Chief Psychiatrist Policies

Mental Health Act 2016

Updated 3 December 2021

Queensland Government

Mental Health Act 2016
Chief Psychiatrist policy

Temporary amendments to Chief Psychiatrist policies

Public health emergency – COVID-19

On 29 January 2020, a public health emergency was declared in Queensland in response to the COVID-19 virus outbreak. The pandemic and associated state of emergency will likely cause significant disruption and have impacts on the provision of treatment and care to patients under the *Mental Health Act 2016* (the Act).

This policy aims to reduce and contain the spread of COVID-19. Temporary provisions within this policy will amend requirements under existing Chief Psychiatrist Policies, to enable administrators and clinicians in authorised mental health services (AMHSs) to continue to meet their obligations and requirements under the Act, while ensuring patients receive appropriate treatment and care for their mental illness in the context of the COVID-19 pandemic.

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Scope

The temporary provisions within this policy are intended to operate **only as a last resort**, when application of the standard provisions result in a conflict with a direction or order given under the *Public Health Act 2005* (PHA) or to relieve workforce capacity pressures arising as a direct impact of the COVID-19 pandemic.

When in effect, this policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

This policy has effect until the Chief Psychiatrist determines upon review that this policy requires amendments, additional measures or is no longer required to support the delivery of good clinical care, or to assist in reducing the spread of COVID-19.

This policy is issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly
Chief Psychiatrist, Queensland Health
6 September 2021

Policy

1 Examination and assessment

The following temporary amendments are made to accommodate potential staff shortages as a result of the COVID-19 pandemic and to facilitate examination and assessment of a person in isolation due to a positive or potential COVID-19 diagnosis.

Chief Psychiatrist Policy for Examination and assessment
Temporary amendment
Examinations and assessments conducted under the Act may be undertaken via audio-visual technology if it is considered clinically appropriate in the circumstances, including: • Examination for Recommendation for Assessment, and • Assessment under a Recommendation for Assessment. Clinicians seeking to conduct an examination or assessment via audio-visual means, must clearly document the rationale for this decision. This should include details of how and why an examination or assessment by audio-visual means is clinically appropriate. However, as required under the Act, an assessment under a recommendation for assessment still **cannot occur in a custodial setting**.

2 Assessment and Risk Management Committee

AMHS administrators are required to establish an Assessment and Risk Management Committee (ARMC) in accordance with the ARMC Terms of Reference. The ARMC's role is of a clinical nature and functions as a peer review of the treatment and care of patients subject to a forensic order, treatment support order or other identified higher risk patients.

The clinical director is responsible for facilitating the operation and function of the ARMC. The ARMC:

- reviews the treatment and care of patients subject to a forensic order, treatment support order or other identified higher risk patients.
- makes recommendations or decisions about a patient's treatment and care
- identifies systematic issues relating to the management of forensic and high-risk patients, and

- determines the frequency of monitoring and assessment of forensic and high-risk patients by the case manager (or equivalent), forensic liaison officer and an authorised psychiatrist.

Community Forensic Outreach Service (CFOS) is available to discuss any concerns regarding high risk patients and development of appropriate response, including when a Tier 2 Violence Risk Assessment and Management assessment has not yet been completed.

The following temporary amendments are made in relation to the Terms of Reference for ARMC, in the event the usual requirements are unable to be met (i.e. staffing shortages) as a direct result of the COVID-19 pandemic.

Chief Psychiatrist policy for Treatment and care of patients subject to a forensic order, treatment support order or other identified higher risk patients	
Current requirements	**Temporary amendment**
Membership The ARMC **must** include at least: • The clinical director (**must** be a psychiatrist nominated by the administrator) • The treating psychiatrist and other members of the persons treating team • The forensic liaison officer, and • A representative from CFOS o If the patient is not an adult, then a representative from the Child and Youth Forensic Outreach Service (CYFOS) should be present instead. **Quorum** Meetings will proceed on the basis that the clinical director, treating psychiatrist, forensic liaison officer and a representative from CFOS (or CYFOS where relevant) are represented.	**Membership and quorum** At a minimum the following members must be present at any ARMC meeting: • clinical director • treating psychiatrist (or a member of the treating team where the treating psychiatrist is unavailable) • CFOS/CYFOS representative (unless advised of unavailability by CFOS/CYFOS psychiatrist or team leader) Should the forensic liaison officer not be available to attend as required (i.e. for reasons related to COVID-19), the ARMC may proceed without that member present. In the absence of being able to hold an ARMC with full membership, AMHS services should establish additional processes to ensure the objects and functions of the ARMC are fulfilled, including: • Members unavailable to attend (excluding minimum quorum) should request a proxy to attend, and • The circulation of minutes to all absent members of an ARMC for review.

	Timeframes All timeframes for review and referrals to CFOS established in the Chief Psychiatrist policy for Treatment and Care of forensic order, treatment support order or other identified higher risk patients, **must** be complied with. This includes: • ARMC reviews • Referrals to CFOS/CYOS • Implementation of CFOS/CYFOS recommendations If there are concerns about a service's ability to meet timeframe requirements ongoing due to the impacts of COVID-19, the Administrator should escalate to the Chief Psychiatrist via email to MHA2016_COVID-19@health.qld.gov.au

3 Notification of legislative non-compliance

Notifications of legislative non-compliance are monitored by the Office of the Chief Psychiatrist to identify statewide trends, address policy reform and/or develop statewide improvement initiatives.

During the COVID-19 public health emergency, notifications will be used to inform appropriate responses from the OCP to address live or arising issues causing challenges with provision of appropriate treatment and care for individuals under the Act.

The OCP acknowledges that all non-compliance events may be COVID-related to some degree during this public health emergency. However, the existing requirements for notification to the Chief Psychiatrist via the approved form should continue to be fulfilled. Only notifications for the temporary non-compliance categories are to be made via the temporary email provided below.

Any failure to comply with requirements of the Act **must** be recorded on the patient's clinical record, including on CIMHA where possible.

The breach should be discussed with the patient, or if not practicable, the patient's nominated support person or other support persons.

Notification to the Chief Psychiatrist of non-compliance with the Act are to be made by the AMHS Administrator as soon as practicable after becoming aware of the breach.

Chief Psychiatrist policy for Notifications to the Chief Psychiatrist of critical incidents and non-compliance with the Mental Health Act 2016

Current requirements	Temporary amendment
Notification to the Chief Psychiatrist of significant or suspected significant non-compliance with the Act, including: • the detention of a person other than in accordance with the Act. • the provision of a regulated treatment (e.g. electroconvulsive therapy) other than in accordance with the Act • the use of seclusion, mechanical restraint, physical restraint or administration of medications other than in accordance with the Act, or • a breach of any other offence provision of the Act (e.g. ill-treatment of patients, contravention of the confidentiality obligations, assisting a patient to unlawfully absent themselves, giving false or misleading information to an official, and obstructing of an official). **Notification** CIMHA Form: *Notification to the Chief Psychiatrist of Significant Non-Compliance with the Act.*	The amendments below are **in addition** to current notification requirements and must be emailed as soon as the Administrator becomes aware of the breach. Additional notifications are required for non-compliance as a result of COVID-19 impact on usual service provision. • Breach of authorised Limited Community Treatment and/or Conditions of an Order/Authority (e.g. involuntary patient with no approved LCT required to self-isolate at home due to positive or potential COVID-19 result) • Breach of statutory timeframes for assessment of persons requiring mental health treatment and care (e.g., Treatment Authority made by an authorised doctor is not able to be confirmed or revoked by an authorised psychiatrist within 72 hours due to staffing shortages resulting from the COVID-19 pandemic). • Another possible breach of the Act determined by the AMHS Administrator as requiring escalation to the Chief Psychiatrist (e.g., a significant breach of a person's rights or repeated breaches of a particular provision). **Notification** 1. Complete the Form: *Notification of Non-Compliance in the context of COVID-19.* 2. Upload the form to CIMHA as a scanned PDF version under the category of 'General' and form type of 'Notification of non-compliance due to COVID-19'. 3. CIMHA will automatically send a notification to the Chief Psychiatrist via email to MHA2016_COVID-19@health.qld.gov.au

4 Social distancing and hygiene practices in Mental Health Review Tribunal

To limit the spread of COVID-19, the Chief Health Officer may issue public health directions restricting access to hospitals as required. Hospital and Health Services can further implement local restrictions to hospitals and regions based on clinical risk.

The Mental Health Review Tribunal (MHRT) aims to maintain face-to-face hearings in services wherever possible and consumers are encouraged to attend their hearing in person if it is clinically appropriate. However, these hearings may be impacted by the restrictions imposed by the public health directions and may be further restricted and differ across the services.

Chief Psychiatrist policy for Support to the Mental Health Review Tribunal
Temporary amendment
This policy ensures that venues used in hospitals for tribunal hearings continue to provide an environment that is safe and secure for face-to-face hearings. Where a requirement in this policy cannot be satisfied due to a public health direction or further local restrictions to limit the spread of COVID-19, the AMHS will follow the directions or restrictions instead. The MHRT will require information relating to social distancing and hygiene practices in venues in order to maintain face-to-face hearings in services. AMHSs will liaise with the MHRT to coordinate face-to-face hearings and ensure appropriate measures are implemented to limit the spread of COVID-19. Clinicians and services should also seek guidance from their local Work Health and Safety teams as necessary.

Further information

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service– all or part of a public or private sector mental health service declared under (and subject to) the *Mental Health Act 2016*
ARMC	Assessment and Risk Management Committee
CFOS	Community Forensic Outreach Service
CYFOS	Child and Youth Forensic Outreach Service
CIMHA	Consumer Integrated Mental Health and Addiction application– the statewide clinical information system and designated patient record for the *Mental Health Act 2016*
LCT	Limited Community Treatment
MHRT	Mental Health Review Tribunal
OCP	Office of the Chief Psychiatrist

Referenced policies and resources

Chief Psychiatrist policies

- Examinations and assessments
- Notifications to the Chief Psychiatrist of critical incidents and non-compliance with the Mental Health Act 2016
- Support to the Mental Health Review Tribunal
- Treatment and care of patients subject to a forensic order, treatment support order or other identified higher risk patients

Mental Health Act 2016 forms and resources

- Notification to the Chief Psychiatrist of non-compliance in the context of COVID-19
- Notification to the Chief Psychiatrist of significant non-compliance with the Act

Legislation

- *Mental Health Act 2016*

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Mental Health Act 2016
Chief Psychiatrist policy

Temporary modifications to the Mental Health Act 2016

On 29 January 2020, a public health emergency was declared in Queensland in response to the COVID-19 virus outbreak. In response to the declaration, various sections of the *Mental Health Act 2016* (the Act) have been modified.

This policy and the temporary modifications aim to reduce any adverse impact on services and patients and authorised mental health services (AMHSs) to meet their obligations and requirements under the Act. Temporary provisions within this policy are available, if required and as a last resort, to modify requirements under existing Chief Psychiatrist policies and enable the Chief Psychiatrist, administrators and clinicians in AMHSs to ensure continuity of appropriate treatment and care for patients with mental illness in the context of the COVID-19 pandemic.

This policy is the second in a set of temporary Chief Psychiatrist policies released in the context of the COVID-19 pandemic. The temporary Chief Psychiatrist policy for Temporary amendments to Chief Psychiatrist policies amends existing mandatory requirements of Chief Psychiatrist policies to reduce the spread of COVID-19 and allow flexibility within authorised mental health services to ensure ongoing delivery of appropriate treatment and care for their patients.

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Scope

This policy does not override or prevent the usual application of existing Chief Psychiatrist policies under the Act. In circumstances where application of this policy is required, an authorised doctor, authorised mental health practitioner, authorised mental health service administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

This policy and the temporary modifications to the Act are in effect until 30 April 2022, unless the declared public health emergency under the *Public Health Act 2005* (for COVID-19) ceases at an earlier date.

This policy is issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly
Chief Psychiatrist, Queensland Health
6 September 2021

Policy

1 Chief Psychiatrist approval of patient absences in relation to COVID-19 emergency period

The Act allows the Chief Psychiatrist to approve temporary absences in an AMHS for patients subject to a forensic order (inpatient), a judicial order, as well as classified patients. The available purposes for approving temporary absences are specified in the Chief Psychiatrist policy for Temporary absence.

During the COVID-19 emergency period, additional powers are granted to the Chief Psychiatrist to approve absences to a wider range of patients.

These powers are intended as a last resort mechanism for the Chief Psychiatrist to approve the absence for a patient if satisfied that the absence is reasonably necessary to comply with a detention order or public health direction given under the *Public Health Act 2005* in relation to the containment of COVID-19.

The Chief Psychiatrist may also disclose approved absences to a registered victim, close relative or another individual about a relevant patient who has been granted an approved absence by the Chief Psychiatrist.

1.1 Temporary modifications to the Act

Mental Health Act 2016: Chapter 18B, section 800I

Power of Chief Psychiatrist to approve absences during COVID-19 emergency period

During the COVID-19 emergency period, the Chief Psychiatrist may, if satisfied that the absence is reasonably necessary to comply with a detention order or public health direction given under the *Public Health Act 2005* in relation to the containment of COVID-19, approve a person's absence from an AMHS for the following patients–

- a patient subject to a forensic order (inpatient)
- a classified patient
- a person subject to a judicial order
- a patient subject to a treatment authority (inpatient)
- a patient subject to a treatment support order (inpatient), or
- a person detained in an AMHS as they are absent without permission from an interstate mental health service.

The Chief Psychiatrist must be satisfied that the treatment and care needs of the patient can reasonably be met for the period of the absence and that the absence will not result in an unacceptable risk to the:

- safety and welfare of the patient, and
- safety of others.

Also, the period of approved absence must end no later than either of the following days (whichever is earlier):

- the day the Chief Psychiatrist becomes aware that the patient no longer meets the requirements for the absence
- the day this policy and the temporary modifications to the Act expires
- the day the declared public health emergency under the *Public Health Act 2005* (for COVID-19) ceases.

As soon as practicable after the approval, the Chief Psychiatrist will give written notice of the approval to:

- the administrator of the AMHS
- for a person under a forensic order, treatment support order or treatment authority–the Mental Health Review Tribunal (MHRT), and
- for a person under a judicial order–the court that made the order.

The AMHS must subsequently give notice to the relevant patient and any appointed nominated support person(s) for the patient.

Mental Health Act 2016: Chapter 18B, sections 800K, 800L, 800M, 800N and 800O

Modification of section 336 (record of relevant patients)

During the COVID-19 emergency period, the administrator of an AMHS must ensure that the relevant patient's record also contains **decisions on approved absences under section 800I**. Refer to section 2.2.3.1 (Application to the Chief Psychiatrist for approved absence in relation to COVID-19 emergency period) of this policy.

