandatory reporting are welcomed because of the symbolic importance of the federal government publicly confirming changes to the controversial mandatory reporting laws – an issue that has been much in the medical profession and government's radar in recent times.

It is up to the states to make changes on the legislative front, but the federal government should be congratulated for setting the agenda nationally, Dr Gannon said.

He renewed calls for WA-style exemptions, and said he was optimistic that the states would be on board in terms of making legislative changes to reflect the needs of doctors seeking help for mental distress. "I think the changes will happen in NSW and I'm very hopeful it will be in the other states. It's not a difficult change [re making changes to mandatory reporting]. "My only fear is that the government will think that's doctors' health ticked. It's far more complicated than this." The AMA NSW's Brad Frankum and NSW Health Minister Brad Hazzard, who have also campaigned strongly for change in the mandatory reporting

laws, reaffirmed their support for changes in the law in the interest of doctors' health in the state. "Young doctors in the recent ministerial forum [in June, organised by NSW Health] say that they reported that they had various pressures on them ... they also reported that they had a reluctance to seek out medical help themselves because they felt at risk of being reported," Mr Hazzard said.

Mr Hazzard said there was confusion over the mandatory requirement laws, which served a useful purpose in some cases.

"But my view at the moment is more inclined for the need for it to be changed on the basis that if the perception has become a reality for those young doctors, that becomes their reality, and they're not prepared to seek out help, then that is extremely damaging."

Medico legal insurer Avant said it strongly supported the adoption of the WA-treating-practitioner exemption from mandatory reporting, saying there should be "no barriers to doctors seeking treatment".

This story was found at: ***http://www.smh.com.au/national/laws-detrimental-to-doctors-mental-health-to-be-changed-20170626-gwyz4q.html***

Change to mental health mandatory reporting rules to offer doctors a lifeline

http://www.dailytelegraph.com.au/news/nsw/change-to-mental-health-mandatory-reporting-rules-to-offer-doctors-a-lifeline/news-story/cd89a25eabf1b767b0edadc6d1182704

ROSE BRENNAN, The Daily Telegraph
June 7, 2017 12:00am

RULES that cause doctors to fear they will be investigated and sacked if they admit to struggling with their mental health are likely to be scrapped by the state government.

To encourage more doctors to seek help for mental health concerns, Health Minister Brad Hazzard will review mandatory reporting laws that result in doctors who disclose their mental issues being reported to health authorities and investigated.

Experts believe the rules mean most in the profession are too scared to seek help for even minor concerns for fear of losing their jobs.

To encourage more doctors to seek help for mental health concerns, Health Minister Brad Hazzard will review mandatory reporting laws.

The state's most powerful health professionals, including Mr Hazzard, met at a forum in Sydney yesterday to plot how to save medicos from mental illness.

The forum was convened in the wake of revelations by The Daily Telegraph of a cluster of suicides among the state's junior doctors which rocked the profession.

The organisation Beyond Blue is aware of NSW doctors fleeing interstate for mental health treatment or even resorting to seeking help anonymously just to avoid mandatory reporting laws.

Beyond Blue will circulate a mental health strategy to every hospital in Australia from August in response to the crisis in the medical community. It will include a recommendation that senior doctors speak openly to their staff about their own mental health concerns.

"It's really critical for (people with mental illness) to be able to talk to someone with absolute confidence and know that person is there to help and not to judge them — that's the critical problem with (mandatory reporting)," Mr Hazzard said.

"Having listened to the young doctors it may be that the mandatory reporting requirements are technically not the problem, but practically they are, because that perception among young doctors is by seeking mental health help they may be damaging their career,'' Mr Hazzard said.

"It looks to me that mandatory reporting provisions do need changing and I undertook to look at all aspects.

"My starting point is that they probably do need changing."

Beyond Blue's general manager of workplace programs Patrice O'Brien supports scrapping mandatory reporting.

"I think that really stops a lot of doctors putting their hand up and seeking help," Ms O'Brien said.

Sydney-based junior doctor and chair of AMA's Alliance of Doctors-in-Training Committee Tessa Kennedy said more debriefing was needed to help health workers cope with the trauma they see.

Ministerial Brief for Noting

RM folder reference No:	C-ECTF-17/5207
Division/HHS:	CED
File Ref No:	

SUBJECT: Review of the Operation of the *Forensic Disability Act 2011*

Recommendations

It is recommended the Minister:

1. **Note** the progress of the Review of the Operation of the *Forensic Disability Act 2011*.

NOTED PLEASE DISCUSS

Cameron Dick MP **Date:** 23/08/17
Minister for Health and Minister for Ambulance Services

Ministerial Office comments

Issues

1. The Department of Communities, Child Safety and Disability Services (DCCSDS) is reviewing the operation of the *Forensic Disability Act 2011* (Act) in consultation with the Department of Health (DoH).
2. The Minister for Disability Services, Minister for Seniors and the Minister Assisting the Premier on North Queensland has requested the co-signature of the Minister for Health and Minister for Ambulance Services on a letter to the Premier and Minster for Arts seeking for approval of the terms of reference for the service system component of the review (Attachment 1).
3. The Terms of Reference, developed jointly by DCCSDS and DoH, cover the broad operation of the forensic disability service system and its inter-relation with other legislative schemes including the mental health service system and the National Disability Insurance Scheme (Attachment 2).
4. A Reference Group co-chaired by the Deputy Directors-General of DoH and DCCSDS, is to be established to guide consideration of the of the forensic disability service system component of the review.
5. A written report which includes recommendations for improvement will be provided to the Directors-General DCCSDS and DoH by 1 December 2017.
6. The service system component of the review will inform finalisation of the review of the operation of the Act, anticipated to be in early 2018. If necessary, a revised *Review of the operation of the Forensic Disability Act 2011 – Final Report* will subsequently be provided to Cabinet for consideration.

Michael Walsh
Director-General
15/8/20017

RM folder reference No:	C-ECTF-17/5207
Division/HHS:	CED
File Ref No:	

Vision

7. This brief aligns with the directions of Delivering healthcare and Pursuing innovation set out in Queensland Health's 10 year vision *My health, Queensland's future: Advancing health 2026.*

Background

8. There has been previous correspondence with the Minister for Disability Services Minister for Seniors and the Minister Assisting the Premier on North Queensland on this matter (MI211671).

Sensitivities

9. The DoH is working with DCCSDS on transitioning the exiting cohort of Forensic Disability Service (FDS) clients to the community. Obstacles to this process include difficulties in locating appropriate supports for these individuals in the community and issues associated with the roll out of the National Disability Insurance Scheme.

10. Due to the limited capacity of the FDS operated by DCCSDS, people subject to a forensic order (disability) are by default, followed up by an Authorised Mental Health Service (AMHS) and if necessary contained in an inpatient facility of an AMHS. As at 30 June 2017, 81 individuals with an intellectual or cognitive disability were managed by an AMHS under a forensic order (disability).

Results of Consultation

11. DCCSDS and DoH have consulted with the Department of Premier and Cabinet and Queensland Treasury in the development of the Terms of Reference.

Resource Implications (including Financial)

12. There are resource implications for Queensland Health in relation to service provision by AMHS for individuals subject to a forensic order (disability).

Attachments

13. Attachment 1: Letter to the Premier from the Honourable Coralie O'Rourke MP, Minister for Disability Services, Minister for Seniors and Minister Assisting the Premier on North Queensland for co-signature by the Minister for Health and Minister for Ambulance Services.

    Attachment 2: Terms of Reference – Review of the operation of the *Forensic Disability Act 2011:* Consideration of Queensland's forensic disability service system.

Department Contact Officer

Ms Jan Rodwell, Manger, Policy, Systems and Compliance, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division, on telephone 3328 9581.

RM folder reference No:	**C-ECTF-17/5207**
Division/HHS:	**CED**
File Ref No:	

Author	Cleared by: (SD/Dir)	Content verified by: (DDG)
Jan Rodwell	Assoc. Prof John Allan	Dr John Wakefield
Manager, Policy, Systems and Compliance	Executive Director Mental Health Alcohol and Other Drugs Branch	Deputy Director-General
Mental Health Alcohol and Other Drugs Branch	Clinical Excellence Division	Clinical Excellence Division
33289581	3328 9536	3405 6181
11 August 2017	11 August 2017	14 August 2017

Queensland Government

Our reference: COM 03825-2017

The Honourable Annastacia Palaszczuk MP
Premier and Minister for the Arts
PO Box 15185
CITY EAST QLD 4002

Dear Premier

Further to recent correspondence to you by Minister O'Rourke regarding the review of the operation of the *Forensic Disability Act 2011* (the Act), we seek your approval of the enclosed terms of reference for the component of the review relating to the forensic disability service system.

The terms of reference for the forensic disability service system component of the review have been developed by the Department of Communities, Child Safety and Disability Services (DCCSDS) and the Department of Health, in consultation with the Department of the Premier and Cabinet and Queensland Treasury. We request your approval of the enclosed terms of reference.

This component of the review will consider the efficacy, efficiency and cost-effectiveness of the existing framework of services, systems, laws and oversight mechanisms in Queensland that make up the forensic disability service system and, as necessary, develop options and make recommendations for improvement.