Modification of section 363 (provisions relating to the transport of absent persons)

During the COVID-19 emergency period, the application of Chapter 11, Part 6, Division 3 (Transport of absent persons) also applies to **approved absences under section 800I**. Refer to section 2.2.3.2 (Completion of an authority to transport absent person) of this policy.

Modification of section 622 (offences relating to patients absconding)

During the COVID-19 emergency period, offences applicable to a person who wilfully allows or knowingly helps a patient abscond from their charge, will also include **approved absences under section 800I** for the following patients–

- a classified patient
- a forensic patient, or
- a person subject to a judicial order.

Modification of section 783(2) (disclosure of particular information relating to classified patient)

During the COVID-19 emergency period, the Chief Psychiatrist may disclose to an eligible victim registered to receive classified patient information, the fact that a relevant patient is absent from an AMHS under an **approval granted under section 800I**, only if the Chief Psychiatrist is satisfied the information is relevant to the safety and welfare of the person entitled to receive information under section 783. Refer to section 2.2.5.1 (Disclosure of particular information relating to classified patient) of this policy.

Modification of Schedule 1, section 5 (information about absences)

During the COVID-19 emergency period, the Chief Psychiatrist may disclose to an eligible victim under an information notice, the fact that a relevant patient is absent from an AMHS under an **approval granted under section 800I**, only if the Chief Psychiatrist is satisfied the information is relevant to the safety and welfare of the person entitled to receive information under the information notice. Refer to section 2.2.5.2 (Temporary provisions for information notices) of this policy.

1.2 Temporary policy

1.2.1 Suitability considerations

The approval of COVID-19 related absences from an AMHS is intended as a last resort mechanism. Approved absences may be subject to conditions. For example, the frequency or mode of treatment and care to be provided by the AMHS to the patient.

Before applying to the Chief Psychiatrist, the AMHS must first consider the patient's circumstances, the clinical situation and suitability for community treatment along with the following considerations.

1.2.1.1 Whether a transfer to an alternative authorised mental health service facility is available

Where a patient does not have sufficient community leave approved to enable discharge or absences from an inpatient unit, and the patient is unable to remain in their current unit (e.g. due to a public health direction) consideration should be given to transferring the patient to another AMHS facility to enable a continued inpatient admission.

1.2.1.2 Whether other mechanisms exist within the Act to facilitate an absence

Patients on a forensic order or treatment support order may already be subject to conditions that allow their treating team to grant leave. AMHSs should consider whether these conditions permit limited community treatment of a level that would enable absences as required.

For patients subject to a treatment authority (inpatient), the AMHS should consider, after having regard to the relevant circumstances under section 51 of the Act, whether the patient could be transitioned to a treatment authority (community).

Consider whether the patient can be safely managed on a community category order or with extended limited community treatment and if so, whether a MHRT hearing can be brought on rapidly to consider the matter.

1.2.2 Application process

As with existing processes for approval of temporary absences under the Act, the AMHS must apply to the Chief Psychiatrist for approval.

The AMHS must complete the new Chief Psychiatrist Approval – Approved Absences in relation to COVID-19 Emergency Period for Particular Patients form and email it to MHA2016@health.qld.gov.au

Applications must include the following information:

- the details of the relevant order or direction given under the *Public Health Act 2005*

- the outcomes of any attempt to transfer the patient to another AMHS or reasons why the transfer has not been considered appropriate
- details of the conditions of the patient's order or authority, including the level of limited community treatment currently approved
- advice regarding when the patient's next hearing in the MHRT is due and details of any contact with the MHRT regarding whether a hearing can be held to facilitate treatment of the patient in the community (if determined that the patient can be safely managed on a community category order or with extended limited community treatment)
- the recommended start and end dates for the proposed absence, including where the patient will reside
- the nature and frequency of care to be provided
- any conditions recommended for the proposed absence (for example, that the person must be accompanied throughout the absence, or that contact must be made with the treating team at specified intervals), and
- a current risk assessment of the patient.

1.2.2.1 Urgent approvals

In urgent circumstances the Chief Psychiatrist may provide initial approval via email following a telephone discussion with the AMHS administrator or clinical director and receipt of an email from the AMHS containing:

- the details of the relevant order or direction given under the *Public Health Act 2005*
- the outcomes of any consideration to transfer the patient to another AMHS or reasons why the transfer is not appropriate, and
- relevant clinical details that justify an initial approval under urgent circumstances.

A full application form **must** be provided to the Chief Psychiatrist via email to MHA2016@health.qld.gov.au within **twenty-four (24) hours** of the email approval being provided.

1.2.3 Documentation and record-keeping

1.2.3.1 Application to the Chief Psychiatrist for approved absence in relation to COVID-19 emergency period

The application form will not be available as an online form in CIMHA due to the temporary nature of this policy. Instead, a new field has been added to the '*Add: MHA Scanned Form*' section under the Temporary Absence category (select '*COVID-19 – Form and documents – Chief Psychiatrist Approval – Approved Absences in relation to COVID-19 Emergency Period*').

Once the Chief Psychiatrist has provided written notice of their decision to the application, the AMHS must scan and upload a copy of the completed form and following documents **as a single scanned form** in CIMHA:

- a copy of the relevant detention order or public health direction,
- the Chief Psychiatrist's written notice of their decision to the application, and
- if an initial approval was sought under urgent circumstances–copies of relevant emails between the Chief Psychiatrist and AMHSs.

1.2.3.2 Completion of an authority to transport absent person

Arrangements may be made under the Act for a patient who is absent without approval to be returned to an AMHS or a public sector health service facility. This includes circumstances where a patient fails to return from an approved absence granted under section 800I at the time required or if the approved absence is revoked.

An Authority to transport absent person form for a patient accessing an approved absence under section 800I, is to be documented as if it were a temporary absence under section 363(g) (refer to the Chief Psychiatrist Policy Managing involuntary patient absences).

1.2.4 Routine reviews of patients with approved absences

The AMHS must review approved absences for COVID-19 at regular intervals of no longer than 14 days[1] and notify the Chief Psychiatrist **as soon as possible** if there is a change in circumstances that would impact the approved absence. For example:

- a change to the need for the approved absence (e.g. person can be transferred to an alternate facility)
- changes to the detention order or public health direction
- an inability to meet the treatment and care needs of the relevant patient
- a change to the relevant patient's risk profile that would result in an unacceptable risk to themselves or others.

The Chief Psychiatrist will advise the AMHS if the approved absence is revoked and the patient must be returned, or if there are changes to the conditions of the approval.

[1] The maximum timeframe (unless extended) for a detention order issued under the *Public Health Act 2005* is 14 days. Public health directives have no maximum timeframe however an expiry date will be noted in the direction.

1.2.5 Chief Psychiatrist notification of approved absences to registered victims

The Act provides a number of processes to support victims of crime when a person charged with an offence has a mental illness or intellectual disability, including provisions for victims to receive information about particular patients that is relevant to the victim's safety and wellbeing.

1.2.5.1 Disclosure of particular information relating to classified patient

The Chief Psychiatrist may provide particular information about a classified patient (i.e. a person admitted to an AMHS from a place of custody) to a victim or other person affected by an offence.

In addition to information about the classified patient provided under section 783(2) of the Act, the Chief Psychiatrist may disclose to an eligible victim, the fact that the relevant patient is granted an approved absence from an AMHS under section 800I. The disclosure may be provided only if the Chief Psychiatrist is satisfied the information is relevant to the safety and welfare of the person entitled to receive information relating to the classified patient.

1.2.5.2 Temporary provisions for information notices

The Chief Psychiatrist may make an information notice in relation to a patient subject to a forensic order or treatment support order. The information notice allows specific information about the patient to be disclosed to an eligible victim as specified in Schedule 1 of the Act.

In addition to the required information under Schedule 1 of the Act, the Chief Psychiatrist may disclose the fact that a relevant patient is granted an approved absence from an AMHS under section 800I. The disclosure is provided only if the Chief Psychiatrist is satisfied the information is relevant to the safety and welfare of the person entitled to receive information under the information notice.

Further information

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service– all or part of a public or private sector mental health service declared under (and subject to) the *Mental Health Act 2016*
CIMHA	Consumer Integrated Mental Health and Addiction application– the statewide clinical information system and designated patient record for the *Mental Health Act 2016*
MHRT	Mental Health Review Tribunal

Referenced policies and resources

Chief Psychiatrist policies

- Managing involuntary patient absences
- Temporary absence
- Temporary amendments to Chief Psychiatrist policies

Mental Health Act 2016 forms and resources

- Chief Psychiatrist approval – Approved absences in relation to COVID-19 emergency period for particular patients
- Authority to transport absent person

Legislation

- *Mental Health Act 2016*
- *Public Health Act 2005*

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Mental Health Act 2016

Chief Psychiatrist Policy

Appointment of authorised doctors and authorised mental health practitioners

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Queensland Government

General

The *Mental Health Act 2016* (the Act) establishes the functions of authorised mental health service (AMHS) administrators, which includes appointing authorised doctors and authorised mental health practitioners (AMHPs). The administrator is required to keep a register of persons holding office as an authorised doctor or AMHP.

Authorised doctors and AMHPs exercise significant powers and functions which impact on the rights of individuals. Accountable appointment processes and the establishment of minimum knowledge and skill requirements for appointment are fundamental to the proper and effective administration of the Act, the protection of individual rights, and patient, carer and wider community confidence in the system of care.

All mental health service clinicians are subject to a range of standards and requirements which govern their clinical practice including, for example, National Practice Standards for the Mental Health Workforce (2013), discipline-specific practice standards, codes of ethics, and registration and credentialing requirements.

In addition, a range of clinical governance arrangements operate at the service level to ensure safe and quality patient care, including clinical accountability and reporting structures, clinical supervision and clinical review processes. The appointment and practice of authorised doctors and AMHPs operate within this context.

Scope

This Policy is mandatory for all Authorised Mental Health Services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this Policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Appointment of authorised doctors

Key Points

An AMHS administrator may, by instrument in writing, appoint a doctor as an authorised doctor.

- A 'doctor' is a person registered under the Health Practitioner Regulation National Law to practice as a medical practitioner, other than as a student.

The administrator **must** be satisfied that the doctor:

- is registered under the Health Practitioner Regulation National Law, and
- has the necessary competencies, as outlined in this Policy, to be an authorised doctor.

An authorised doctor who is a psychiatrist is an authorised psychiatrist. If the AMHS administrator is a psychiatrist, the administrator is an authorised psychiatrist.

- A 'psychiatrist' is a person registered under the Health Practitioner Regulation National Law to practice in the medical profession:
  - as a specialist registrant in the specialty of psychiatry or
  - who is able to practice psychiatry as another type of registrant prescribed by regulation.

The required competencies are:

a. substantial clinical expertise in the examination and assessment of persons suspected of having a mental illness and the treatment and care of persons with a diagnosed mental illness, and

b. substantial knowledge of the Act and the Chief Psychiatrist's Policies as they relate to the functions of an authorised doctor, including in the following areas:
   - the objects and principles of the Act, and
   - examinations and recommendations for assessment, including the treatment criteria and the less restrictive way of treatment, and assessments and the making of treatment authorities, and
   - the treatment and care of persons on treatment authorities, forensic orders and treatment support orders, and
   - classified patients, and
   - mechanical restraint, seclusion and physical restraint, and
   - psychiatrist reports for persons charged with an offence, and
   - the rights of patients and support persons, and
   - the role of the Mental Health Review Tribunal, and

- searches and transporting patients.

At a minimum, competencies **must** be demonstrated through satisfactory completion of the Act eLearning modules for authorised doctors. Verification will be by the provision of a Certificate of Completion of the eLearning modules.

1.1 Authorised doctor (private)

Authorised doctors who only practice in the private sector, may be appointed as an authorised doctor (private).

This appointment requires the successful completion of the assessment in ten (10) identified eLearning modules (see Attachment 5).

- The limited eLearning module course does not prevent an authorised doctor who only practices in the private sector from completing the full suite of eLearning modules.

It is essential that doctors who are appointed as an authorised doctor (private) only perform functions under the Act for which they are appointed.

1.2 Authorised doctor (limited practice)

In some circumstances, public sector doctors may be appointed as authorised doctors for a more limited range of functions. This may apply for the following categories of doctors:

- resident medical officers (junior house officers and senior house officers only), or
- emergency department doctors in services where an authorised doctor may not be readily available, or
- doctors in rural and remote locations.

Where justified by service delivery benefits, such doctors may be appointed as an authorised doctor (limited practice).

This appointment requires the successful completion of assessments in eight (8) identified eLearning modules (see Attachment 5).

- The availability of this limited practice eLearning module course does not prevent a doctor from completing the full suite of eLearning modules.

It is essential that doctors who are appointed as an authorised doctor (limited practice) only perform functions under the Act for which they are appointed.

An administrator may further limit the functions and powers of an authorised doctor (limited practice) when appointing the authorised doctor (see Example Instrument of Appointment - Authorised doctors (Attachment 3)).

For resident medical officers (junior house officers and senior house officers), these arrangements do not affect the supervised practice requirements set by the Medical Board of Australia. Supervision arrangements **must** be based on levels and conditions of appointment.

2 Appointment of AMHP

Key Points

An AMHS administrator may, by instrument in writing, appoint a health practitioner as an AMHP.

- A 'health practitioner' is a person registered under the Health Practitioner Regulation National Law, or another person who provides health services, including, for example, a social worker.

The administrator **must** be satisfied that the health practitioner has the competencies, as outlined in this policy, necessary to be an AMHP.

The required competencies are:

a. substantial clinical expertise in the examination and assessment of persons suspected of having a mental illness, and knowledge of the treatment and care of persons with a diagnosed mental illness, and

b. substantial knowledge of the Act and the Chief Psychiatrist's Policies as they relate to the functions of an AMHP, including in the following areas:

- the objects and principles of the Act
- examinations and recommendations for assessment, including the treatment criteria and the less restrictive way of treatment
- classified patients
- mechanical restraint, seclusion and physical restraint
- the rights of patients and support persons, and
- searches and transporting patients.

At a minimum, competencies **must** be demonstrated through satisfactory completion of the Act eLearning modules for AMHP's. Verification will be by the provision of a Certificate of Completion of the eLearning modules.

2.1 Limited practice

Where a person does not meet one or more of the competencies in full, a limited or conditional appointment may apply.

- For example, if the health practitioner does not complete the eLearning modules in full, the appointment will be limited to functions of an AMHP relevant to the eLearning modules that have been completed.

3 Conditions on appointment

Key Points

In appointing an authorised doctor or AMHP, the administrator may:

- limit the powers that may be exercised by the appointed person, or
- establish conditions under which powers may be exercised by the person.

A condition or limitation may be stated in the person's instrument of appointment, or by way of signed notice given to the person.

All appointments as an authorised doctor or AMHP **must** be:

- for a specified term or subject to the person's ongoing employment in the AMHS at which they are appointed, and
- conditional upon the authorised doctor or AMHP exercising powers in accordance with the AMHS clinical governance and clinical review process (e.g. Assessment and Risk Management Committee).

The persons appointment as an authorised doctor or AMHP is on the condition that the person continues to have the competencies necessary to be an authorised doctor or AMHP.

The powers of an authorised doctor or AMHP are not limited to patients of the AMHS at which they are appointed. An authorised doctor or AMHP may exercise their powers in relation to a patient of any Queensland AMHS.

- In exercising their powers under the Act, authorised doctors and AMHPs must also have regard to employment requirements in other services, including credentialing and scope of clinical practice.

4 Ending an appointment

Key Points

The Act sets out when an authorised doctor or AMHP's appointment ends including circumstances where:

- the authorised doctor ceases to be a doctor or the AMHP ceases to be a health practitioner of the type that was the basis for the person's appointment, or
- the appointment is for a stated term and the term ends, or
- the appointment is subject to a condition that is no longer satisfied (e.g. the appointment is conditional on the person being an employee of the AMHS and the employment ceases), or
- the Chief Psychiatrist is satisfied the person is unable to perform the functions of office and gives written notice to the person stating that the person stops holding office from a specified date, or
- the appointed person resigns by written notice given to the administrator of the AMHS who appointed the person.

In addition, the administrator who appointed the person may revoke the instrument of appointment (Section 24AA, *Acts Interpretation Act 1954*).

5 Process and documentation requirements

AMHS administrators are responsible for ensuring an accountable system for the appointment of authorised doctors and AMHPs.

The AMHS administrator **must** keep a register of persons holding office as an authorised doctor, AMHP or health practitioner appointed under section 341 to perform certain functions.

- The register of appointments is to be maintained in the Consumer Integrated Mental Health Application (CIMHA).

The administrator **must** also maintain a system of records relating to appointments, amendments to appointment conditions and terminations of appointment, including copies of written instruments of appointment and any verifying documentation.

The administrator **must** undertake an annual review of the register of appointments in CIMHA, to ensure the register is up to date.

Key Points

The administrator **must** have local policies or procedures in place for the appointment of authorised doctors and AMHPs at the AMHS, including:

- the process for appointment, i.e. how an appointment application is initiated (e.g. by way of application by the prospective appointee, on the recommendation of the team leader/clinical director), assessed to ensure competencies are met (e.g. verification by team leader/clinical director), and determined, and
- accountabilities for ongoing oversight of statutory functions exercised by appointees and ensuring competencies continue to be satisfied.

6 Instruments of appointment

The instrument of appointment **must**:

- state the name of the person appointed,
- the powers of the appointee (i.e. whether the appointment provides for all powers of an authorised doctor or AMHP), and
- any conditions of appointment including the term and/or circumstances under which the appointment ends.

Example instruments of appointment can be found in attachment 3 and 4.

7 Identity cards

AMHS administrators are required to issue an identity card for authorised doctors and AMHPs.

The card **must:**

- contain a recent photograph of the person, and
- identify the statutory position to which they are appointed, and
- state an expiry date for the card.

The expiry date on the card is intended to ensure recency of the appointee's photograph. The time frame for the ID cards validity may be aligned with local Hospital and Health Service or private sector facility protocols for identity cards (e.g. 5 years).

An authorised doctor or AMHP **must:**

- produce or display their identity card when exercising their functions.
- return the card to the administrator within **twenty-one (21) days** of the office ending.

The administrator should institute local processes to ensure the timely return of identity cards.

The legislative requirements for the issuing of an identity card may be met by identifying the statutory appointment on an existing health service employee identification card or by establishing a distinct card for the statutory appointment.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service - a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
AMHP	Authorised Mental Health Practitioner
Doctor	A 'doctor' is a person registered under the Health Practitioner Regulation National Law to practice as a medical practitioner, other than as a student.
Health Practitioner	A person registered under the Health Practitioner Regulation National Law, or another person who provides health services, including, for example, a social worker.
Psychiatrist	A person registered under the Health Practitioner Regulation National Law to practice in the medical profession: • as a specialist registrant in the specialty of psychiatry, or • who is able to practice psychiatry as another type of registrant prescribed by regulation.

Referenced documents and sources
National Practice Standards for the Mental Health Workforce (2013),
Mental Health Act 2016
Acts Interpretation Act 1954

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Attachment 1: Example AMHS Procedures for Appointment of Authorised doctors and Authorised Mental Health Practitioners

Procedure for Appointment of Authorised Mental Health Practitioners
XXXX Authorised Mental Health Service

Purpose

This procedure sets out the processes for appointment of AMHP's at the XXXX Authorised Mental Health Service (AMHS).

Context

Legislative requirements for the appointment of AMHP's are set out in Chapter 11 Part 4 of the *Mental Health Act 2016*.

The Chief Psychiatrist Policy on Appointment of Authorised doctors and AMHP's is mandatory for all AMHS and requires the AMHS administrator to document processes and requirements for the appointment of these practitioners.

Procedure

Appointment of authorised mental health practitioners

1. AMHP's will be appointed by the [position title e.g. Executive Director, Mental Health Service, XXXX HHS] as Administrator for the XXXX AMHS.
   (NB: The Administrator's powers, including appointment of AMHP's, may be exercised by a person temporarily acting in the position that is appointed to be the AMHS administrator.)
2. Applications for appointment are to be made using the *Application for appointment as authorised mental health practitioner* template at Attachment A.
3. All components of the *Mental Health Act 2016* eLearning modules relevant to the functions of an AMHP **must** be completed. Verification of the health practitioner's satisfactory completion of the eLearning modules **must** be provided with the recommendation.
4. Applications are to be reviewed by the relevant Team Leader or Nurse Unit Manager prior to submission to the Administrator. The Team Leader/Nurse Unit Manager is accountable for verifying that the applicant satisfies the competencies for appointment.
5. On appointment, the Administrator will provide the appointee with the *Instrument of appointment*. A copy of the *Instrument of appointment* is to be retained on the appointee's human resource file.
6. The Administrator will notify the [position title e.g. Mental Health Act Administration Officer] of all appointments for registering in the Consumer Integrated Mental Health Application (CIMHA).
7. Team Leaders and Nurse Unit Managers are accountable for ongoing oversight of the statutory functions exercised by appointees to ensure compliance with legislative, policy and operational requirements.

8. Team Leaders and Nurse Unit Managers **must** advise the Administrator in writing in circumstances where the Team Leader/Nurse Unit Manager believes the appointee ceases to meet the appointment requirements or is no longer required to undertake the functions, powers and duties of an AMHP.

Cessation of appointment of authorised mental health practitioners

1. The circumstances in which an AMHP appointment ceases are set out in the Act and the *Instrument of appointment*.
2. Revocations of appointment by the Administrator will be in writing and will be provided to the appointee.
3. With the exception of appointments that cease at the end of a specified term, a written record of the date of, and reasons for, the cessation of appointment is to be retained on the person's human resource file (e.g. written advice from appointee that a condition of appointment is no longer satisfied or the person's resignation from office).
4. The [position title e.g. Mental Health Act Administration Officer] is responsible for ending the practitioner's appointment status in CIMHA:
   - at the end of a specified term of appointment (unless a further appointment has been made by the Administrator)
   - on the Administrator's advice that the person has ceased to be an AMHP.

Review of register of appointments

1. The [position title e.g. Mental Health Act Administration Officer] will undertake a review of persons registered as AMHP's at the XXXX AMHS in March of each calendar year.
2. The [position title] will liaise with Team Leaders and Nurse Unit Managers as required to ensure the register is accurate and up to date (e.g. to ensure that there have been no oversights in removing individuals from the register on termination of employment with the Mental Health Service).

Resources

- Mental Health Act 2016
- Chief Psychiatrist Policy: Appointment of Authorised doctors and Authorised Mental Health Practitioners

Application for appointment as Authorised Mental Health Practitioner

XXXX Authorised Mental Health Service

Part A - To be completed by applicant

Name: _____

Position title: _____

Team/Unit: _____

☐ I am a 'health practitioner' as defined under the *Mental Health Act 2016*

Profession:_____

AHPRA registration number:_____ and registration expiry date _____

(Not required for social workers)

☐ I have ___ years clinical experience in mental health service delivery

☐ I have attached the Proof of Completion for the *Mental Health Act 2016* authorised mental health practitioner training.

Signed:_____ Date:_____

Part B - To be completed by line manager

Name: _____

Position title: _____

Team/Unit: _____

☐ I have been the applicant's line manager since _____

☐ I am able / unable to verify that the applicant has the competencies required for appointment as an authorised mental health practitioner. Specifically:

- ☐ the applicant has / has not demonstrated substantial clinical expertise in the examination and assessment of persons suspected of having a mental illness,

and knowledge of the treatment and care of persons with a diagnosed mental illness

☐ the applicant has / has not demonstrated substantial knowledge of the *Mental Health Act 2016* and Chief Psychiatrist policies relevant to the powers, functions and responsibilities of an authorised mental health practitioner.

Additional comments:

_____
_____
_____
_____

Signed:_____ Date:
_____

Part C – To be completed by Administrator

Name: _____

The applicant's appointment as an authorised mental health practitioner is approved / not approved

Additional comments (including any specific limitations and conditions to be included in the Instrument of appointment):

_____
_____
_____
_____

Signed: _____ Date: _____

Procedure for Appointment of Authorised doctors

XXXX Authorised Mental Health Service

Purpose

This procedure sets out the processes for appointment of authorised doctors at the XXXX Authorised Mental Health Service (AMHS).

Context

Legislative requirements for the appointment of authorised doctors are set out in Chapter 11 Part 4 of the *Mental Health Act 2016*.

The Chief Psychiatrist Policy on Appointment of Authorised doctors and Authorised Mental Health Practitioners (AMHP) is mandatory for all AMHS and requires the AMHS Administrator to document processes and requirements for appointment of authorised doctors.

Procedure

Appointment of authorised doctors

1. Authorised doctors will be appointed by the [position title e.g. Executive Director, Mental Health Service, XXXX HHS] as Administrator for the XXXX AMHS.
   (NB: The Administrator's powers, including appointment of authorised doctors, can be exercised by a person temporarily acting in the position that is appointed to be the AMHS administrator.)
2. Recommendations for appointment are to be made by the Clinical Director or a Consultant Psychiatrist using the *Recommendation for authorised doctor appointment* template at Attachment A.
3. The Clinical Director/Consultant Psychiatrist is accountable for verifying that the doctor satisfies the competencies for appointment and, where relevant, recommending any conditions or limitations for the appointment.
4. Verification of the doctor's satisfactory completion of the *Mental Health Act 2016* eLearning modules **must** be provided with the recommendation.
5. If a doctor does not complete the eLearning modules in full, the appointment will be limited i.e. the appointment will be limited to authorised doctor functions relevant to the eLearning modules that have been completed.
6. The [position title] is responsible for confirming the doctor's registration under the Health Practitioner Regulation National Law and, where relevant, that the registration meets the statutory definition for 'psychiatrist'.
7. On appointment, the Administrator will provide the appointee with the *Instrument of appointment*. A copy of the *Instrument of appointment* is to be retained on the appointee's human resource file.
8. The Administrator will notify the [position title e.g. Mental Health Act Administration Officer] of all appointments for registering in the Consumer Integrated Mental Health Application (CIMHA).

9. The Clinical Director/Consultant Psychiatrist is accountable for ongoing oversight of the statutory functions exercised by appointees to ensure compliance with legislative, policy and operational requirements.

The Clinical Director/Consultant Psychiatrist **must** advise the Administrator in writing in circumstances where the Clinical Director/Consultant Psychiatrist believes the practitioner ceases to meet the appointment requirements.

Cessation of appointment of authorised doctors

1. The circumstances in which an authorised doctor appointment ceases are set out in the Act and the *Instrument of appointment*.
2. Revocations of appointment by the Administrator will be in writing and will be provided to the appointee.
3. With the exception of appointments that cease at the end of a specified term, a written record of the date of, and reasons for, the cessation of appointment is to be retained on the person's human resource file (e.g. written advice from appointee that a condition of appointment is no longer satisfied or the person's resignation from office, revocation of appointment by the Administrator).

4. The [position title e.g. Mental Health Act Administration Officer] is responsible for ending the practitioner's appointment status in CIMHA:-
   - at the end of a specified term of appointment (unless a further appointment has been made by the Administrator)
   - on the Administrator's advice that the person has ceased to be an authorised doctor.

Review of register of appointments

1. The [position title e.g. Mental Health Act Administration Officer] will undertake a review of persons registered as authorised doctors at the XXXX AMHS in March of each calendar year.
2. The [position title] will liaise with Team Leaders and Nurse Unit managers as required to ensure the register is accurate and up to date (e.g. to ensure that there have been no oversights in removing individuals from the register on termination of employment with the Mental Health Service).

Resources

- *Mental Health Act 2016*
- *Chief Psychiatrist Policy: Appointment of Authorised doctors and Authorised Mental Health Practitioners*

Recommendation for Authorised doctor appointment

XXXX Authorised Mental Health Service

Part A – Recommendation by Clinical Director or Consultant Psychiatrist

I recommend that _____ be appointed as an authorised doctor and confirm that the competencies required for appointment are satisfied. Specifically, I believe the nominee has demonstrated:

- substantial clinical expertise in the examination and assessment of persons suspected of having a mental illness and the treatment and care of persons with a diagnosed mental illness, and
- substantial knowledge of the *Mental Health Act 2016* and Chief Psychiatrist policies relevant to the powers, functions and responsibilities of an authorised doctor.

☐ A copy of the Proof of Completion for the *Mental Health Act 2016* authorised doctor training is attached or

☐ *Mental Health Act 2016* competency requirements have previously been verified at another Authorised Mental Health Service.