The service system component will inform the finalisation of the review of the operation of the Act, which is anticipated to be in early 2018. If necessary, a revised *Review of the operation of the Forensic Disability Act 2011 – Final Report* will subsequently be provided to Cabinet for consideration and approval for tabling.

Following your approval of the terms of reference, DCCSDS will proceed with procurement, in order for the systems component of the review of the Act to be completed by the end of December 2017.

If you require any further information or assistance in relation to this matter, please contact Ms Carolyn Nicholas, Chief of Staff in Minister O'Rourke's office on 3719 7170.

I look forward to hearing from you about this proposal.

Yours sincerely

Cameron Dick MP
Minister for Health
Minister for Ambulance Services

Coralee O'Rourke MP
Minister for Disability Services
Minister for Seniors
Minister Assisting the Premier on North Queensland

Enc. (1)

Review of the operation of the *Forensic Disability Act 2011*: Consideration of Queensland's forensic disability service system Terms of reference

Background

The Queensland Government is committed to ensuring that Queensland has a fair and effective system for the care and support of people with intellectual or cognitive disability on a forensic disability order, and for the protection of community safety.

Definition

The term '*forensic disability service system*' (the system) refers to the broad framework of legislation, services, systems and oversight mechanisms in Queensland that:

- relate to, and are delivered to persons with an intellectual or cognitive disability, who have committed serious or indictable offences, where the Mental Health Court has: determined the person was either of unsound mind at the time of committing the offence, or is unfit for trial as a consequence of their intellectual disability; and made a forensic order (disability) or forensic order (mental health) that the person be detained for involuntary care or treatment, and
- provide for these individuals' subsequent care, support, accommodation, rehabilitation, habilitation, protection, and reintegration into the community, including through both disability services and mental health services.

Terms of reference

This component of the review of the *Forensic Disability Act 2011* will:

1) consider the efficacy, efficiency and cost-effectiveness in delivering intended outcomes for clients of the existing:
   a) delivery of services, and support, provided to individuals with intellectual disability subject to forensic orders, and how positive outcomes for these individuals are delivered;
   b) interrelationships and connections between the services, systems, laws and oversight mechanisms within the forensic disability service system; and
   c) policies, laws and service delivery that relate to the making, exercising, review and administration of forensic orders for people with intellectual disability;

2) consider the best legislative and administrative arrangements for the portfolio responsibility for the delivery and operation of the system, including the results of the work to date on the review of the *Forensic Disability Act 2011*;

3) consider whether any improvements could be made to:
   a) better meet the needs of individuals, and ensure individuals are provided with reasonable and necessary care, support and accommodation, and the best promotion of their rehabilitation, habilitation, safe community placement and reintegration into the community;
   b) ensure individuals are able to access services locally, as far as is reasonable to maintain connection to culture, family, language and community, and ensure access to advocates and other support persons of the individual;

c) existing oversight, monitoring and investigative mechanisms; and
d) how the system meets community safety needs and expectations;

4) have regard to:
   a) Australia's international human rights obligations, including the principles from the United Nations Convention on the Rights of Persons with Disabilities;
   b) the different and complex needs of the cohort of individuals subject to a forensic order, including their cultural, religious or spiritual beliefs and practices; the needs of persons from culturally and linguistically diverse backgrounds; and in particular, the need for Aboriginal people and Torres Strait Islanders in the system to maintain connection to their culture and community;
   c) the review of the *Mental Health Act 2000*, the Honourable William J Carter's report *Challenging Behaviour and Disability: A Targeted Response*, and His Honour Judge Brendan Butler AM SC's report *Promoting balance in the forensic mental health system – Final Report – Review of the Queensland Mental Health Act 2000*;
   d) the *Mental Health Act 2016,* in particular with regard to changed provisions relating to people with intellectual disability, including those on a forensic order;
   e) the legislation for, and operation of, the National Disability Insurance Scheme (NDIS), and its interface with the system and forensic disability services;
   f) the evidence base for best practice delivery of forensic disability services, including contemporary literature, research, and consideration of other forensic disability service system models (either existing or proposed) in other jurisdictions; and

5) identify options that are safe, affordable, deliverable, and provide for effective and efficient outcomes for clients and the community.

Outside scope

The following are outside the scope of this component of the review of the *Forensic Disability Act 2011*:

- the mental health system which treats and cares for people who have mental illnesses, to the extent that it does not relate to individuals with an intellectual or cognitive disability who are subject to a forensic order (disability) or forensic order (mental health);
- specific investigation of the individuals currently subject to a forensic order and their particular circumstances, for example why an individual was detained on a forensic order by the Mental Health Court, (this is not intended to limit consideration of the circumstances and needs of the cohort of individuals subject to a forensic order); and
- the development of options for the policies and procedures providing for the day-to-day operation of services within the system.

Guidance

A reference group will be established to guide consideration of the forensic disability service system component of the review of the Act, co-chaired by Deputy Directors-General of the Department of Health and the Department of Communities, Child Safety and Disability Services, which will also include representatives nominated by the Directors-General or Commissioners respectively of the Department of Justice and Attorney-General, the Office of the Public Guardian, Office of the Public Advocate, the Department of the Premier and Cabinet, Queensland Treasury, the Anti-Discrimination Commission of Queensland, the Queensland Mental Health Commission, and representatives on behalf of consumers.

Timeframe

A written report, which includes recommendations for improvement, will be provided to the Directors-General of the Department of Communities, Child Safety and Disability Services and the Department of Health, by 1 December 2017.

RECEIVED
DATE 8/9 BY

Ministerial Brief for Approval

RM folder reference No:	C-ECTF-17/5366
Division/HHS:	CED
File Ref No:	

SUBJECT: Amendments to the *Hospital and Health Boards Regulation 2012*

Recommendations

It is recommended the Minister:

1. **Approve** the drafting of amendments to the *Hospital and Health Boards Regulation 2012* to prescribe the updated Memorandum of Understanding between Queensland Health and the Queensland Police Service for Mental Health Collaboration and the updated Memorandum of Understanding between Queensland Health and Queensland Corrective Services for Confidential Information Disclosure

APPROVED / ~~NOT APPROVED~~ ~~PLEASE DISCUSS~~

Cameron Dick MP **Date:** 14/9/17
Minister for Health and Minister for Ambulance Services

Ministerial Office comments

Issues

1. Urgent: approval to draft amendments is required by 15 September 2017 in order to be actioned in 2017.
2. Amendments are proposed for the *Hospital and Health Boards Regulation 2012* (HHB Regulation) to update schedule 3, part 2, 10 to reflect the updated Memorandum of Understanding between Queensland Health and the Queensland Police Service for Mental Health Collaboration (MOU for MHC) (Attachment 1) and schedule 3, part 2, 11 to reflect the updated Memorandum of Understanding between Queensland Health and Queensland Corrective Services for Confidential Information Disclosure (MOU for CID) (Attachment 2).
2. The MOU for MHC and the MOU for CID were revised in 2016 (BR064276) and (BR064157); however further revisions are required in line with the commencement of the *Mental Health Act 2016* (MHA 2016) on 5 March 2017.
3. The minor changes made to the MOU for MHC and the MOU for CID are detailed in Attachment 3.
4. The MOU for MHC and the MOU for CID have been signed by both parties.
5. The proposed amendments to the HHB Regulation will be progressed via a Health Legislation Amendment Regulation.

Vision

6. The MOU for MHC and the MOU for CID support direction number 2 – delivering healthcare. The MOU for MHC and the MOU for CID allow for enhanced communication and coordination with other agencies for the delivery of health and other services, ensuring safe and appropriate health care is provided.

Michael Walsh
Director-General
8 / 9 / 2017

RM folder reference No:	C-ECTF-17/5366
Division/HHS:	CED
File Ref No:	

Results of Consultation

7. Targeted consultation was undertaken for the minor changes made to the MOU for MHC and the MOU for CID in 2017. All stakeholders consulted are supportive of the minor changes.

8. The Legislative Policy Unit (LPU) was consulted about amending the HHB Regulation to update the references to the prescribed MOUs. LPU provided advice around timeframes and the process to progress the amendments.

Resource Implications (including Financial)

9. There are no financial implications anticipated for the updated MOU for MHC and the MOU for CID.

Background

10. The *Hospital and Health Boards Act 2011* (HHB Act) establishes a duty of confidentiality that applies to Queensland Health staff. The HHB Act prescribes a number of exceptions to the duty of confidentiality, in recognition of circumstances where it is necessary to disclose confidential information. Section 151(1)(b) permits information to be disclosed if the disclosure is to an entity of the State and the disclosure is allowed under an agreement with the entity, which is prescribed under a regulation and is considered by the Chief Executive to be in the public interest. Agreements with State entities under this exception are prescribed in Schedule 3, Part 2 of the HHB Regulation.

Sensitivities

11. There are no known sensitivities in regard to the proposed amendments.

Attachments

12. Attachment 1: the MOU for MHC
    Attachment 2: the MOU for CID
    Attachment 3: background and changes for the MOU for MHC and the MOU for CID.

Department Contact Officer

Ms Christianne Dashwood, Principal Policy Officer, Policy Systems and Compliance, Legislation Unit, Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch, 3328 9609.

RM folder reference No:	C-ECTF-17/5366
Division/HHS:	CED
File Ref No:	

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
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Principal Policy Officer, PSC	Executive Director	Deputy Director-General
Legislation Unit, Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch	Mental Health Alcohol and Other Drugs Branch	Clinical Excellence Division
3328 9609	3328 9538	3405 6181
10 August 2017	14 August 2017	14 August 2017
4 September 2017	4 September 2017	
	Amended by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
	David Harmer	Bronwyn Nardi
	A/Senior Director	A/Deputy Director-General
	Strategic Policy and Legislation Branch	Strategy, Policy and Planning Division
	3708 5574	3708 5745
	30 August 2017	30 August 2017

Queensland Government

MEMORANDUM OF UNDERSTANDING

BETWEEN

The State of Queensland acting through Queensland Health

AND

The State of Queensland acting through the Queensland Police Service

Mental Health Collaboration

This **MEMORANDUM OF UNDERSTANDING** is made on the 15th day of June 2017

BETWEEN

The State of Queensland acting through Queensland Health, 147-163 Charlotte Street Brisbane ("**QH**")

AND

The State of Queensland acting through the Queensland Police Service, 200 Roma Street Brisbane ("**QPS**")

(together, the **"Parties"**)

RECITALS

A. QH and the QPS often provide services to the same people with a Mental Illness and/or Vulnerable Persons.

B. The Parties acknowledge that each Party has its various and respective roles and responsibilities with regard to people with a Mental Illness and/or Vulnerable Persons (as defined in this MOU) and will work collaboratively and cooperatively, to:

   a) proactively develop Mental Health Intervention Strategies; and
   b) respond to Mental Health Incidents and Situations Involving Vulnerable Persons.

C. The Parties agree to work collaboratively and cooperatively to prevent and resolve Mental Health Incidents involving people with a Mental Health Problem and Vulnerable Persons who are known to QH (Mental Health Consumers) and people with a Mental Health Problem and Vulnerable Persons who are not known to QH.

D. Designated Persons have a duty to maintain confidentiality under section142 of the *Hospital and Health Boards Act 2011* (HHB Act) and are prohibited from disclosing Confidential Information to the QPS unless one of the exceptions to section 142 of the HHB Act (sections143-161) applies. This MOU is prescribed under the exception provided for in section 151(1)(b) of the HHB Act to allow for the disclosure of Confidential Information in the circumstances specified within this MOU. This MOU does not preclude the disclosure of Confidential Information authorised under any of the other exceptions at Part 7 of the HHB Act.

E. The Parties acknowledge that any relevant Confidential Information must be shared in accordance with the processes established in the MOU, without delay, to reduce the risk to the life, health or safety of the person to whom the Confidential Information relates and/or to public safety.

F. The Parties agree that QH Staff are, under section 151(1)(b)(i)(A)&(B) of the HHB Act, permitted to disclose Confidential Information relating to Mental Health Consumers:

   a) when responding to Mental Health Incidents; and
   b) when developing Mental Health Intervention Strategies (including, but not limited to, the development of Police and Ambulance Intervention Plans and/or Acute Management Plans).

G. It is not intended that this MOU create any contractual relationship or that it be legally binding on the Parties.

H. This MOU replaces the MOU 'Mental Health Collaboration 2016' executed by the Parties on 24 November 2016.

THE PARTIES TO THIS MOU AGREE AS FOLLOWS:

1. DEFINITIONS

1.1. In this MOU the following definitions apply:

Acute Management Plan (AMP) means a plan ideally developed in consultation with the Consumer, the Mental Health Treating Team and other relevant stakeholders to provide relevant clinical Information for the Department of Emergency Medicine, Acute Treatment Services and other mental health practitioners to assist clinicians respond to or prevent a Mental Health Incident from occurring.

Care includes a range of Health Care Services provided by QH and other non-government service providers.

Carer means an individual who provides, in a non-contractual and unpaid capacity, ongoing care or assistance to another person who, because of disability, frailty, chronic illness or pain, requires assistance with everyday tasks.

CIMHA means the consumer integrated mental health application used by QH.

Clinical File means a collection of data and Information gathered or generated to record the clinical care and health status of a Mental Health Consumer.

Collaborative Software means application software designed to help people involved in a common task to achieve their goals.

Commissioner means the Commissioner of the QPS.

Confidential Information has the same meaning as at section 139 of the HHB Act and includes the Confidential Information described in Schedule 3 of the MOU.

Consumer means a Mental Health Consumer (also known as a patient of a Mental Health Service) as defined in this clause 1.1.

Contact Officer means the persons described in schedule 4.

Designated Person for purposes of this MOU has the same meaning as at section 139A of the HHB Act and includes health service employees in a QH Mental Health and Alcohol, Tobacco and Other Drugs Service.

The *Mental Health Act 2016* extends the definition of Designated Person to include Independent Patient Rights Advisers.

Director-General means the Director-General of QH.

Health Care Service means a service that provides a range of services to improve, restore and maintain the health and wellbeing of a person.

HHB Act means the *Hospital and Health Boards Act 2011* (Qld).

HHB Regulation means the *Hospital and Health Boards Regulation 2012* (Qld).

Independent Patient Rights Adviser means a person appointed as an Independent Patient Rights Adviser (Rights Adviser) under section 293(2) of the MHA 2016. A Rights Adviser performs the functions listed under section 294 of the MHA 2016 and ensures patients and nominated support persons, family, carers and other support persons are aware of their rights under the MHA 2016. Rights Advisers liaise between clinical teams, patients and support persons.

Information includes a document (as defined under section 36 of the *Acts Interpretation Act 1954*) that is in the possession or under the control of either Party (whether brought into existence or received by either Party) and knowledge and opinions of staff of either Party (whether verbal or recorded in some form including a statement). Information also includes Confidential Information and Personal Information.

Local Committee means a group of stakeholders from a particular geographical area that meet to discuss and resolve relevant issues, establishing effective collaborative working relationships.

MHA 2016 means the *Mental Health Act 2016* (Qld).

Mental Health Assessment means the data gathering process involved in formulating a clinical opinion on the condition of a Mental Health Consumer's mental health and, where necessary, identifying the appropriate treatment, management or Care.

Mental Health Clinician means a registered Mental Health Service clinician, with an appropriate professional qualification, who provides Mental Health Services.

Mental Health Consumer means a person who is receiving, or has received, any service from a public Mental Health Service. Services include triage, assessment and delivery of treatment by a Mental Health Clinician, including inpatient and community management.

Mental Health Incident or Situation Involving a Vulnerable Person (Mental Health Incident) means situations that:

a) involves a series of events or a combination of circumstances in which a person is demonstrating behaviour that is indicative of a Mental Health Problem;

b) may involve a serious risk to the life, health, or, safety of the person or of another person; and

c) requires communication and coordination between the Parties at the earliest opportunity and ongoing communication as required.

Mental Health Intervention Strategy means a strategy or plan (including, but not limited to, the development of a PAIP or an AMP), developed in partnership by the QPS and QH, to:

a) reduce the likelihood of a Mental Health Incident from occurring; and
b) to better prepare both Parties to respond if a Mental Health Incident does occur.

Mental Health Problem means disequilibrium in a person's biological and/or psychological and/or sociological functioning resulting in diminished state of mental health.

Mental Health Service means a QH Mental Health Service that provides specialised Mental Health Assessment, treatment and care for people with a Mental Illness.

Mental Health Treating Team means the team of appropriately qualified and registered mental health professionals treating a particular Mental Health Consumer.

Mental Illness as defined in the *Mental Health Act 2016* is a condition characterized by a clinically significant disturbance of thought, mood, perception or memory. Mental Illness is a clinically diagnosable disorder that significantly interferes with an individual's usual biological and/or psychological and/or sociological functioning.

MOU means this Memorandum of Understanding and any schedules to the MOU.

Notice means a Notice given pursuant to clause 10 of the MOU.

Personal Information has the same meaning as at section 12 of the *Information Privacy Act 2009* (Qld).

Police and Ambulance Intervention Plan (PAIP) means a plan ideally developed in consultation with the Consumer, the Mental Health Treating Team and other stakeholders including the QPS. It extrapolates considerations for intervention and outlines potential risks as a means to support both the Consumer and police officers to safely resolve a Mental Health Incident.

Privacy Laws include any laws that apply to one or both Parties regarding the nature of the Information disclosed, including Confidential Information and Personal Information.

QH Facility means a facility that provides a range of services to improve, restore and maintain the health and wellbeing of a person.

QH Staff means a Designated Person.

QPS Officer means a person declared under section 2.2(2) of the *Police Service Administration Act 1990* (Qld) to be a police officer.

Relevant Emergency Services Personnel means personnel from the Queensland Ambulance Service, the Queensland Fire and Rescue Service and Emergency Management Queensland that are required to help prevent or resolve a Mental Health Incident, dependent on the nature of the Mental Health Incident.

Risk Taking Behaviours means behaviours that have the potential to be harmful or dangerous.

Schedule means a Schedule to this MOU.

Treatment for a person who has a Mental Illness, means anything done, or to be done, with the intention of having a therapeutic effect on the person's illness, including the provision of a diagnostic procedure.