In addition, I recommend that the appointment be subject to the following conditions or limitations:
(Strike out if not applicable)

_____
_____
_____

Signed:_____ Date:_____

Name: _____

Designation: Clinical Director / Consultant Psychiatrist

Part B – Verification of medical practitioner registration details

AHPRA registration number: _____ and registration expiry date _____

For psychiatrists: The Registration Type is in accordance with the statutory definition of psychiatrist; specifically:

- ☐ Specialist (Psychiatry)
- ☐ (Categories to be specified on making of Regulation)

Signed:_____ Date:_____

Name:_____

Designation: _____

Part C – Administrator decision

The applicant's appointment as an authorised doctor is approved / not approved

Additional comments (including any specific conditions and limitations to be included in Instrument of appointment):

_____
_____
_____
_____

Signed:_____ Date:_____

Name:_____

Attachment 2: Example Instrument of Appointment – Authorised doctors

Mental Health Act 2016

INSTRUMENT OF APPOINTMENT

For full appointment (i.e. all authorised doctor powers and functions) insert:

I, **Name of Administrator**, Administrator, **Title** **Authorised Mental Health Service**, under and for the purpose of the *Mental Health Act 2016* (Act), pursuant to Chapter 11, Part 4, Division 1, section 338 of that Act, hereby appoint **Full name of doctor** as an authorised doctor to exercise all of the powers, functions and duties of an authorised doctor under the Act.

OR for limited appointment insert:

I, **Name of Administrator**, Administrator, **Title** **Authorised Mental Health Service**, under and for the purpose of the *Mental Health Act 2016* (Act), pursuant to Chapter 11, Part 4, Division 1, section 338 of that Act, hereby appoint **Full name of doctor** as an authorised doctor to exercise those powers, functions and duties set out in the Schedule. (Note: remove relevant functions from Schedule. For example, for appointment of an authorised doctor (private), delete sections 3 (Forensic orders), 4 (Treatment support orders) and 5 (Classified patients) from the Schedule).

If the doctor meets the statutory definition for 'psychiatrist' insert:

In addition, pursuant to the definition of 'authorised psychiatrist' in Schedule 3 of the Act, the appointee is authorised to exercise all of the powers, functions and duties of an authorised psychiatrist set out in the Act.

For all appointments insert:

This appointment is effective from the date of this Instrument.

OR if the appointment is to take effect on a date after the signing:

This appointment is effective from **Date**.

For all appointments insert:

This appointment is subject to the following conditions:

1. In exercising the powers of an authorised doctor, the appointee is subject to the **Title** Authorised Mental Health Service clinical governance processes including, but not limited to, clinical accountability structures, clinical supervision and clinical review processes.
2. The appointment is effective until **Date of cessation** unless, at a sooner time:
   (a) the appointee ceases to be person registered under the Health Practitioner Regulation National Law to practice in the medical profession
   (b) the appointment is revoked by the Administrator
   (c) the Chief Psychiatrist gives written notice that the appointee stops holding the office of authorised doctor, or
   (d) the appointee resigns from the position by written notice given to the Administrator.

OR

The appointment is effective for the duration of the appointee's employment at the **Title** Authorised Mental Health Service unless, at a sooner time:

(a) the appointee ceases to be person registered under the Health Practitioner Regulation National Law to practice in the medical profession

(b) the appointment is revoked by the Administrator

(c) the Chief Psychiatrist gives written notice that the appointee stops holding the office of authorised doctor, or

(d) the appointee resigns from the position by written notice given to the Administrator.

(Note: Insert any other conditions if required).

Signed by:

Name of Administrator

Administrator, Title Authorised Mental Health Service

Date

Functions and Powers of Authorised doctors

Function or Power	Act Reference
1. Examinations, Assessments and making of Treatment Authorities	
Examining persons under an examination authority	• Chapt. 2, Pt. 2, Div. 2 (Powers under examination authorities)
Examining persons under an examination order made by a magistrate and preparing an examination report	• Chapt. 6, Pt. 2, Div. 3 (Examination orders)
Making recommendations for assessment	• Chapt. 2, Pt. 2, Div. 3 (Detention of particular persons to make recommendation for assessment) • Chapt. 2, Pt., Div. 4 (Recommendations for assessment)
Assessing a person under a recommendation for assessment to decide whether to make a treatment authority	• Chapt. 2, Pt. 3 (Assessments)
Making treatment authorities	• Chapt. 2, Pt. 4 (Treatment authorities), except sections 56 to 58
Reviewing the making of treatment authorities – authorised psychiatrist only	• Sections 56 to 58
2. Treatment authorities	
Managing patients subject to treatment authorities • Responsibility for treatment and care • Categories • Limited community treatment • Conditions	• Chapt. 7, Pt. 2 (Responsibility to provide treatment and care) • Chapt. 7, Pt.3 (Patients subject to treatment authorities)

	• Chapt. 7, Pt.7 (Obligations in relation to treatment in the community)
3. Forensic orders	
Managing patients subject to forensic orders • Responsibility for treatment and care • Categories • Limited community treatment • Conditions • Temporary absences	• Chapt. 7, Pt. 2 (Responsibility to provide treatment and care) • Chapt. 7, Pt.4 (Patients subject to forensic orders) • Chapt. 7, Pt.7 (Obligations in relation to treatment in the community)
4. Treatment support orders	
Managing patients subject to treatment support orders • Responsibility for treatment and care • Categories • Limited community treatment • Conditions • Temporary absences	• Chapt. 7, Pt. 2 (Responsibility to provide treatment and care) • Chapt. 7, Pt.5 (Patients subject to treatment support orders) • Chapt. 7, Pt.7 (Obligations in relation to treatment in the community)
5. Classified patients	
Managing the transfer of persons to an AMHS as a classified patient, including making transfer recommendations	• Chapt. 3, Pt. 2 (Transport of persons in custody to authorised mental health services) • Chapt. 3, Pt.3 (Persons in custody remaining in authorised mental health services) • Chapt. 3, Pt. 4 (Requirements applying when person in custody becomes classified patient)
Managing classified patients • Responsibility for treatment and care	• Chapt. 7, Pt. 2 (Responsibility to provide treatment and care)

• Limited community treatment • Temporary absences	• Chapt. 7, Pt.6 (Classified patients and patients subject to judicial orders) • Section 221
Managing the return of classified patients to custody or the release of classified patients	Chapt. 3, Pt.5 (Return to custody, or release from detention in authorised mental health service, of classified patient)
6. Judicial order patients	
Managing judicial order patients • Limited community treatment • Temporary absences	• Chapt. 7, Pt.6 (Classified patients and patients subject to judicial orders) • Section 221
7. Mechanical restraint	
Authorising the mechanical restraint of patients in an AMHS	Chapt. 8, Pt. 2 (Mechanical restraint)
8. Seclusion	
Authorising the seclusion of patients in an AMHS	Chapt. 8, Pt. 3 (Seclusion)
9. Physical restraint	
Authorising the physical restraint of patients in an AMHS	Section 270
10. Regulated treatments	
Performing ECT on a patient in an AMHS	• Chapt. 7, Pt. 10, Div. 2 (Informed consent) • Chapt. 7, Pt. 10, Div. 3 (Electroconvulsive therapy)
Performing non-ablative neurosurgery on a patient in an AMHS	• Chapt. 7, Pt. 10, Div. 2 (Informed consent)

	• Chapt. 7, Pt. 10, Div. 4 (Non-ablative neurosurgical procedures)
10. Psychiatrist reports	
Preparing psychiatrist reports for serious offences – authorised psychiatrists only	Chapt. 4 (Psychiatrist reports for serious offences)
11. Mental Health Review Tribunal	
Preparing reports for Tribunal hearings	Section 723
12. Examinations	
Examine a person under a court examination order made by the Mental Health Court	Ch.16, Pt.1, Div.8 (Court examination orders)
Examine a person under an order of Mental Health Review Tribunal	Section 721
13. Searches	
Carry out searches for harmful things	Chapt. 11, Pt. 7, Div. 3 (Searches of patients of authorised mental health services or public sector health service facilities)
14. Transport of patients	
Managing the transport of patients - authorising transport - authorised person	Chapt. 11, Pt, 6 (Transport of persons)

Attachment 3: Example Instrument of Appointment – Authorised Mental Health Practitioners

Mental Health Act 2016

INSTRUMENT OF APPOINTMENT

For full appointment (i.e. all authorised mental health practitioner powers and functions) insert:

I, **Name of Administrator**, Administrator, **Title** **Authorised Mental Health Service**, under and for the purpose of the *Mental Health Act 2016*, pursuant to Chapter 11, Part 4, Division 1, section 340 of that Act, hereby appoint **Full name of health practitioner,** a health practitioner, namely **Profession,** as an AMHP to exercise all of the powers, functions and duties of an AMHP under the Act.

OR for limited appointment insert:

I, **Name of Administrator**, Administrator, **Title** **Authorised Mental Health Service**, under and for the purpose of the *Mental Health Act 2016*, pursuant to Chapter 11, Part 4, Division 1, section 340 of that Act, hereby appoint **Full name of health practitioner,** a health practitioner, namely **Profession** as an AMHP to exercise those powers, functions and duties set out in the Schedule. (Note: Remove relevant functions from Schedule).

For all appointments insert:

This appointment is effective from the date of this Instrument.

OR if the appointment is to take effect on a date after the signing:

This appointment is effective from **Date**.

For all appointments insert:

This appointment is subject to the following conditions:

1. In exercising the powers of an AMHP, the appointee is subject to the **Title** Authorised Mental Health Service clinical governance processes including, but not limited to, clinical accountability structures, clinical supervision and clinical review processes.
2. The appointment is effective until **Date of cessation** unless, at a sooner time:
   (a) the appointee ceases to be a health practitioner of the type that is the basis for this appointment namely, **Profession**
   (b) the appointment is revoked by the Administrator
   (c) the Chief Psychiatrist gives written notice that the appointee stops holding the office of AMHP, or
   (d) the appointee resigns from the position by written notice given to the Administrator.

OR

The appointment is effective for the duration of the appointee's employment at the **Title** Authorised Mental Health Service unless, at a sooner time:

(a) the appointee ceases to be a health practitioner of the type that is the basis for this appointment namely, **Profession**

the appointment is revoked by the Administrator.

(a) the Chief Psychiatrist gives written notice that the appointee stops holding the office of AMHP, or

(b) the appointee resigns from the position by written notice given to the Administrator.

(Note: Insert any other conditions if required).

Signed by:

Name of Administrator

Administrator, Title Authorised Mental Health Service

Date

Functions and Powers of Authorised Mental Health Practitioners

Function or Power	Act Reference
1. Examinations and Assessments	
Examining persons under an examination authority	• Chapt. 2, Pt. 2, Div. 2 (Powers under examination authorities)
Examination orders – extension of examination period	• Chapt. 6, Pt. 2, Div. 3 (Examination orders)
Making recommendations for assessment	• Chapt. 2, Pt. 2, Div. 3 (Detention of particular persons to make recommendation for assessment) • Chapt. 2, Pt. 2, Div. 4 (Recommendations for assessment)
2. Classified patients	
Managing the transfer of persons to an AMHS as a classified patient, including making transfer recommendations	• Chapt. 3, Pt. 2 (Transport of persons in custody to authorised mental health services) • Chapt. 3, Pt.3 (Persons in custody remaining in authorised mental health services) • Chapt. 3, Pt. 4 (Requirements applying when person in custody becomes classified patient)
3. Mechanical restraint	
Use of mechanical restraint of patients in an AMHS	Chapt. 8, Pt. 2 (Mechanical restraint)
4. Seclusion	

Use of seclusion of patients in an AMHS	Chapt. 8, Pt. 3 (Seclusion)
5. Searches	
Carry out searches for harmful things	Chapt. 11, Pt. 7, Div. 3 (Searches of patients of authorised mental health services or public sector health service facilities)
6. Transport of patients	
Managing the transport of patients - authorising transport - authorised person	Chapt. 11, Pt, 6 (Transport of persons)

Attachment 4: MHA2016 eLearning Course – Modules for Authorised doctors and Authorised Mental Health Practitioners (AMHPs)

Module	Authorised doctors	AMHPs	Authorised doctors (Private)	Authorised doctors (Limited practice)
1. Objects and Principles of Act	X	X	X	X
2. Treatment Criteria and Less Restrictive way of Treatment (pre-requisite for modules 3 & 4)	X	X	X	X
3. Examinations and recommendations for assessment (includes examination authorities & examination orders)	X	X	X	X
4. Assessments and Treatment Authorities	X		X	X
5. Persons on forensic orders	X			
6. Persons on treatment support orders	X			
7. Classified patients	X	X		
8. Restrictive Practices	X	X	X	X
9. Psychiatrist Reports	X		X	
10. Patient Rights and Confidentiality	X	X	X	X
11. Mental Health Review Tribunal	X		X	
12. Searches	X	X	X	X
13. Powers of Authorised Persons (Transport)	X	X	X	X

Mental Health Act 2016
Chief Psychiatrist Policy

Classified patients

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General

The *Mental Health Act 2016* (the Act) makes provision for a person to be transferred from a place of custody (e.g. prison or watch house) to an inpatient authorised mental health service (AMHS) for assessment or treatment of mental illness. The person is admitted as a classified patient.

A classified patient admission can only occur with:

- a Recommendation for Assessment or Transfer Recommendation made by a doctor or authorised mental health practitioner (AMHP), and
- consent from the relevant AMHS administrator, and
- consent from the relevant custodian.

Classified patient status ends when:

- the person ceases to be subject to a custodial order, or
- when a person subject to a custodial order no longer requires assessment or treatment in an inpatient AMHS and is returned to the relevant custodian's care.

Scope

This policy is mandatory for all AMHSs. An authorised doctor, AMHP, AMHS administrator, or other person performing a function or exercising a power under the Act must comply with this policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

This policy **must** be read in conjunction with the relevant provisions of the Act.

Policy

1 Admission of classified patients

The Statewide Coordinator - Classified Patients monitors statewide classified patient referrals, admissions and returns to custody and supports identification of an appropriate inpatient AMHS for admission of classified patients.

The Statewide Coordinator should be notified at the earliest opportunity of the need to transport a person to an AMHS for admission as a classified patient.

Statewide Coordinator – Classified patients
07 3837 5820 or ClassifiedPatientsMHA2016@health.qld.gov.au

1.1 Voluntary and involuntary status

A person may be transported to an AMHS and become a classified patient (involuntary) or classified patient (voluntary).

Classified patient (involuntary) status applies when:

- the person is subject to a recommendation for assessment, or
- the person is subject to an existing order or authority under the Act.

Classified patient (voluntary) status applies when:

- the person is consenting to treatment and care in an AMHS, and
- the person is not subject to an existing order or authority under the Act.