Vulnerable Person means a person who is considered to be experiencing instability in their biological and/or psychological and/or social functioning and in consequence:

d) is at risk of being unable to take care of themselves or is unable to take care of

themselves; and/or

e) is at risk of being unable to protect themselves against harm or is unable to protect themselves against harm by reason of age, illness (including Mental Illness), trauma or disability, or any other reason.

2. COMMENCEMENT & DURATION

2.1 This MOU will commence on the date it is prescribed in the HHB Regulation and will continue in force until the Regulation is repealed or until clause 8 of this MOU is invoked.

3. OPERATION OF MOU

3.1. The operation of this MOU is contingent on the following:

(a) all Parties understanding and agreeing to their role in the execution of the MOU;

(b) the MOU having been prescribed under the HHB Regulation pursuant to section 151(1)(b)(i)(A)&(B) of the HHB Act;

(c) implementation of the Protocol attached to this MOU as Schedule 1, which sets out the practice obligations of each Party and its officers regarding the disclosure of Confidential Information when developing Mental Health Intervention Strategies;

(d) implementation of Schedule 2 which sets out the Information to be disclosed by the QPS to QH; and

(e) implementation of Schedule 3 which sets out the Information to be disclosed by a Designated Person to the QPS.

3.2. This MOU applies to the disclosure of relevant Confidential Information between QH Staff and the QPS for the purposes of:

(a) assisting to safely resolve Mental Health Incidents that do not involve detainees under State preventative detention orders issued under the *Terrorism (Preventative Detention) Act 2005* (Qld); and

(b) proactive collaboration between the Parties for the development of Mental Health Intervention Strategies.

3.3. This MOU is intended to work in conjunction with, and not derogate from, any other prescribed MOU between the QPS and QH. The Parties agree that for the proactive development of Mental Health Intervention Strategies and when responding to a Mental Health Incident:

(a) the QPS has responsibility to protect the health and safety of all persons;

(b) QH Staff and the QPS should maintain and share the ongoing commitment to ensure that services are provided in a way that reflects the rights of a Consumer and their Carer, in particular, the preservation of the Consumer's rights and dignity in accordance with the *Mental Health Act 2016 Statement of Rights for patients of mental health services*[1] within the overall objective of ensuring the life, health, safety or welfare of all parties;

(c) primacy is always given to the life, health, safety or welfare of all persons concerned and, where not able to be avoided, the imposition of minimum restriction upon the Mental Health Consumer or Vulnerable Person.

[1] Department of Health

4. INFORMATION DISCLOSURE RELATING TO THE DEVELOPMENT OF MENTAL HEALTH INTERVENTION STRATEGIES (INCLUDING PAIPs and AMPs)

4.1. The Parties agree to continue to improve knowledge, skills, attitudes and values of their respective staff to ensure a coordinated system of care and improved service delivery to Mental Health Consumers.

4.2. The Parties will endeavour to ensure their respective staff complies with the Protocol set out in Schedule 1 for the development of Mental Health Intervention Strategies.

4.3. The Parties agree to ensure provisions are made for the QPS staff and Designated Persons to meet on a regular basis to identify current and emerging specific issues relating to Mental Health Consumers and to develop Mental Health Intervention Strategies. The disclosure of Confidential Information, detailed in schedule 2 and 3, is appropriate and necessary at these forums to prevent serious risk to the life, health or safety of an individual, or to public safety.

5. INFORMATION DISCLOSURE DURING A MENTAL HEALTH INCIDENT OR SITUATION INVOLVING A VULNERABLE PERSON (MENTAL HEALTH INCIDENT)

5.1. Each Party will endeavour to ensure their respective staff provides all the necessary relevant Information and assistance required by the other Party to support the safe and effective resolution of a Mental Health Incident.

5.2. To assist the QPS determine if a person involved in a Mental Health Incident has a Mental Illness or has been a Mental Health Consumer, the QPS will provide sufficient Information as listed in Schedule 2 to the relevant QH Staff member.

5.3. The role of QH Staff is:

(a) to discuss the situation with the QPS and determine whether or not the situation meets the criteria of a Mental Health Incident as per the definition in clause 1.1;

(b) to identify if the person is a Mental Health Consumer;

(c) if the person is a Mental Health Consumer, to decide whether or not disclosing relevant Confidential Information about the Mental Health Consumer would assist in safely resolving the Mental Health Incident;

(d) to disclose to the QPS relevant Confidential Information, of the nature set out in Schedule 3, as soon as reasonably practicable, where such disclosure would likely assist in the safe resolution of the Mental Health Incident;

(e) to collaborate with the QPS to ensure that police have access to expert advice to assist them to accurately interpret and appropriately use the Confidential Information disclosed and assist them to safely resolve the Mental Health Incident; and

(f) to ensure that a record of the Confidential Information disclosed is made in the Mental Health Consumer's Clinical File and CIMHA and communicated, where clinically advisable, to the Mental Health Consumer, or their parent or Carer, at a time considered appropriate by treating clinicians.

5.4 The Parties agree that QPS officers may disclose relevant Information specified in Schedule 2 and QH Staff may disclose relevant Confidential Information specified in Schedule 3, as soon as reasonably practicable, using the most appropriate channel of communication, having regard to the urgency of the situation.

5.5 The QPS agrees that in circumstances where a Consumer is coming to the attention of the QPS on a regular basis, the QPS will contact the relevant Mental Health Service to check the accuracy and currency of Confidential Information held about the Consumer. The Parties will collaborate on the current challenges being faced by the Consumer and develop a Mental Health Intervention Strategy, ideally in consultation with the Consumer, to help prevent the likelihood of a Mental Health Incident from occurring.

5.6 When a person involved in a Mental Health Incident is not known to QH, QH staff should provide the QPS with assistance in regard to the behaviour being demonstrated by the person if Mental Illness is suspected as the cause of the person's actions.

6. INFORMATION DISCLOSURE AND CONFIDENTIALITY

6.1 QH's preferred position is that disclosing Confidential Information to the QPS should, in the first instance, occur with the Mental Health Consumer's consent. However, the Parties recognise that situations will arise where it will not be possible or reasonable to obtain consent from the Consumer, or consent from the Consumer's parent or Carer.

6.2 This MOU is not intended to exclude other processes on which the QPS may rely to obtain information from QH, including by way of warrant, summons or subpoena, where available and practicable.

6.3 The Parties acknowledge that disclosing Confidential Information pursuant to this MOU may involve Information that is confidential and/or subject to Privacy Laws. In particular, the QPS acknowledges that, pursuant to section 151 of the HHB Act, the QPS must ensure any Confidential Information disclosed is used only for the purpose for which it was given under the MOU.

6.4 The Parties agree at all times to recognise and observe the confidentiality of Information released under this MOU and agree that the collection, disclosure and use of Information will comply, so far as they apply to the relevant Party, with all applicable Queensland government policy and legislative requirements including those set out in the:

(a) *Hospital and Health Boards Act 2011*

(b) *Hospital and Health Boards Regulation 2012*

(c) *Public Health Act 2005*

(d) *Mental Health Act 2016*

(e) *Police Powers and Responsibilities Act 2000*

(f) *Police Powers and Responsibilities Regulation 2012 (Schedule 9, Responsibilities Code)*

(g) *Police Service Administration Act 1990*

(h) *Crime and Corruption Act 2001*

(i) *Criminal Code Act 1899*

(j) *Information Privacy Act 2009*

(k) Code of Conduct for the Queensland Public Service

(l) Queensland Police Service Operational Procedures Manual

(m) Queensland Government Information Standard 18 (Information Security).

6.5 The Parties agree to:

(a) ensure appropriate security measures are in place to protect any Information provided by the other Party from unauthorised access, use or disclosure;

(b) restrict any person from accessing or using information released under this MOU unless the person is legally authorised to do so; and

(c) comply with any reasonable confidentiality conditions or restrictions imposed by the other Party in respect of the handling or disclosure of Confidential Information disclosed under this MOU.

6.6 It is acknowledged that Information sharing between the Parties may occur utilising a variety of channels dependant on the nature of the Mental Health Incident being discussed and the availability of staff from the Parties. These communication channels may include: Information provided over the phone, face to face, via email, via Collaborative Software and/or in a written format. However, both Parties acknowledge that the other Party may require Information to verify the identity of the person receiving the Information before disclosing that Information.

6.7 All Information disclosed must be documented by the Parties, who both disclose and receive the Information, as soon as is practicable after the disclosure or receipt of the Information.

6.8 The QPS acknowledges that it must not disclose to third parties any Confidential Information disclosed under this MOU unless the MOU expressly permits the disclosure or approval for the disclosure has been given in writing by the Director-General, or as required by law.

7. VARIATION AND REVIEW

7.1 This MOU may be varied by written agreement between the Parties. Any proposed amendments must be approved by the Commissioner and the Director-General.

7.2 The Parties agree that this MOU will be reviewed within 12 months of the date of it taking effect and thereafter every three years on the anniversary of the initial review, or at such other earlier time as may be agreed by the Parties.

8. TERMINATION

8.1 Either Party may terminate this MOU by giving the other Party 28 days prior Notice in writing of its intention to terminate.