A classified patient (voluntary) may withdraw their consent at any time. In this instance, the person may be returned to the relevant custodian's care unless a Treatment Authority is made for the person (see section 3).

1.2 Admission

A person can be admitted to an AMHS from custody as a classified patient under either a Recommendation for Assessment or a Transfer Recommendation.

1.2.1 Transport for assessment

A Recommendation for Assessment may be made when a person in custody:

- requires admission to an AMHS for assessment, and
- is not subject to an existing order or authority under the Act, and
- is not able to consent to the transfer – i.e. transfer for assessment (involuntary).

An admission under this process **must** meet the following requirements:

- a Recommendation for Assessment **must** be made by a doctor or AMHP who has examined the person in the preceding **seven (7) days**, and
- an Administrator Consent form **must** be signed by the administrator of the AMHS where the patient is to be admitted, and
- a Custodian Consent form must be signed by the relevant custodian.

A Recommendation for Assessment can only be made if the relevant requirements under Chapter 2 of the Act are met (see Chief Psychiatrist Policy – Examinations and Assessment).

1.2.2 Transport for treatment

A Transfer Recommendation may be made when a person in custody:

- requires admission to an AMHS for treatment, and
- is consenting to treatment and care in an AMHS – i.e. transfer for treatment (voluntary), or
- is already subject to an order or authority under the Act – i.e. transfer for treatment (involuntary).

An admission under this process must meet the following requirements:

- a Transfer Recommendation **must** be made by a doctor or AMHP who has examined the person in the preceding **seven (7) days**, and
- an Administrator Consent form **must** be signed by the administrator of the AMHS where the patient is to be admitted, and
- a Custodian Consent form must be signed by the relevant custodian.

A Transfer Recommendation can only be made if the doctor or AMHP is satisfied it is clinically appropriate for the person to receive treatment and care for mental illness at an AMHS.

1.2.2.1 Extension of admission for persons under a Judicial Order

The Act allows a person already admitted to an AMHS under an Examination Order (made by a magistrate) or Court Examination Order (made by a court) to remain as a classified patient where the transport for treatment requirements are met. See also Chief Psychiatrist Policy – Judicial Orders.

In these cases, the Statewide Coordinator – Classified Patients should be notified at the earliest opportunity of the patient's status as a classified patient.

Statewide Coordinator – Classified patients
07 3837 5820 or ClassifiedPatientsMHA2016@health.qld.gov.au

An authorised doctor who examines the person under an Examination Order may make a Treatment Authority for the person.

1.2.2.2 Admission of persons subject to a Forensic Order (Disability)

Persons in custody subject to a Forensic Order (disability) may be admitted to an AMHS under any of the above mentioned classified patient provisions if they require assessment or treatment and care for a mental illness.

A person subject to a Forensic Order (disability) cannot be admitted as a classified patient for the sole purpose of being provided care for their intellectual or cognitive disability.

1.3 Recommendations and referrals

All recommendations (Recommendations for Assessment and Transfer Recommendations) must be completed electronically in CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

A record of the examination **must** be recorded in a Classified Patient Initiation Activity clinical note in CIMHA including any collateral material not already recorded in CIMHA.

The doctor or AMHP **must** tell the person and their support person/s of their decision to make the recommendation and explain the effect of the decision.

Information does not need to be provided to a support person if the doctor or AMHP considers that one of the following exceptions to informing the support person/s applies:

- the patient requests, at a time when they have capacity, that the communication not take place, or
- the person is not readily available or willing for the communication to take place (e.g. the person is unable to be contacted after numerous attempts), or
- the communication with the person is likely to be detrimental to the patient's health and wellbeing (e.g. the person has previously disrupted the patient's treatment and care resulting in deterioration of the patient's condition).

A copy of the recommendation **must** be provided on request of the person, their appointed nominated support person/s, or appointed guardian or attorney.

Note: A copy is not required to be provided to the person if the doctor or AMHP believes that this may adversely affect the person's health and wellbeing.

The doctor or AMHP **must** record the information provided, or the reasons for not providing the information, in a Classified Patient Initiation Activity clinical note in CIMHA.

When a recommendation is made it **must** be sent via email or CIMHA to the relevant AMHS, as determined under section 1.10 of this document.

The recommendation **must** be sent under a covering referral letter and include any supporting collateral material. This will provide a more detailed picture of a person's circumstances for the relevant AMHS to consider.

All recommendations and collateral material **must** also be emailed to the Statewide Co-ordinator – Classified Patients.

Statewide Coordinator – Classified patients
07 3837 5820 or ClassifiedPatientsMHA2016@health.qld.gov.au

1.4 Determining the relevant AMHS

1.4.1 High security inpatient service

Admission to the high security inpatient service (HSIS) may be required due to:

- the nature of the offence/s
- the patient's criminal history
- the patient's treatment, care and security requirements
- risk profile and issues, and
- community safety.

If the person is a minor, prior approval **must** be provided by the Chief Psychiatrist before admission to the HSIS can occur (see section 1.7.2.1).

1.4.2 Other AMHS

Key points

If the person does not require admission to the HSIS and is fit to travel (see section 1.9.1), the referral must be made to the AMHS:

- that is responsible for the person's Treatment Authority, Forensic Order (mental health) or Treatment Support Order, or
- where the person has an open service episode (other than a service episode initiated by the Prison Mental Health Service or Court Liaison Service), or
- in the locality the person resided, or the person's last known residential address prior to arrest, or
- where the person has recent or strong treatment links.

If none of the above criteria apply or the person is homeless, other considerations need to be taken into account, such as:

- location of the court where the person was processed, and
- location of key supports in the community, and
- geographical distance to a proposed service, and
- the person's fitness for travel, and
- the person's intended address upon release.

Where there is no preferred AMHS based on the above criteria, admission should be negotiated with the nearest appropriate AMHS. The Statewide Coordinator - Classified Patients should be contacted if assistance is required to identify a relevant AMHS.

Statewide Coordinator – Classified patients
07 3837 5820 or ClassifiedPatientsMHA2016@health.qld.gov.au

1.4.3 Prioritisation of patients

A referring service which has made multiple recommendations to a relevant AMHS **must** advise the relevant AMHS the order of priority of patients.

- The referring service **must** regularly update the relevant AMHS and the Statewide Coordinator – Classified Patients if the order of priority changes.
- Referrals can be sent from a number of different services and those services can only provide priority information for the patients under their care.
- The relevant AMHS **must** take information from all referral services into consideration when determining the patients for whom administrator consent is to be made.

1.5 Administrator consent and admission

To obtain administrator consent, the referring service **must** provide the administrator of the relevant AMHS with a copy of the recommendation, referral letter and any collateral material via CIMHA. The referral letter or email **must** be attached to a *Classified Patient Initiation Activity clinical note* in CIMHA.

Key points

An administrator may consent to the person's admission as a classified patient if satisfied that:

- the AMHS has capacity to provide the assessment or treatment and care for the person's mental illness, and
- for an AMHS other than the HSIS – the person's admission would not pose an unreasonable risk to the safety of the person or others having regard to:
  - the person's mental state and psychiatric history,
  - the person's treatment and care needs, and
  - the security requirements of the person.

The administrator's consent must be provided on the Administrator Consent form.

The administrator of the AMHS **must** respond to the referring service within **seventy-two (72) hours** of receiving the documentation.

All correspondence through and between the referring service and the relevant AMHS, including identified pathways or challenges, **must** be copied to the Statewide Coordinator – Classified patients to determine if a Classified Patient Committee (CPC) should be convened to assist with placement of the patient (see section 1.7).

The following options apply for providing a response to a referring service:

- **If a bed is available**, the Administrator Consent form is signed, and arrangements made for the person's transport to the AMHS.
    - The administrator **must** send a copy of the signed Administrator Consent via CIMHA to the:
        - referring service, and
        - Statewide Coordinator - Classified Patients, and
        - make a follow-up phone call to confirm receipt of the Administrator Consent.
- **If a bed is not currently available**, the administrator **must** advise on the expected timeframe for when a bed will be available. Clinical considerations are to be discussed between the referring service and the AMHS with regard to the timeframe and the suitability of that timeframe given the patient's treatment and care needs.
- **If a bed will not be available within seventy-two (72) hours** of receiving the documentation and it is not clinically appropriate for the person to wait for a bed to become available, the administrator **must** outline the efforts made to contact other relevant AMHSs to find a bed. The referring service may offer assistance in this regard.
    - The administrator must keep the referring service informed as negotiations proceed.

The administrator is responsible for determining whether another relevant AMHS could accept the admission. This determination **must** be made with consideration to section 1.4.

During the time of reply from the AMHS, the referring service must keep the AMHS and Statewide Coordinator up to date with any clinical change to the patient's status and provide further collateral material as it comes to hand.

If an admission is delayed due to unforeseen circumstances (e.g. due to transport delays), the administrator's consent remains in place until the transfer can take place.

A current recommendation is required for an admission to occur.

If an alternative AMHS can accept the transfer within **seventy-two (72) hours**, the administrator of the alternative AMHS must:

- send a copy of the signed Administrator Consent via CIMHA to the:
    - administrator of the relevant AMHS who originally received the referral, and
    - referring service, and
    - Statewide Coordinator – Classified Patients, and
- make a follow-up phone call to confirm receipt of the Administrator Consent.

If, **seventy-two (72) hours** after the documentation has been received, there is not an identified pathway that meets the person's clinical and risk management needs, the Statewide Coordinator – Classified Patients **must** be notified.

Statewide Coordinator – Classified patients
07 3837 5820 or ClassifiedPatientsMHA2016@health.qld.gov.au

The Chief Psychiatrist will be automatically notified via CIMHA if the person is not transported at the end of **seventy-two (72) hours** of the Recommendation being made.

The Statewide Coordinator – Classified Patients meets regularly with the Chief Psychiatrist to consider matters that may require a CPC to be convened (see section 1.7).

1.6 Escalation of recommendations if administrator consent not given

If a suitable arrangement for the person's admission cannot be determined or if concern or dispute arises between the referring service and the inpatient service, the matter is to be escalated without delay to the:

- clinical director Court Liaison Services, or
- clinical director of a Prison Mental Health Service, and
- clinical director of the inpatient service receiving the patient.

If the matter cannot be resolved between clinical directors (or relevant counterparts), the matter may then be escalated to the Statewide Coordinator – Classified Patients. Where necessary, the Statewide Coordinator – Classified Patients may convene a meeting of the CPC with the relevant parties (see 1.7.1).

Statewide Coordinator – Classified patients
07 3837 5820 or ClassifiedPatientsMHA2016@health.qld.gov.au

The Chief Psychiatrist will be automatically notified via CIMHA if the person is not transported at the end of **seventy-two (72) hours** of a Recommendation being made.

The Statewide Coordinator – Classified Patients meets regularly with the Chief Psychiatrist to consider matters that may require a CPC to be convened (see section 1.7).

1.7 Classified Patient Committee

The purpose and structure of the CPC is described in Attachment 2 – Terms of reference for Classified Patient Committee.

Key points

A referral may be made to the CPC if:

- after **seventy-two (72) hours** there is not an identified pathway that meets the person's clinical and risk management needs in accordance with section 1.5 of this policy, or
- escalation of the recommendation is required where administrator consent has not been given (see section 1.6), or
- there is an issue or concern with a return of a patient to custody, and after the escalation pathway has been followed (see section 3.1.3) the issue or concern is not resolved.

1.7.1 Referral to Classified Patient Committee

Where an issue or concern regarding a classified patient cannot has not been resolved via the escalation pathway at section 1.6 of this policy, referral to the CPC **may** occur.

Referral to the CPC can be made by:

- a staff member of the referring service,
- the relevant AMHS,
- another AMHS involved in the negotiation of admission of a person,
- the Statewide Coordinator - Classified Patients,
- the Prison Mental Health Service, Court Liaison Service, or Director Queensland Forensic Mental Health Service, or
- the Chief Psychiatrist.

Referrals **are to be made via** the Statewide Coordinator - Classified Patients who will consider options for convening an out of session CPC in consultation with the Chief Psychiatrist. Chief Psychiatrist consent

1.7.2 Consent not given by administrator

If administrator consent cannot be obtained, the Chief Psychiatrist may provide consent for a classified patient to be transported to an inpatient unit of an AMHS. The Chief Psychiatrist's consent has the same effect as the administrator's consent.

Prior to making this decision, the Chief Psychiatrist will contact the administrator of the relevant AMHS where the person is proposed to be admitted to discuss the admission.

Key points

If the Chief Psychiatrist consents to the admission, a signed Administrator Consent will be sent via CIMHA to:

- the administrator of the AMHS where the person is being admitted
- the referring service, and
- the Statewide Coordinator – Classified Patients.

1.7.2.1 Minors

The processes outlined above apply for minors (persons under 18) in the same way as for adults unless the person is to be admitted to the HSIS.

Prior to a minor's admission as a classified patient to the HSIS, the administrator **must** seek written approval from the Chief Psychiatrist. The Chief Psychiatrist's approval is given on the Administrator Consent form.

Following Chief Psychiatrist approval, the administrator of the HSIS may provide consent to the admission via the Administrator Consent form.

See the Chief Psychiatrist Policy – Treatment and Care of Minors for further information on the reporting requirements on admission of a minor to HSIS.

1.8 Custodian consent

Key points

All classified patient admissions require the consent of the person's custodian prior to their admission.

A custodian **must** give consent unless satisfied that the person's assessment or treatment and care at the AMHS would pose an unreasonable risk to the safety of the person, or others, having regard to the security requirements of the person.

The custodian's consent **must** be provided on the Custodian Consent form.

The referring service is responsible for contacting the relevant custodian to seek completion of the Custodian Consent form. If assistance is required to identify the appropriate custodian, the Statewide Coordinator - Classified Patients may be contacted.

Statewide Coordinator – Classified patients
07 3837 5820 or ClassifiedPatientsMHA2016@health.qld.gov.au

The Custodian Consent **must** be uploaded on CIMHA as soon as practicable after receipt of the form.

1.9 Transport of patients

The custodian is responsible for organising the transportation of the person from the custodial setting to an AMHS.

The referring service **must** advise the custodian about any clinical issues that need to be considered for the person's transportation.

For transporting a classified patient, correctional officers and youth detention officers are authorised persons under the Act.

The Queensland Interagency Agreement for the safe transport of people accessing mental health assessment, treatment and care (Queensland Health, Queensland Ambulance Service and Queensland Police) Section 14 Transfers for patients in custody sets out the roles and responsibilities of the agencies involved in transport and the agreed processes for working together.