8.2 Where this MOU is terminated under clause 8.1, the Parties agree to provide all reasonable assistance and cooperation necessary to ensure a smooth transition.

9. DISPUTE RESOLUTION

9.1 For any matter in relation to this MOU that may be in dispute, the Parties:

(a) will attempt to resolve the matter at the local level between relevant QH staff and QPS officers;

(b) agree that, if the matter is not resolved at the local level, the matter will be referred to appropriate senior managers within the QPS and QH for resolution; and

(c) agree that, during the time when the Parties attempt to resolve the matter, the Parties continue to comply with the MOU.

10. NOTICES

10.1 Any Notice or communication given under this MOU must be:

(a) in writing; and

(b) delivered personally, sent by ordinary prepaid post, facsimile or email to the Contact Officer's address, facsimile number or email address (as the case may be) notified by the Contact Officer from time to time.

10.2 A Notice or other communication given under clause 10.1 is taken to be received (as the case may be):

(a) if delivered personally, on the business date it is delivered;

(b) if sent by ordinary prepaid post, seven business days after posting;

(c) if sent by facsimile, when the sender receives confirmation that the facsimile has been transmitted to the addressee's facsimile number in its entirety; or

(d) if sent by email, when the sender's email arrives at the information system from which the recipient can access it.

SCHEDULE 1

PROTOCOL FOR PROACTIVE INFORMATION SHARING AND THE DEVELOPMENT OF MENTAL HEATLH INTERVENTION STRATEGIES (INCLUDING PAIPs and AMPs)

Objectives

The **objectives** for Information sharing between the Parties for the development of Mental Health Strategies include:

(a) To ensure **all the relevant and appropriate Information can be shared by the Parties**, as required, throughout the development and implementation of Mental Health Intervention Strategies.
(b) To enable a **more integrated approach** between the Parties for the assessment and treatment of a Mental Health Consumer.
(c) To **foster collaborative, responsive relationships between the Parties** that enable effective partnering when developing a Mental Health Intervention Strategy and responding to a Mental Health Incident.
(d) To **reduce the likelihood of Mental Health Incidents from occurring** through timely, accurate and appropriate Information sharing, resulting in the development of comprehensive Mental Health Intervention Strategies.

Principles

The **principles** underpinning Information sharing for the development of Mental Health Intervention Strategies include:

(a) **Collaborative relationships** – collaborative working relationships enable the development of comprehensive Mental Health Intervention Strategies.
(b) **Proactive approach to managing risk** – the Parties share a proactive approach to the steps involved in the development and execution of Mental Health Intervention Strategies.
(c) **Cooperation** – the Parties cooperate as required to assist with the development of the Mental Health Intervention Strategies.
(d) **Compliance** – Confidential Information shared is protected in accordance with this MOU and relevant legislation.
(e) **Trustworthy** – Information shared is relevant, accurate and timely.
(f) **Managed** – Information sharing is actively planned and managed.
(g) **Accountability** – roles, responsibilities and accountabilities of the QPS and QH are understood and respected.

The Information sharing pathway and the development of a Mental Health Intervention Strategy

1. The development of a comprehensive Mental Health Intervention Strategy is a progressive process, involving multiple components, requiring input, Information sharing and flexibility from both Parties.
2. Components that contribute to the development of a comprehensive Mental Health Intervention Strategy can include, but are not limited to:
    (a) **Early identification** - both Parties should actively consider Vulnerable Persons that demonstrate behaviour indicating they may be suffering from Mental Illness. This includes, but is not limited to, behaviour demonstrated in a QH Facility or behaviour demonstrated by a Vulnerable Person, with whom a QPS officer has had contact. Discussion about the behavioural characteristics of Mental Illness is encouraged between the Parties to assist with the early identification of people suffering from a Mental Illness and the development of Mental Health Intervention Strategies.
    (b) **Assessment** – a comprehensive clinical assessment of the Mental Health Consumer must be undertaken to ensure appropriate treatment is provided while in a QH Facility and to confirm the Mental Health Consumer has received the appropriate treatment and is ready to be discharged from the QH Facility.
    (c) **Risk mitigation** – Parties may communicate Mental Health Intervention Strategies to Relevant Emergency Services Personnel and clinicians to mitigate the risk of the Mental Health Consumer harming themselves or others.
    (d) **Prevention planning** – planning by both Parties to prevent a Mental Health Consumer or Vulnerable Person from becoming involved in a Mental Health Incident.
    (e) **Treatment** – Information shared between both Parties assists with informing the most appropriate Treatment plan based on a comprehensive clinical assessment supported through knowledge of both static and dynamic risk factors.
    (f) **Discharge planning** – discharge planning is a multidisciplinary and multi agency responsibility undertaken in collaboration with the Mental Health Consumer.
    (g) **Continuing care in the community** – comprehensive Mental Health Intervention Strategies include planning for continuing care in the community. Collaboratively QH and the QPS have a joint responsibility to mitigate risk by maintaining open lines of communication supported through regular reviews of Mental Health Intervention Strategies for Mental Health Consumers and/or Vulnerable Persons considered to be at significant risk to themselves and/or others and/or property and/or engaging in Risk Taking Behaviours.

The success of these components informing a Mental Health Intervention Strategy is heavily dependent on the collaborative relationship established between the Parties and the Information shared.

3. There are a variety of communication channels that Information may be shared though, these include, but are not limited to:

    (a) face to face meetings,
    (b) discussions via phone or teleconference,
    (c) email,
    (d) Collaborative Software,
    (e) interagency stakeholder meetings; and
    (f) relevant Local Committee meetings.

SCHEDULE 2

The following Information may be disclosed, where relevant, by a QPS officer to QH Staff under this MOU about a Vulnerable Person or Mental Health Consumer during a Mental Health Incident or for the development of a Mental Health Intervention Plan:

(a) name
(b) alias names
(c) date of birth
(d) last known address
(e) the current location
(f) criminal history
(g) QP9s (court briefs)
(h) any relevant significant risks, history or cautions
(i) current behaviour i.e. description of actions, mood, speech
(j) street checks relating to mental health interactions
(k) any relevant past behaviour
(l) other services that are involved in the situation
(m) presence or availability of family members
(n) evidence of firearms, dangerous weapons or drugs
(o) relevant outstanding matters (warrants, court and/or investigative)
(p) any other significant information that can assist in informing risk mitigation.

SCHEDULE 3

The following Information may be disclosed, where relevant, by QH Staff to a QPS officer under this MOU about a Vulnerable Person or a Mental Health Consumer during a Mental Health Incident or in the development of a Mental Health Intervention Plan:

(a) name

(b) date of birth

(c) address

(d) contact details

(e) the nature of their Mental Illness

(f) a description of the characteristics of a Mental Illness

(g) clarification that the behaviour being demonstrated is not indicative of Mental Illness

(h) intoxication from substances and/or alcohol; behaviour to expect in these circumstances; impact on behaviour and propensity of verbal/physical aggression towards others and/or harm to self

(i) medical history/chart Information including recent behaviour, most recent assessment and expected responses

(j) details of relevant health professionals, for example, Mental Health Clinician, psychiatrist or treating doctor

(k) any relevant significant risks, including the propensity for violence or self harm

(l) history of possessing firearms, dangerous weapons or drugs

(m) the person's medication (including effects of medication and of non-compliance)

(n) warning signs indicating deterioration in their mental health

(o) 'triggers' that may escalate the Mental Health Incident

(p) suicide risk including Information about previous suicidal ideation or attempts to commit suicide; lethality of previous suicide attempts

(q) self-harm behaviours; propensity to act of these thoughts

(r) details of next-of-kin and carers

(s) de-escalation strategies

(t) details of any person nominated as a contact in the event of a crisis situation

(u) content of any PAIP implemented for the Mental Health Consumer.

SCHEDULE 4 – Contact Officers

QUEENSLAND HEALTH CONTACT OFFICER

Position: Executive Director, Mental Health Alcohol and Other Drugs Branch

Location Address: Level 1, 15 Butterfield Street, Herston, Qld, 4006

Postal Address: PO Box 2368, Fortitude Valley BC, Qld, 4006

Telephone: 3328 9536
Facsimile: 3328 9619
Email: ED_MHAODD@health.qld.gov.au

QUEENSLAND POLICE SERVICE CONTACT OFFICER

Position: Domestic, Family Violence and Vulnerable Persons Unit, Community Contact Command, Queensland Police Service

Location Address: Level 5, Police Headquarters, 200 Roma Street, Brisbane, Qld, 4000

Postal Address: GPO Box 1440, Brisbane, Qld, 4001

Telephone: 3364 4081
Facsimile: 3055 6305
Email: ManagerDomesticFamilyViolence.AndVulnerablePersonsUnit@police.qld.gov.au

SIGNED:

For and on behalf of the **State of Queensland** acting through **Queensland Health** in the presence of:

Signature of witness

Name: Axèle-Brigitte Mary

Signature
Michael Walsh

Chief Executive, Queensland Health

I, Michael Walsh, Chief Executive, Queensland Health, state that in signing this MOU, pursuant to s.151(1)(b)(ii) of the *Hospital and Health Boards Act 2011* (Qld), I consider the disclosure of Confidential Information for the purpose of this MOU is in the public interest.

For and on behalf of the **State of Queensland** acting through **Queensland Police Service** in the presence of:

Signature provided
Signature of witness

Insp David Askelly 6259
Name

Signature
Ian Stewart APM

Commissioner of the Queensland Police Service

Queensland Government

MEMORANDUM OF UNDERSTANDING

BETWEEN

The State of Queensland acting through Queensland Health

AND

The State of Queensland acting through the Queensland Police Service

Mental Health Collaboration

This **MEMORANDUM OF UNDERSTANDING** is made on the 15th day of June 2017

BETWEEN

The State of Queensland acting through Queensland Health, 147-163 Charlotte Street Brisbane ("**QH**")

AND

The State of Queensland acting through the Queensland Police Service, 200 Roma Street Brisbane ("**QPS**")

(together, the **"Parties"**)

RECITALS

A. QH and the QPS often provide services to the same people with a Mental Illness and/or Vulnerable Persons.

B. The Parties acknowledge that each Party has its various and respective roles and responsibilities with regard to people with a Mental Illness and/or Vulnerable Persons (as defined in this MOU) and will work collaboratively and cooperatively, to:

   a) proactively develop Mental Health Intervention Strategies; and
   b) respond to Mental Health Incidents and Situations Involving Vulnerable Persons.

C. The Parties agree to work collaboratively and cooperatively to prevent and resolve Mental Health Incidents involving people with a Mental Health Problem and Vulnerable Persons who are known to QH (Mental Health Consumers) and people with a Mental Health Problem and Vulnerable Persons who are not known to QH.

D. Designated Persons have a duty to maintain confidentiality under section142 of the *Hospital and Health Boards Act 2011* (HHB Act) and are prohibited from disclosing Confidential Information to the QPS unless one of the exceptions to section 142 of the HHB Act (sections143-161) applies. This MOU is prescribed under the exception provided for in section 151(1)(b) of the HHB Act to allow for the disclosure of Confidential Information in the circumstances specified within this MOU. This MOU does not preclude the disclosure of Confidential Information authorised under any of the other exceptions at Part 7 of the HHB Act.

E. The Parties acknowledge that any relevant Confidential Information must be shared in accordance with the processes established in the MOU, without delay, to reduce the risk to the life, health or safety of the person to whom the Confidential Information relates and/or to public safety.

F. The Parties agree that QH Staff are, under section 151(1)(b)(i)(A)&(B) of the HHB Act, permitted to disclose Confidential Information relating to Mental Health Consumers:

   a) when responding to Mental Health Incidents; and
   b) when developing Mental Health Intervention Strategies (including, but not limited to, the development of Police and Ambulance Intervention Plans and/or Acute Management Plans).

G. It is not intended that this MOU create any contractual relationship or that it be legally binding on the Parties.

H. This MOU replaces the MOU 'Mental Health Collaboration 2016' executed by the Parties on 24 November 2016.

THE PARTIES TO THIS MOU AGREE AS FOLLOWS:

1. DEFINITIONS

1.1. In this MOU the following definitions apply:

Acute Management Plan (AMP) means a plan ideally developed in consultation with the Consumer, the Mental Health Treating Team and other relevant stakeholders to provide relevant clinical Information for the Department of Emergency Medicine, Acute Treatment Services and other mental health practitioners to assist clinicians respond to or prevent a Mental Health Incident from occurring.

Care includes a range of Health Care Services provided by QH and other non-government service providers.

Carer means an individual who provides, in a non-contractual and unpaid capacity, ongoing care or assistance to another person who, because of disability, frailty, chronic illness or pain, requires assistance with everyday tasks.

CIMHA means the consumer integrated mental health application used by QH.

Clinical File means a collection of data and Information gathered or generated to record the clinical care and health status of a Mental Health Consumer.

Collaborative Software means application software designed to help people involved in a common task to achieve their goals.

Commissioner means the Commissioner of the QPS.

Confidential Information has the same meaning as at section 139 of the HHB Act and includes the Confidential Information described in Schedule 3 of the MOU.

Consumer means a Mental Health Consumer (also known as a patient of a Mental Health Service) as defined in this clause 1.1.

Contact Officer means the persons described in schedule 4.

Designated Person for purposes of this MOU has the same meaning as at section 139A of the HHB Act and includes health service employees in a QH Mental Health and Alcohol, Tobacco and Other Drugs Service.

The *Mental Health Act 2016* extends the definition of Designated Person to include Independent Patient Rights Advisers.

Director-General means the Director-General of QH.

Health Care Service means a service that provides a range of services to improve, restore and maintain the health and wellbeing of a person.

HHB Act means the *Hospital and Health Boards Act 2011* (Qld).

HHB Regulation means the *Hospital and Health Boards Regulation 2012* (Qld).

Independent Patient Rights Adviser means a person appointed as an Independent Patient Rights Adviser (Rights Adviser) under section 293(2) of the MHA 2016. A Rights Adviser performs the functions listed under section 294 of the MHA 2016 and ensures patients and nominated support persons, family, carers and other support persons are aware of their rights under the MHA 2016. Rights Advisers liaise between clinical teams, patients and support persons.

Information includes a document (as defined under section 36 of the *Acts Interpretation Act 1954*) that is in the possession or under the control of either Party (whether brought into existence or received by either Party) and knowledge and opinions of staff of either Party (whether verbal or recorded in some form including a statement). Information also includes Confidential Information and Personal Information.

Local Committee means a group of stakeholders from a particular geographical area that meet to discuss and resolve relevant issues, establishing effective collaborative working relationships.

MHA 2016 means the *Mental Health Act 2016* (Qld).

Mental Health Assessment means the data gathering process involved in formulating a clinical opinion on the condition of a Mental Health Consumer's mental health and, where necessary, identifying the appropriate treatment, management or Care.

Mental Health Clinician means a registered Mental Health Service clinician, with an appropriate professional qualification, who provides Mental Health Services.

Mental Health Consumer means a person who is receiving, or has received, any service from a public Mental Health Service. Services include triage, assessment and delivery of treatment by a Mental Health Clinician, including inpatient and community management.

Mental Health Incident or Situation Involving a Vulnerable Person (Mental Health Incident) means situations that:

a) involves a series of events or a combination of circumstances in which a person is demonstrating behaviour that is indicative of a Mental Health Problem;

b) may involve a serious risk to the life, health, or, safety of the person or of another person; and

c) requires communication and coordination between the Parties at the earliest opportunity and ongoing communication as required.

Mental Health Intervention Strategy means a strategy or plan (including, but not limited to, the development of a PAIP or an AMP), developed in partnership by the QPS and QH, to:

a) reduce the likelihood of a Mental Health Incident from occurring; and
b) to better prepare both Parties to respond if a Mental Health Incident does occur.

Mental Health Problem means disequilibrium in a person's biological and/or psychological and/or sociological functioning resulting in diminished state of mental health.

Mental Health Service means a QH Mental Health Service that provides specialised Mental Health Assessment, treatment and care for people with a Mental Illness.

Mental Health Treating Team means the team of appropriately qualified and registered mental health professionals treating a particular Mental Health Consumer.

Mental Illness as defined in the *Mental Health Act 2016* is a condition characterized by a clinically significant disturbance of thought, mood, perception or memory. Mental Illness is a clinically diagnosable disorder that significantly interferes with an individual's usual biological and/or psychological and/or sociological functioning.

MOU means this Memorandum of Understanding and any schedules to the MOU.

Notice means a Notice given pursuant to clause 10 of the MOU.

Personal Information has the same meaning as at section 12 of the *Information Privacy Act 2009* (Qld).

Police and Ambulance Intervention Plan (PAIP) means a plan ideally developed in consultation with the Consumer, the Mental Health Treating Team and other stakeholders including the QPS. It extrapolates considerations for intervention and outlines potential risks as a means to support both the Consumer and police officers to safely resolve a Mental Health Incident.

Privacy Laws include any laws that apply to one or both Parties regarding the nature of the Information disclosed, including Confidential Information and Personal Information.

QH Facility means a facility that provides a range of services to improve, restore and maintain the health and wellbeing of a person.

QH Staff means a Designated Person.

QPS Officer means a person declared under section 2.2(2) of the *Police Service Administration Act 1990* (Qld) to be a police officer.

Relevant Emergency Services Personnel means personnel from the Queensland Ambulance Service, the Queensland Fire and Rescue Service and Emergency Management Queensland that are required to help prevent or resolve a Mental Health Incident, dependent on the nature of the Mental Health Incident.

Risk Taking Behaviours means behaviours that have the potential to be harmful or dangerous.

Schedule means a Schedule to this MOU.

Treatment for a person who has a Mental Illness, means anything done, or to be done, with the intention of having a therapeutic effect on the person's illness, including the provision of a diagnostic procedure.

Vulnerable Person means a person who is considered to be experiencing instability in their biological and/or psychological and/or social functioning and in consequence:

d) is at risk of being unable to take care of themselves or is unable to take care of

themselves; and/or

e) is at risk of being unable to protect themselves against harm or is unable to protect themselves against harm by reason of age, illness (including Mental Illness), trauma or disability, or any other reason.