1.9.1 Fitness for travel

Patient safety is a priority in the transfer of patients. Clinical consideration should be given to the mode of transport used to transfer a person from a custodial facility to an AMHS or between AMHSs.

The Queensland Interagency Agreement for the safe transport of people accessing mental health assessment, treatment and care (Queensland Health, Queensland Ambulance Service and Queensland Police), suggests that as a general rule, air travel should be considered for journeys that would take more than **two (2) hours** (one way) by road.

If it is not considered appropriate for a patient to travel by air, and road transport over **two (2) hours** is required, admission to the closest AMHS should be considered as the first option.

- It is recognised that Queensland Corrective Services or Queensland Police Service are responsible for the decision on how a patient should travel. The consideration of air travel can only be a recommendation to these services.

If the referring service determines that the person is not fit to travel, referral is to be made to the closest or, if in South East Queensland, the next closest AMHS to the custodial setting. This is to ensure patient safety and quality of care in the first instance.

Once stabilised and fit for travel, patients may be transferred to another AMHS in accordance with the criteria outlined in section 1.9.

As required, the Statewide Coordinator – Classified Patients may be consulted with to identify alternate pathways to admission.

1.9.2 Transport within an AMHS

A classified patient (involuntary) or classified patient (voluntary) may be transported within an AMHS with the approval of the AMHS administrator or health practitioner.

Limited Community Treatment (LCT) is not required for the transport of a classified patient within an AMHS.

The administrator or health practitioner may also approve another person (e.g. consumer support worker) to transport the patient from one place to another in an AMHS.

Transport within a service may occur, for example:

- from one inpatient facility in the AMHS to another, or
- from a community facility in the AMHS to an inpatient facility, or
- from an inpatient facility in the AMHS to another place for examination or diagnostic test.

1.10 Recording and notification requirements on admission

1.10.1 Administrator responsibilities

Key points

As soon as practicable after a classified admission, the administrator must notify the Chief Psychiatrist by sending a copy of the Custodian Consent.

- If the patient is a minor and has been admitted to a HSIS, the administrator must also provide a copy of the Custodian Consent to the Mental Health Review Tribunal.

The administrator must give written notice of the patient's admission to the patient's appointed nominated support person/s. A template letter is available for this purpose in CIMHA.

The administrator must ensure the patient's admission as a classified patient is recorded in CIMHA, including charge and/or sentence details. If the patient is subject to a Treatment Authority, Forensic Order or Treatment Support Order, the administrator must, where applicable:

- change the category of the order or authority to inpatient, and
- cease any existing authorisation for limited community treatment made by an authorised doctor.

1.10.2 Photographs

All classified patients must be photographed. The photograph must be uploaded to CIMHA on admission and as changes to appearance are noted.

1.10.3 Suspension of proceedings

When a person charged with an offence, other than a Commonwealth offence, becomes a classified patient, legal proceedings are suspended until the person's classified status ends.

- This does not affect a Court's authority to make a decision under the *Bail Act 1980*, and does not prevent the charge being discontinued by the prosecuting authority.

The Chief Psychiatrist **must** give notice to the Chief Executive for Justice of the suspension as soon as practicable after the person is admitted. Notice is provided via a copy of the Custodian Consent.

The Chief Executive for Justice is responsible for notifying the relevant court or prosecuting authority of the suspension.

- If the person is a minor, the Chief Executive for Justice **must** also give notice to the Chief Executive for Youth Justice.

2 Assessment, treatment and care

2.1 Examination on admission

As soon as practicable after a patient is admitted or classified admission is commenced, an authorised doctor **must** examine the patient to decide:

- for a patient subject to a Recommendation for Assessment – whether a Treatment Authority is to be made for the patient (see Chief Psychiatrist Policy – Treatment Authorities)
- for a patient subject to a Treatment Authority, Forensic Order (mental health) or Treatment Support Order or a patient who is consenting to treatment and care - the nature and extent of treatment and care to be provided.

In deciding the treatment and care to be provided, the authorised doctor **must** have regard to the patient's views, wishes and preferences including for example, those expressed in an Advance Health Directive.

The authorised doctor **must**:

- consider whether it is clinically appropriate for the patient to receive treatment and care for their mental illness in the inpatient unit. If, after consideration with the

psychiatrist responsible for the patient's care, they are satisfied it is not clinically appropriate they must notify the Chief Psychiatrist. See Section 3.1 Return Events.

- explain the classified provisions to the person (including, for example, the person's detention and their assessment or treatment and care), and
- discuss the nature and extent of treatment to be provided.

If the person is not able to understand the explanation, the authorised doctor may provide the explanation at a later time.

- The authorised doctor may also seek the assistance of an Independent Patient Rights Adviser to provide further explanation about the patient's classified status.

The authorised doctor **must** also explain the information to the patient's support persons unless they consider that an exception to informing the support person applies.

A record of the authorised doctor's examination **must** be documented in, or uploaded to, CIMHA clinical notes. The clinical note **must** include details of:

- the clinical assessment,
- the nature and extent of treatment to be provided, and
- information provided to the patient and their support person, or the reasons why the information was not provided.

An Involuntary Patient and Voluntary High-Risk Patient Summary form for the patient **must** be completed and/or updated on the patient's admission.

Under a Recommendation for Assessment the person may be detained for the assessment for a period of up to **twenty-four (24) hours**.

- An authorised doctor may extend the assessment period up to a maximum of **seventy-two (72) hours** if the extension is necessary to complete the assessment.

2.2 Ongoing treatment and care

The authorised doctor **must** assess the patient at regular intervals to ensure the treatment and care provided continues to be appropriate for the patient's treatment and care needs.

- A record of the patient's treatment and care that is planned and provided **must** be recorded in a clinical note on CIMHA.

The authorised doctor **must** ensure that the patient's treatment and care is discussed with the patient and, where relevant, their support person (See Definitions and abbreviations).

- A record of the doctor's communication with the patient and support person **must** be recorded in CIMHA clinical notes.

The Involuntary Patient and Voluntary High Risk Patient Summary form **must** be regularly updated during the patient's admission.

2.2.1 Limited Community Treatment

An authorised doctor may authorise Limited Community Treatment (LCT) for a classified patient if:

- the Chief Psychiatrist has given written approval for the LCT, and
- the authorised doctor is satisfied the patient is unlikely to abscond from the AMHS while accessing LCT.

LCT for a classified patient **must** be escorted (i.e. in the physical presence of a health service employee) and limited to the grounds and buildings of the AMHS.

LCT is not required for the transport of a classified patient within an AMHS.

The authorised doctor **must** request the written approval by the chief psychiatrist by completing the Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients form.

- This form is to be completed electronically or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

The authorised doctor **must** complete the Order / Authority Amendment form detailing:

- the conditions of LCT,
- the actions to be taken if conditions are not adhered to,
- the duration of LCT, and
- the duration of the authorisation.

LCT taken by the patient **must** be recorded on the Limited Community Treatment Access and Return form and **must** be recorded in, or uploaded to, CIMHA.

2.2.2 Temporary absence

Key points

The Chief Psychiatrist may approve a temporary absence from an AMHS for a classified patient for any of the following reasons:

- to receive medical, dental or other health treatment,
- to appear before a court, tribunal or other body,
- to look for accommodation for the patient for when the patient is discharged from the service,
- for a purpose based on compassionate grounds, or
- for another purpose the Chief Psychiatrist is satisfied is justified.

The authorised doctor must request the written approval of the Chief Psychiatrist by completing the Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients form.

- The form must be completed electronically, or uploaded, in CIMHA.

The Chief Psychiatrist **must** determine the outcome of the request as soon as is practicable and provide the response to the administrator on the Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients.

3 Ending a classified admission

The classified patient provisions no longer apply if:

- a **return event** occurs, and the person is returned to custody, or
- a release event occurs.

3.1 Return events

Key points

An authorised doctor must notify the chief psychiatrist if:

- a classified patient (voluntary) withdraws consent to be treated in the AMHS,
- an assessment period for the person ends, a treatment authority is not made for the person and the person does not become a classified patient (voluntary)
- the person is no longer subject to an authority or order under the Act, and the person does not become a classified patient (voluntary).

In these circumstances, the chief psychiatrist **must** arrange for the person to be returned to custody.

On examination of a classified patient, an authorised doctor **must** notify the Chief Psychiatrist if they are satisfied that it is no longer clinically appropriate for the patient to receive treatment and care in an AMHS.

- The Chief Psychiatrist **must** decide whether or not it is clinically appropriate for the person to receive treatment and care in an AMHS or if they should be returned to custody.

A determination that a person no longer needs to receive treatment and care in an AMHS **must** be made regardless of whether the person was a classified patient (voluntary) or classified patient (Involuntary).

If a classified patient (voluntary) withdraws consent, the authorised doctor **must** ensure that the effect of this decision is discussed with the person and document the outcome of this discussion in a CIMHA clinical note.

Key points

To commence the return of a classified patient to custody, the authorised doctor must send a copy of the Classified Patient (Notice Event) form to the administrator of the AMHS and the Chief Psychiatrist.

- This form must outline the reason why the patient is being returned to custody, and the arrangements for ongoing treatment or care in custody.

The authorised doctor must ensure:

- a verbal handover of clinical care has occurred with a clinician from the service who initiated the classified patient referral,
- all relevant collateral material is provided to the service that will be responsible for the person's care in custody, and
- all relevant collateral material about the admission as a classified patient and the discharge summary is uploaded on CIMHA.

If there is a clinically significant disagreement in relation to treatment needs or capacity to appropriately meet those needs between the authorised doctor at the AMHS and the receiving service, a case discussion should be initiated between PMHS and AMHS. If still cannot be resolved, this issue can be escalated to the Chief Psychiatrist via email at MHA2016@health.qld.gov.au.

All return documentation and collateral material must also be sent to the Statewide Co-ordinator - Classified Patients.

The Chief Psychiatrist may also, on their own initiative, determine that it is no longer clinically appropriate for the person to receive treatment and care in an AMHS and that they should be returned to custody.

- Prior to making a decision, the Chief Psychiatrist will contact the clinical director of the relevant AMHS where the person has been admitted to discuss the return to custody.

3.1.1 Notifications

Key points

As soon as practicable after receiving a Classified Patient (Notice Event), or where the Chief Psychiatrist determines on their own initiative to return a person, the Chief Psychiatrist must provide written notice to:

- the administrator of the relevant AMHS where the person was admitted,
- the referring service,
- the relevant custodian, and
- the Chief Executive for Justice (if charged or awaiting sentence).

The authorised doctor **must** explain the effect of the notice event to the person. The information **must** also be provided to the patient's support person unless the authorised doctor is satisfied that an exception to providing the information applies.

A record of this communication, or reasons why a support person was not informed, should be recorded in a CIMHA clinical note.

3.1.2 Person subject to a Forensic Order

If the person being returned to custody is subject to a Forensic Order the category of their order **must** be changed to community, to enable the person to continue to reside in the place of custody. See Chief Psychiatrist Policy – Forensic Order, Treatment Support Order and Other Identified Higher Risk Patients and Chief Psychiatrist Policy – Amending Categories Conditions and LCT.

If the category of the order is inpatient, the person **must** remain in an inpatient unit of an AMHS under the classified patient provisions**.**

3.1.3 Return to custody

Once notified by the Chief Psychiatrist of a person's return to custody, the custodian must make arrangements for an authorised person to transfer the person from an AMHS to their place of custody within **one (1) day.**

- The person ceases to be a classified patient when discharged into the custody of the Custodian.
- The AMHS administrator must ensure the classified patient status is ceased on CIMHA.

Where the timeframe for transfer cannot reasonably be met due to logistics, the Chief Psychiatrist must be notified via email to MHA2016@health.qld.gov.au and arrangements made for the transfer to take place as soon as practicable.

3.2 Release events

A release event includes for example:

- a person being granted bail, or
- the prosecution being discontinued, or
- the person's sentence ending, or
- parole being granted.

Within **one (1) day** of a release event, the relevant custodian **must** notify the administrator of the AMHS where the classified patient is currently admitted. The person's classified patient status ends immediately after the administrator receives the notice.

- The person may continue to be detained in the AMHS other than as a classified patient.

Key points

The administrator must ensure:

- the classified patient status is ceased on CIMHA,
- the Chief Psychiatrist is notified by way of a Classified Patient (Notice Event) form,
- the person is advised of the ending of the status, and
- the person is not detained in the AMHS as a classified patient.

The person may remain in the AMHS as a voluntary patient or an involuntary patient (e.g. subject to a Forensic Order, Treatment Support Order or Treatment Authority).

Issued under section 305 of the Mental Health Act 2016

Dr John Reilly
Chief Psychiatrist, Queensland Health
22 May 2020

Definitions and abbreviations

Term	Definition
Administrator Consent	The approved form used by the administrator of the relevant AMHS, or the Chief Psychiatrist, to give consent for a classified patient to be admitted for assessment or treatment of a mental illness under the classified patient provisions.
AMHS	Authorised Mental Health Service - a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
Classified Patient (involuntary)	(a) A person who – (i) is subject to any of the following – • A recommendation for assessment • A treatment authority • A forensic order (mental health) • A treatment support order. (ii) Transported under Part 2 from a place of custody to an inpatient unit of an authorised mental health service; and (iii) Admitted to the inpatient unit of the authorised mental health service; or (b) A person who – (i) Is subject to any of the following – • A Treatment Authority • A Forensic Order (mental health) • A Treatment Support Order; and (ii) Remains in an inpatient unit of an authorised mental health service under section 74.

Term	Definition
Classified Patient (voluntary)	(c) A person who – (i) Is transported under Part 2 from a place of custody to an inpatient unit of an authorised mental health service; and (ii) Is admitted to the inpatient unit of the authorised mental health service; and (iii) Consents under section 67 or 79 to receiving treatment and care for the person's mental illness in the inpatient unit of the authorised mental health service; or (d) A person who – (i) Remains in an inpatient unit of an authorised mental health service under section 74; and (ii) Consents under section 74 to receiving treatment and care for the person's mental illness in the inpatient unit of the authorised mental health service.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Custodian Consent	The approved form used by the relevant Custodian to provide consent to the patient's transportation from a custodial facility and the custody of the relevant Custodian to an inpatient unit of an AMHS under the classified patient provisions.
Collateral material	Any material currently available to a doctor or authorised mental health practitioner making a recommendation that is relevant to the assessment, treatment, care and management of the patient and includes clinical notes, medication chart, risk screen, court hearing and discharge dates, details of offences, and verdict and judgment records.
Custodian	Determined with reference to the relevant authority responsible for the person prior to their transport to an AMHS. Examples include Queensland Corrective Services, Queensland Police Service, Queensland Youth Justice or another custodian, such as the Australia Federal Police or Australian Border Force.
Exceptions to informing support person	Means circumstances where: • the patient requests that the communication with the support person not occur, and the authorised doctor considers the patient has capacity to make the request. • the support person is not readily available or is not willing to communicate, or • communication with the support person is likely to be detrimental to the patient's health and wellbeing.
HSIS	High security inpatient service.

Term	Definition
Person subject to custodial order	Includes persons remanded without bail for a charge or awaiting a sentence, sentenced prisoners, and other persons lawfully detained under another Act.
Recommendation	A Recommendation for Assessment or Transfer Recommendation
Referring service	The service responsible for making the Recommendation.
South East Queensland	Includes the Children's Health Queensland., Darling Downs, Gold Coast, The Park – Centre for Mental Health Service, The Park – High Security Program, Metro North (Redcliffe-Caboolture, Royal Brisbane Women's Hospital, The Prince Charles Hospital), Metro South (Bayside, Logan and Princess Alexandra), Sunshine Coast and West Moreton AMHSs.
Support person	In relation to the requirement to explain or discuss a matter with support persons; support person means a nominated support person, a family member, carer or other support person.

Referenced forms, clinical notes and templates:
Administrator Consent form
Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients form
Classified Patient (Notice Event) form
Custodian Consent form
Involuntary Patient and Voluntary High Risk Patient Summary clinical note
Limited Community Treatment Access and Return form
Order / Authority Amendment form
Recommendation for Assessment form
Transfer Recommendation form

Referenced documents and sources
Chief Psychiatrist Policy: Classified Patients
Bail Act 1980
Mental Health Act 2016

Document status summary	
Date of Chief Psychiatrist approval:	22 May 2020
Date of effect:	1 June 2020
Supersedes version that took effect on:	5 March 2017
To be reviewed by:	1 June 2023

Attachment 1 – Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@qhealth.qld.gov.au
Statewide Coordinator – Classified Patients	Phone: 07 3837 5820 Email: ClassifiedPatientsMHA2016@health.qld.gov.au
Clinical Director/Administrator	Phone: Email:
Mental Health Administration Delegate	Phone: Email:
Independent Patient Rights Adviser	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Attachment 2 – Terms of reference for Classified Patient Committee

Purpose

The purpose of the Classified Patient Committee (CPC) is to provide a forum for discussion, review and resolution of issues, and provision of advice, in relation to the Chief Psychiatrist Policy - Classified Patients regarding the transportation, admission, treatment and care, and return of classified patients.

Functions

The CPC will:

1. At least four times per year, as a whole committee, review:
    - referrals made in the preceding three months
    - policy and operational processes
    - complex cases, and
    - the agreed number of minimum statewide classified beds and the breakup of those beds across AMHSs; the CPC may recommend to the Chief Psychiatrist a change to the statewide bed numbers and the breakup of those beds across AMHSs.
2. Meet on an 'as needed' basis with the relevant members to resolve a referral, admission or return concern. When a matter cannot be resolved the matter is to be referred to the Chief Psychiatrist to make a determination.

Membership

The CPC is comprised of:

- the Chief Psychiatrist,
- the Director of Queensland Forensic Mental Health Service,
- the administrators of each AMHS,
- clinical directors of the Court Liaison Service,
- clinical directors of Prison Mental Health Services, and
- the Statewide Coordinator – Classified Patients.

Member responsibilities

It is expected that all members will:

- attend and contribute to meetings or nominate a proxy,
- ensure any nominated proxy is briefed about the purpose and functions of the committee and is given the authority to make decisions on behalf of the member, and
- represent the perspectives of the specific service they represent.

Proxy

Members may nominate a proxy to attend a meeting on their behalf. When a proxy is nominated, the member is to notify the secretariat of the nomination prior to the meeting.

Governance

The CPC will be chaired by the Chief Psychiatrist or nominated delegate. The chair will ensure the committee focuses on matters relevant to its function and considers each matter with propriety. Secretariat support will be provided by the Office of the Chief Psychiatrist.

Frequency of meetings

The CPC is required to meet four (4) times a year as a whole committee and on an as needed basis with the relevant members.

Quorum

Whole committee meetings will proceed on the basis that a quorum of half of the membership is represented.

Meetings on an as needed basis can proceed when at least the following relevant members are in attendance:

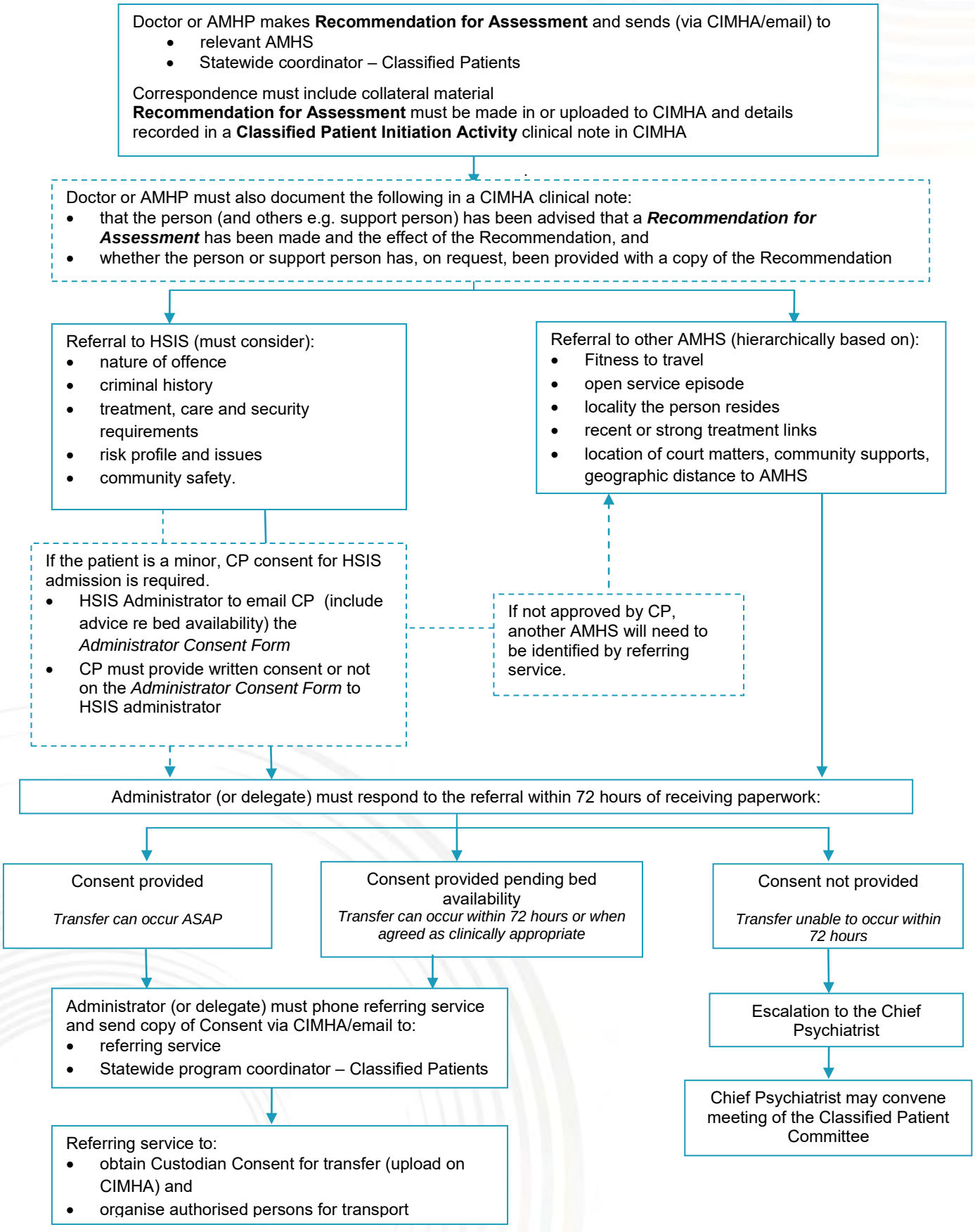
- administrator of the relevant AMHS, and
- clinical director of the referring service, and
- the Chief Psychiatrist or their nominated proxy.

Review of terms of reference

The Terms of Reference may be amended at any time by the Chief Psychiatrist or by a majority agreement of the CPC and approval by the Chief Psychiatrist.

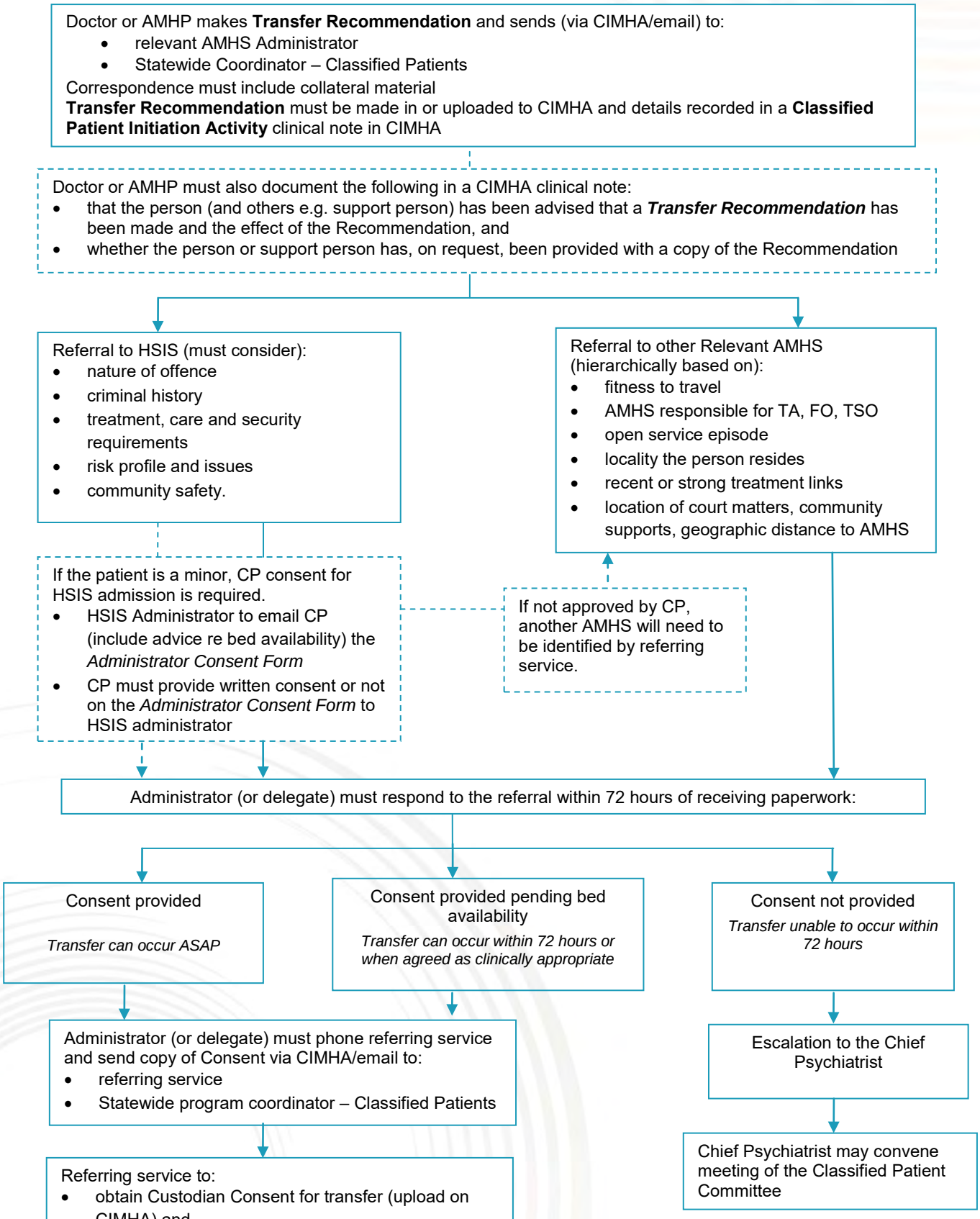
Attachment 1 Flowchart 1 - Transport for assessment

Applies to person in custody and subject to Recommendation for Assessment



Attachment 2 Flowchart 2 – Transport for treatment and care

**Applies to person in custody and subject to Treatment Authority (TA), Forensic Order (mental health) (FO), Treatment Support Order (TSO) or a person who consents to treatment and care in an AMHS



Mental Health Act 2016

Chief Psychiatrist Policy

Clinical need for medication

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Queensland Government

General

The *Mental Health Act 2016* (the Act) makes it an offence for a person to administer medication to a patient unless the medication is clinically necessary for the patient's treatment and care for a medical condition.

Treatment and care of a medical condition includes preventing imminent serious harm to the patient, or others. Medication includes the use of sedation.

Authorised mental health services (AMHSs) are responsible for the quality use of medicines (QUM) under the *National Strategy for QUM*, within the *National Medicines Policy*.

QUM involves:

- a considered selection of treatment options,
    - medicines, whether prescribed, recommended, and/or self-selected should be used only when appropriate, with non-medicinal alternatives considered as needed
- appropriate choice of medicine when medicine is required, and
- safe and effective use of medicines.

In addition, AMHSs must comply with the *National Safety and Quality Health Service Standards*. These include medication safety, with the intention of ensuring that competent clinicians safely prescribe and administer appropriate medicines to informed patients and carers.

Scope

This policy is mandatory for all Authorised Mental Health Services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

Key Points

AMHSs **must** apply their local clinical governance arrangements in monitoring the appropriate use of medications for persons with a mental illness.

- The use of medications outside of the usual indications or doses must be monitored within each AMHS under these clinical governance arrangements.

The Chief Psychiatrist may be contacted for guidance on these matters.

The Chief Psychiatrist may audit the use of medications in AMHSs.

The Chief Psychiatrist may investigate the use of medications for a non-therapeutic purpose.

In undertaking an investigation, the Chief Psychiatrist may seek advice from a senior clinician with specific expertise in the use of the medication.

Where it is found that the use of a particular medication has no therapeutic benefit to a patient, the Chief Psychiatrist may issue directives about the administration of certain medications or dosages of certain medications.

1 Notifications

Key Points

The AMHS administrator or a clinical director **must** notify the Chief Psychiatrist as soon as practicable if they have any concerns regarding the non-therapeutic use of a medication on a patient.

The Chief Psychiatrist **must** be notified immediately where the use of a medication results in or appears to be associated with:

- the death of a patient during the use of the medication or within 24 hours of the use of the medication, or
- significant harm to a patient during the use of the medication or within 24 hours of the use of the medication.