2. COMMENCEMENT & DURATION

2.1 This MOU will commence on the date it is prescribed in the HHB Regulation and will continue in force until the Regulation is repealed or until clause 8 of this MOU is invoked.

3. OPERATION OF MOU

3.1. The operation of this MOU is contingent on the following:

(a) all Parties understanding and agreeing to their role in the execution of the MOU;

(b) the MOU having been prescribed under the HHB Regulation pursuant to section 151(1)(b)(i)(A)&(B) of the HHB Act;

(c) implementation of the Protocol attached to this MOU as Schedule 1, which sets out the practice obligations of each Party and its officers regarding the disclosure of Confidential Information when developing Mental Health Intervention Strategies;

(d) implementation of Schedule 2 which sets out the Information to be disclosed by the QPS to QH; and

(e) implementation of Schedule 3 which sets out the Information to be disclosed by a Designated Person to the QPS.

3.2. This MOU applies to the disclosure of relevant Confidential Information between QH Staff and the QPS for the purposes of:

(a) assisting to safely resolve Mental Health Incidents that do not involve detainees under State preventative detention orders issued under the *Terrorism (Preventative Detention) Act 2005* (Qld); and

(b) proactive collaboration between the Parties for the development of Mental Health Intervention Strategies.

3.3. This MOU is intended to work in conjunction with, and not derogate from, any other prescribed MOU between the QPS and QH. The Parties agree that for the proactive development of Mental Health Intervention Strategies and when responding to a Mental Health Incident:

(a) the QPS has responsibility to protect the health and safety of all persons;

(b) QH Staff and the QPS should maintain and share the ongoing commitment to ensure that services are provided in a way that reflects the rights of a Consumer and their Carer, in particular, the preservation of the Consumer's rights and dignity in accordance with the *Mental Health Act 2016 Statement of Rights for patients of mental health services*[1] within the overall objective of ensuring the life, health, safety or welfare of all parties;

(c) primacy is always given to the life, health, safety or welfare of all persons concerned and, where not able to be avoided, the imposition of minimum restriction upon the Mental Health Consumer or Vulnerable Person.

[1] Department of Health

4. INFORMATION DISCLOSURE RELATING TO THE DEVELOPMENT OF MENTAL HEALTH INTERVENTION STRATEGIES (INCLUDING PAIPs and AMPs)

4.1. The Parties agree to continue to improve knowledge, skills, attitudes and values of their respective staff to ensure a coordinated system of care and improved service delivery to Mental Health Consumers.

4.2. The Parties will endeavour to ensure their respective staff complies with the Protocol set out in Schedule 1 for the development of Mental Health Intervention Strategies.

4.3. The Parties agree to ensure provisions are made for the QPS staff and Designated Persons to meet on a regular basis to identify current and emerging specific issues relating to Mental Health Consumers and to develop Mental Health Intervention Strategies. The disclosure of Confidential Information, detailed in schedule 2 and 3, is appropriate and necessary at these forums to prevent serious risk to the life, health or safety of an individual, or to public safety.

5. INFORMATION DISCLOSURE DURING A MENTAL HEALTH INCIDENT OR SITUATION INVOLVING A VULNERABLE PERSON (MENTAL HEALTH INCIDENT)

5.1. Each Party will endeavour to ensure their respective staff provides all the necessary relevant Information and assistance required by the other Party to support the safe and effective resolution of a Mental Health Incident.

5.2. To assist the QPS determine if a person involved in a Mental Health Incident has a Mental Illness or has been a Mental Health Consumer, the QPS will provide sufficient Information as listed in Schedule 2 to the relevant QH Staff member.

5.3. The role of QH Staff is:

(a) to discuss the situation with the QPS and determine whether or not the situation meets the criteria of a Mental Health Incident as per the definition in clause 1.1;

(b) to identify if the person is a Mental Health Consumer;

(c) if the person is a Mental Health Consumer, to decide whether or not disclosing relevant Confidential Information about the Mental Health Consumer would assist in safely resolving the Mental Health Incident;

(d) to disclose to the QPS relevant Confidential Information, of the nature set out in Schedule 3, as soon as reasonably practicable, where such disclosure would likely assist in the safe resolution of the Mental Health Incident;

(e) to collaborate with the QPS to ensure that police have access to expert advice to assist them to accurately interpret and appropriately use the Confidential Information disclosed and assist them to safely resolve the Mental Health Incident; and

(f) to ensure that a record of the Confidential Information disclosed is made in the Mental Health Consumer's Clinical File and CIMHA and communicated, where clinically advisable, to the Mental Health Consumer, or their parent or Carer, at a time considered appropriate by treating clinicians.

5.4 The Parties agree that QPS officers may disclose relevant Information specified in Schedule 2 and QH Staff may disclose relevant Confidential Information specified in Schedule 3, as soon as reasonably practicable, using the most appropriate channel of communication, having regard to the urgency of the situation.

5.5 The QPS agrees that in circumstances where a Consumer is coming to the attention of the QPS on a regular basis, the QPS will contact the relevant Mental Health Service to check the accuracy and currency of Confidential Information held about the Consumer. The Parties will collaborate on the current challenges being faced by the Consumer and develop a Mental Health Intervention Strategy, ideally in consultation with the Consumer, to help prevent the likelihood of a Mental Health Incident from occurring.

5.6 When a person involved in a Mental Health Incident is not known to QH, QH staff should provide the QPS with assistance in regard to the behaviour being demonstrated by the person if Mental Illness is suspected as the cause of the person's actions.

6. INFORMATION DISCLOSURE AND CONFIDENTIALITY

6.1 QH's preferred position is that disclosing Confidential Information to the QPS should, in the first instance, occur with the Mental Health Consumer's consent. However, the Parties recognise that situations will arise where it will not be possible or reasonable to obtain consent from the Consumer, or consent from the Consumer's parent or Carer.

6.2 This MOU is not intended to exclude other processes on which the QPS may rely to obtain information from QH, including by way of warrant, summons or subpoena, where available and practicable.

6.3 The Parties acknowledge that disclosing Confidential Information pursuant to this MOU may involve Information that is confidential and/or subject to Privacy Laws. In particular, the QPS acknowledges that, pursuant to section 151 of the HHB Act, the QPS must ensure any Confidential Information disclosed is used only for the purpose for which it was given under the MOU.

6.4 The Parties agree at all times to recognise and observe the confidentiality of Information released under this MOU and agree that the collection, disclosure and use of Information will comply, so far as they apply to the relevant Party, with all applicable Queensland government policy and legislative requirements including those set out in the:

(a) *Hospital and Health Boards Act 2011*

(b) *Hospital and Health Boards Regulation 2012*

(c) *Public Health Act 2005*

(d) *Mental Health Act 2016*

(e) *Police Powers and Responsibilities Act 2000*

(f) *Police Powers and Responsibilities Regulation 2012 (Schedule 9, Responsibilities Code)*

(g) *Police Service Administration Act 1990*

(h) *Crime and Corruption Act 2001*

(i) *Criminal Code Act 1899*

(j) *Information Privacy Act 2009*

(k) Code of Conduct for the Queensland Public Service

(l) Queensland Police Service Operational Procedures Manual

(m) Queensland Government Information Standard 18 (Information Security).

6.5 The Parties agree to:

(a) ensure appropriate security measures are in place to protect any Information provided by the other Party from unauthorised access, use or disclosure;

(b) restrict any person from accessing or using information released under this MOU unless the person is legally authorised to do so; and

(c) comply with any reasonable confidentiality conditions or restrictions imposed by the other Party in respect of the handling or disclosure of Confidential Information disclosed under this MOU.

6.6 It is acknowledged that Information sharing between the Parties may occur utilising a variety of channels dependant on the nature of the Mental Health Incident being discussed and the availability of staff from the Parties. These communication channels may include: Information provided over the phone, face to face, via email, via Collaborative Software and/or in a written format. However, both Parties acknowledge that the other Party may require Information to verify the identity of the person receiving the Information before disclosing that Information.

6.7 All Information disclosed must be documented by the Parties, who both disclose and receive the Information, as soon as is practicable after the disclosure or receipt of the Information.

6.8 The QPS acknowledges that it must not disclose to third parties any Confidential Information disclosed under this MOU unless the MOU expressly permits the disclosure or approval for the disclosure has been given in writing by the Director-General, or as required by law.

7. VARIATION AND REVIEW

7.1 This MOU may be varied by written agreement between the Parties. Any proposed amendments must be approved by the Commissioner and the Director-General.

7.2 The Parties agree that this MOU will be reviewed within 12 months of the date of it taking effect and thereafter every three years on the anniversary of the initial review, or at such other earlier time as may be agreed by the Parties.

8. TERMINATION

8.1 Either Party may terminate this MOU by giving the other Party 28 days prior Notice in writing of its intention to terminate.

8.2 Where this MOU is terminated under clause 8.1, the Parties agree to provide all reasonable assistance and cooperation necessary to ensure a smooth transition.

9. DISPUTE RESOLUTION

9.1 For any matter in relation to this MOU that may be in dispute, the Parties:

(a) will attempt to resolve the matter at the local level between relevant QH staff and QPS officers;

(b) agree that, if the matter is not resolved at the local level, the matter will be referred to appropriate senior managers within the QPS and QH for resolution; and

(c) agree that, during the time when the Parties attempt to resolve the matter, the Parties continue to comply with the MOU.

10. NOTICES

10.1 Any Notice or communication given under this MOU must be:

(a) in writing; and

(b) delivered personally, sent by ordinary prepaid post, facsimile or email to the Contact Officer's address, facsimile number or email address (as the case may be) notified by the Contact Officer from time to time.

10.2 A Notice or other communication given under clause 10.1 is taken to be received (as the case may be):

(a) if delivered personally, on the business date it is delivered;

(b) if sent by ordinary prepaid post, seven business days after posting;

(c) if sent by facsimile, when the sender receives confirmation that the facsimile has been transmitted to the addressee's facsimile number in its entirety; or

(d) if sent by email, when the sender's email arrives at the information system from which the recipient can access it.

SCHEDULE 1

PROTOCOL FOR PROACTIVE INFORMATION SHARING AND THE DEVELOPMENT OF MENTAL HEATLH INTERVENTION STRATEGIES (INCLUDING PAIPs and AMPs)

Objectives

The **objectives** for Information sharing between the Parties for the development of Mental Health Strategies include:

(a) To ensure **all the relevant and appropriate Information can be shared by the Parties**, as required, throughout the development and implementation of Mental Health Intervention Strategies.
(b) To enable a **more integrated approach** between the Parties for the assessment and treatment of a Mental Health Consumer.
(c) To **foster collaborative, responsive relationships between the Parties** that enable effective partnering when developing a Mental Health Intervention Strategy and responding to a Mental Health Incident.
(d) To **reduce the likelihood of Mental Health Incidents from occurring** through timely, accurate and appropriate Information sharing, resulting in the development of comprehensive Mental Health Intervention Strategies.

Principles

The **principles** underpinning Information sharing for the development of Mental Health Intervention Strategies include:

(a) **Collaborative relationships** – collaborative working relationships enable the development of comprehensive Mental Health Intervention Strategies.
(b) **Proactive approach to managing risk** – the Parties share a proactive approach to the steps involved in the development and execution of Mental Health Intervention Strategies.
(c) **Cooperation** – the Parties cooperate as required to assist with the development of the Mental Health Intervention Strategies.
(d) **Compliance** – Confidential Information shared is protected in accordance with this MOU and relevant legislation.
(e) **Trustworthy** – Information shared is relevant, accurate and timely.
(f) **Managed** – Information sharing is actively planned and managed.
(g) **Accountability** – roles, responsibilities and accountabilities of the QPS and QH are understood and respected.

The Information sharing pathway and the development of a Mental Health Intervention Strategy

1. The development of a comprehensive Mental Health Intervention Strategy is a progressive process, involving multiple components, requiring input, Information sharing and flexibility from both Parties.
2. Components that contribute to the development of a comprehensive Mental Health Intervention Strategy can include, but are not limited to:
    (a) **Early identification** - both Parties should actively consider Vulnerable Persons that demonstrate behaviour indicating they may be suffering from Mental Illness. This includes, but is not limited to, behaviour demonstrated in a QH Facility or behaviour demonstrated by a Vulnerable Person, with whom a QPS officer has had contact. Discussion about the behavioural characteristics of Mental Illness is encouraged between the Parties to assist with the early identification of people suffering from a Mental Illness and the development of Mental Health Intervention Strategies.
    (b) **Assessment** – a comprehensive clinical assessment of the Mental Health Consumer must be undertaken to ensure appropriate treatment is provided while in a QH Facility and to confirm the Mental Health Consumer has received the appropriate treatment and is ready to be discharged from the QH Facility.
    (c) **Risk mitigation** – Parties may communicate Mental Health Intervention Strategies to Relevant Emergency Services Personnel and clinicians to mitigate the risk of the Mental Health Consumer harming themselves or others.
    (d) **Prevention planning** – planning by both Parties to prevent a Mental Health Consumer or Vulnerable Person from becoming involved in a Mental Health Incident.
    (e) **Treatment** – Information shared between both Parties assists with informing the most appropriate Treatment plan based on a comprehensive clinical assessment supported through knowledge of both static and dynamic risk factors.
    (f) **Discharge planning** – discharge planning is a multidisciplinary and multi agency responsibility undertaken in collaboration with the Mental Health Consumer.
    (g) **Continuing care in the community** – comprehensive Mental Health Intervention Strategies include planning for continuing care in the community. Collaboratively QH and the QPS have a joint responsibility to mitigate risk by maintaining open lines of communication supported through regular reviews of Mental Health Intervention Strategies for Mental Health Consumers and/or Vulnerable Persons considered to be at significant risk to themselves and/or others and/or property and/or engaging in Risk Taking Behaviours.

The success of these components informing a Mental Health Intervention Strategy is heavily dependent on the collaborative relationship established between the Parties and the Information shared.

3. There are a variety of communication channels that Information may be shared though, these include, but are not limited to:

    (a) face to face meetings,
    (b) discussions via phone or teleconference,
    (c) email,
    (d) Collaborative Software,
    (e) interagency stakeholder meetings; and
    (f) relevant Local Committee meetings.

SCHEDULE 2

The following Information may be disclosed, where relevant, by a QPS officer to QH Staff under this MOU about a Vulnerable Person or Mental Health Consumer during a Mental Health Incident or for the development of a Mental Health Intervention Plan:

(a) name
(b) alias names
(c) date of birth
(d) last known address
(e) the current location
(f) criminal history
(g) QP9s (court briefs)
(h) any relevant significant risks, history or cautions
(i) current behaviour i.e. description of actions, mood, speech
(j) street checks relating to mental health interactions
(k) any relevant past behaviour
(l) other services that are involved in the situation
(m) presence or availability of family members
(n) evidence of firearms, dangerous weapons or drugs
(o) relevant outstanding matters (warrants, court and/or investigative)
(p) any other significant information that can assist in informing risk mitigation.

SCHEDULE 3

The following Information may be disclosed, where relevant, by QH Staff to a QPS officer under this MOU about a Vulnerable Person or a Mental Health Consumer during a Mental Health Incident or in the development of a Mental Health Intervention Plan:

(a) name

(b) date of birth

(c) address

(d) contact details

(e) the nature of their Mental Illness

(f) a description of the characteristics of a Mental Illness

(g) clarification that the behaviour being demonstrated is not indicative of Mental Illness

(h) intoxication from substances and/or alcohol; behaviour to expect in these circumstances; impact on behaviour and propensity of verbal/physical aggression towards others and/or harm to self

(i) medical history/chart Information including recent behaviour, most recent assessment and expected responses

(j) details of relevant health professionals, for example, Mental Health Clinician, psychiatrist or treating doctor

(k) any relevant significant risks, including the propensity for violence or self harm

(l) history of possessing firearms, dangerous weapons or drugs

(m) the person's medication (including effects of medication and of non-compliance)

(n) warning signs indicating deterioration in their mental health

(o) 'triggers' that may escalate the Mental Health Incident

(p) suicide risk including Information about previous suicidal ideation or attempts to commit suicide; lethality of previous suicide attempts

(q) self-harm behaviours; propensity to act of these thoughts

(r) details of next-of-kin and carers

(s) de-escalation strategies

(t) details of any person nominated as a contact in the event of a crisis situation

(u) content of any PAIP implemented for the Mental Health Consumer.

SCHEDULE 4 – Contact Officers

QUEENSLAND HEALTH CONTACT OFFICER

Position: Executive Director, Mental Health Alcohol and Other Drugs Branch

Location Address: Level 1, 15 Butterfield Street, Herston, Qld, 4006

Postal Address: PO Box 2368, Fortitude Valley BC, Qld, 4006

Telephone: 3328 9536
Facsimile: 3328 9619
Email: ED_MHAODD@health.qld.gov.au

QUEENSLAND POLICE SERVICE CONTACT OFFICER

Position: Domestic, Family Violence and Vulnerable Persons Unit, Community Contact Command, Queensland Police Service

Location Address: Level 5, Police Headquarters, 200 Roma Street, Brisbane, Qld, 4000

Postal Address: GPO Box 1440, Brisbane, Qld, 4001

Telephone: 3364 4081
Facsimile: 3055 6305
Email: ManagerDomesticFamilyViolence.AndVulnerablePersonsUnit@police.qld.gov.au

SIGNED:

For and on behalf of the **State of Queensland** acting through **Queensland Health** in the presence of:

Signature of witness

Name: Axèle-Brigitte Mary

Signature
Michael Walsh

Chief Executive, Queensland Health
I, Michael Walsh, Chief Executive, Queensland Health, state that in signing this MOU, pursuant to s.151(1)(b)(ii) of the *Hospital and Health Boards Act 2011* (Qld), I consider the disclosure of Confidential Information for the purpose of this MOU is in the public interest.

For and on behalf of the **State of Queensland** acting through **Queensland Police Service** in the presence of:

Signature provided
Signature of witness

Insp Davis Ashley 6259
Name

Signature
Ian Stewart APM

Commissioner of the Queensland Police Service