Notifications must be made by the AMHS administrator or a clinical director (or appropriately delegated person) via phone or email to the Chief Psychiatrist.

Notifications are in addition to AMHS responsibilities under the Chief Psychiatrist Policy - Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with Act.

2 Monitoring and Reporting

Monitoring the use of medication that is used outside clinical indications or outside the usual dosage range is necessary to ensure the appropriate use of medications in AMHSs. De-identified and aggregate data may be publicly reported in the Chief Psychiatrist Annual Report in accordance with national standards.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
Clinical Director	Means a senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the clinical director functions and responsibilities.
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.
Relevant AMHS administrator	The relevant AMHS administrator is: • the administrator of the AMHS currently providing clinical services to the person, or • if the person is not currently receiving mental health services (i.e. no open service episode), the administrator of the AMHS for the location where the person resides.

Referenced documents and sources
Chief Psychiatrist Policy – Notifications to the Chief Psychiatrist of critical incidents and non-compliance with the Act
National Safety and Quality Health Service Standards
Quality Use of Medicines under the National Strategy for QUM

Document status summary	
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Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Local AMHS Administrator	Name: Phone: Email:
Local AMHS Administrator Delegate	Name: Phone: Email:
Clinical Director	Name: Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Mental Health Act 2016

Chief Psychiatrist Policy

Court Liaison Service

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General

The *Mental Health Act 2016* (the Act) gives the Magistrates Court powers to dismiss complaints if a person was, or appears to have been, of unsound mind when the alleged offence was committed, or is unfit for trial.

The Queensland Health (QH) Court Liaison Service (CLS) supports these provisions by assisting in the identification of mental health treatment needs of a person and facilitating appropriate referral to services, including diversion from the criminal justice system.

The CLS also assists the Magistrates Court in their disposal of simple offences, by undertaking Mental Health Assessments in relation to a person's unsoundness of mind at the time of committing the alleged offence or fitness for trial. These assessments are conducted by accredited senior mental health clinicians with the support of a consultant psychiatrist, to assist Magistrates.

Scope

This policy must be read in conjunction with the relevant provisions in Chapter 6, Part 2 and Chapter 17, Part 3 of the Act and other relevant Chief Psychiatrist Policies.

This policy is mandatory for all authorised mental health service (AMHS) staff exercising a power or function under the Act.

This policy is mandatory for authorised psychiatrists, authorised doctors, health practitioners and other staff of an AMHS who work within the CLS.

Policy

1 Communicating information and disclosure

1.1 Court lists

Each business morning a Court Liaison Service Practitioner (CLSP) **must**:

- process a CIMHA/QWIC match in CIMHA.
- compile a list of all persons currently subject to a Forensic Order, Treatment Support Order or Treatment Authority identified on the court list for that day by completing the *CLS Notification of Involuntary Patients on Court List form* (Available from the Queensland Forensic Mental Health Service).
- provide the CLS *Notification of Involuntary Patients on Court List form* to the CLS administration by email.

1.2 Providing information to a lawyer

A CLSP may disclose personal information about a patient to a lawyer if the disclosure is to enable the lawyer to provide legal services to a person for a court or tribunal proceeding.

Personal information includes the patient's health records and written notices given under the Act.

1.3 Tendering report to Courts

A Mental Health Assessment is tendered to the Magistrates Court by the CLSP emailing the report to the Registrar of the Magistrates Court in which the matter is to be heard.

The Registrar will provide a copy of the report to the person (or the person's lawyer), the prosecutor and the Magistrate.

2 Referrals between services

Referral to Prison Mental Health Service (PMHS) **must** occur when a person is charged with murder, attempt murder, arson and stalking, regardless of whether mental illness has been identified.

Decisions as to whether a referral to PMHS occurs must take into consideration:

- evidence of an acute mental illness based on the person's previous or collateral history, presentation at assessment and whether or not a recommendation for assessment is made, and
- whether the person is currently open to an AMHS, has had recent contact with a mental health service or emergency department for the purposes of mental health treatment and/or assessment or is receiving private treatment for a major mental illness, and
- if the person has a diagnosis of and/or is prescribed medication for treatment of a major mental illness.

CLS referrals to PMHS must be made in accordance with section 2.1 of this document.

Where PMHS become aware that a patient from their service will transition though a watch-house and will require assistance from a CLSP, the steps set out in section 2.2 must be followed.

2.1 CLS referral to Prison Mental Health Service

When making a referral to PMHS, CLS **must** provide:

- a copy of the *Forensic Intake form*, including rationale for referral and relevant court and corrective services information, and
- all other collateral obtained by the CLSP (if material not already on CIMHA), and
- if the CLSP has arranged for the administration of depot medication whilst the person is held in the watch-house, a copy of the signed medication chart, including details of the medication given, time given, and name of the person who administered the medication, and

- if the person is prescribed clozapine, the details of the prescription and administration whilst in watch-house and any information the CLSP has regarding details of last blood test and/or when next blood test is due, and
- any other information the CLSP considers relevant.

2.2 Prison Mental Health Service referral to the Court Liaison Service

If the PMHS is aware that a current patient of their service is to transition through a watch-house and requires assistance from a CLSP, PMHS **must:**

- advise the CLSP at the local Magistrates Court, and
- provide any collateral material and information relevant to the CLSP assisting the person.

Provision of service to persons open to PMHS exiting custody via court is to be negotiated with the CLSP on a case by case basis.

2.3 Court Liaison Service referrals for children and young persons

Most child and youth mental health services are voluntary facilities, meaning that CLS can only make a referral to the service where the young person has consented to engage with their services.

If the young person has consented to be referred to a service, CLS must complete the referral in accordance with the relevant service's referral policies, guidelines or procedures.

2.4 Liaison with authorised mental health services

The CLSPs **must** provide any relevant and available collateral material and information to assist the AMHS in providing appropriate treatment and care for the person.

In relation to a person subject to an Examination Order, the Chief Psychiatrist Policy - Judicial Orders **must** be followed.

In relation to a person subject to the classified patient provisions, the Chief Psychiatrist Policy - Classified Patients **must** be followed.

3 Court Liaison Service responsibilities

3.1 Governance

Local case review meetings should occur on a **weekly** basis and include, as far as practicable, all CLSPs within that local location.

All CLSPs **must** complete training, in addition to any local service required training, as determined by the Queensland Forensic Mental Health Service and Child and Youth Forensic Outreach Service.

3.2 Mental Health Assessments – Training and accreditation

The CLS has two primary functions:

- to assist in the identification of mental health treatment needs of a person and facilitating appropriate referral to services, including diversion from the criminal justice system, and
- to assist the Magistrates Court in their disposal of simple offences, by undertaking Mental Health Assessments in relation to a person's unsoundness of mind at the time of committing the alleged offence or fitness for trial.

In performing the first function of the CLS all mental health clinicians employed by the CLS may undertake assessments to assist in the identification of mental health treatment needs of a person and facilitating appropriate referral to services, including diversion from the criminal justice system.

In performing the second function, due to the requirements of the Magistrates Court in relation to evidence and witness testimony, Mental Health Assessments[1] can only be undertaken by senior mental health clinicians that have received accreditation from the Chief Psychiatrist.

[1] Means a report relating to a mental health assessment, fitness for trial or unsoundness of mind that is prepared by an accredited senior mental health clinician with the support of a consultant psychiatrist.

Accreditation requirements for Mental Health Assessments

Prior to receiving accreditation to provide Mental Health Assessments, senior mental health clinicians **must**:

- be employed within the CLS at a level equal to, or higher than, Nurse Grade 7 or Health Practitioner Level 4, and
- participate in a number of standardised education and training activities provided by the CLS.

Education and training activities provided by the CLS include but may not be limited to:

- orientation topics detailing specific elements of their role, report writing requirements, and ethical issues and principles in forensic psychiatry, and child and youth specific training (if applicable), and
- three training components based on expert witness testimony, fitness for trial concepts, and soundness of mind concepts.

Accredited senior mental health clinicians **must** also attend regular training and professional events, including regional and statewide CLS meetings and the annual CLS symposium.

3.3 Recordkeeping and recording of data

CLSPs **must:**

- keep records in CIMHA of all persons referred to, offered assessment or assessed by, the CLS, and provide data as required by the Chief Psychiatrist, and
- Complete all relevant fields in the CLS module on CIMHA.

All documents that contain clinical information about a person and the interactions that CLSPs have with persons **must** be uploaded to CIMHA. This includes, but is not limited to:

- feedback or advice provided to a Magistrates Court in relation to a person,
- reports prepared by a CLSP in relation to a Mental Health Assessment,
- referrals made or generated to the CLS where the person declines an examination – even if this requires a new record to the be opened for the person in CIMHA, and
- collateral material that is obtained by a CLSP, including QP9s.

All clinical assessments conducted by a CLSP **must** be completed in CIMHA on the Forensic Intake form or the Child and Youth specific report template.

If this is not possible, they **must** be completed in hard copy and uploaded to CIMHA.

3.4 Access to Queensland Wide Interlinked Court system

Key points

QH requires access to the Queensland Wide Interlinked Court System (QWIC) to achieve an effective and efficient method of identifying individuals who have a mental illness and are in contact with the justice system.

QWIC data is provided to QH for uploading into CIMHA each business day.

The access and use of data in QWIC or QWIC data uploaded to CIMHA is governed by a Memorandum of Understanding (MOU) between the Queensland Court Service and QH.

The purpose of the MOU is to provide a protocol for the use of QWIC by users who have been granted access to QWIC in accordance with the MOU.

Only CLSPs who have been granted a QWIC licence can access the QWIC match module in CIMHA.

Before a person can be granted access to QWIC, the person will need to sign a QWIC User Responsibility Agreement, complete the QWIC Access Application and ensure familiarity with the responsibilities stated below:

- only users granted access to QWIC may access QWIC.
- users can only access and print information on matters relating to their functions.
- users can only access the QWIC screens.
- users will not download or record, either electronically or in hard copy or in any other manner whatsoever, any data on QWIC other than directly relevant to matters relating to their functions.
- users will comply at all times with the Information Privacy Act 2009, the Queensland Government's Information Standard 18 – Information Security and the QWIC Security Application Policy and Rules contained in the QWIC Application Security manual.
- users will not disclose any QWIC information to any person or use it for any reason other than to fulfil the person's function.
- users must not disclose their QWIC or CIMHA login information to any other person.

All access to QWIC by users will be logged, and the Queensland Court Service may at any time conduct a random audit of the log to confirm Queensland Health's compliance with its responsibilities under the memorandum of understanding.

Issued under section 305 of the Mental Health Act 2016.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and Abbreviations

Term	Definition
AMHS	Authorised Mental Health Service - a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
CLS Administration	Means the administration officers employed by the Queensland Forensic Mental Health Service or Child and Youth Forensic Outreach Service.
CLS	Court Liaison Service and Child and Youth Court Liaison Service
CLSP	Court Liaison Service Practitioners
Mental Health Assessment	Means a report relating to a mental health assessment, fitness for trial or unsoundness of mind that is prepared by an accredited senior mental health clinician with the support of a consultant psychiatrist.
MOU	Memorandum of Understanding
PMHS	Prison Mental Health Service
Serious offence	Means an indictable offence other than an indictable offence that must be heard by a Magistrate.
QFMHS	Queensland Forensic Mental Health Service
QH	Queensland Health
QWIC	Queensland Wide Interlinked Court (system)

Referenced forms, clinical notes and templates

CLS Notification of Involuntary Patients on Court List form (available from QFMHS)
CLS Magistrates Court Report – Form 1: Mental Health Assessment Court Liaison Service Report (available from QFMHS)
CLS Magistrates Court Report – Form 2: Mental Health and Fitness for Trial Assessment Court Liaison Service Report (available from QFMHS)
CLS Magistrates Court Report – Form 3: Mental Health, Fitness and Soundness Assessment Court Liaison Service Report (available from QFMHS)
Forensic Intake form (available in CIMHA)
Referral to Forensic CYMHS (MHATODS) form

Referenced documents and sources

Chief Psychiatrist Policy – Classified Patients
Chief Psychiatrist Policy – Judicial Orders
Memorandum of Understanding (MOU) between the Queensland Court Service and Queensland Health
Magistrates Courts Practice Direction No. 1 of 2017 – Mental Health Act 2016 proceedings in the Magistrates Court
Magistrates Courts Practice Direction No. 7 of 2017 – Mental Health Act 2016 proceedings in the Children's Court when constituted by a Magistrate
Mental Health Act 2016
Information Privacy Act 2009
Mental Health Amendment Bill 2016 (Explanatory Notes)
Queensland Government's Information Standard 18 – Information Security

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Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Statewide Coordinator Court Liaison Service	Phone: Email:
Local Independent Patient Rights Adviser	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Mental Health Act 2016
Chief Psychiatrist Policy

Electroconvulsive therapy

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General

Electroconvulsive therapy (ECT) is a 'regulated treatment' under the *Mental Health Act 2016* (the Act). ECT is an evidence-based treatment for certain severe psychiatric disorders. It can also be used as a maintenance treatment for certain severe psychiatric disorders.

ECT may only be performed with the informed consent of an adult patient, with the approval of the Mental Health Review Tribunal (MHRT), or in emergency circumstances to save a relevant patient's[1] life or prevent the patient suffering irreparable harm.

The Queensland Health Guidelines for the Administration of Electroconvulsive Therapy outline best practice in the administration of ECT.

Scope

This policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

This policy **must** be read in conjunction with the relevant provisions of the Act.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

[1] A relevant patient is an involuntary patient subject to a treatment authority, forensic order or treatment support order, or person from interstate detained in an AMHS.

Policy

1 Application of ECT provisions

Key points

ECT may only be performed in the following circumstances:

- with the informed consent of an adult patient
- for an adult who is unable to give informed consent – with the approval of the MHRT
- for a minor – with the approval of the MHRT, or
- for certain involuntary patients in emergency circumstances (see section 4).

ECT may only be performed in an AMHS.

It is an offence to perform ECT other than in accordance with the Act.

The Queensland Health Guidelines for the Administration of Electroconvulsive Therapy outline a consistent, evidence-based approach to the administration of ECT.

2 Performance of ECT with consent

ECT may be performed with the informed consent of an adult patient.

Informed consent for ECT is given by a person only if:

- the person has capacity to give consent to the treatment, and
- the consent is in writing, signed by the person, and
- the consent is given freely and voluntarily.

A minor, or their parent or guardian, **cannot give consent** to undertake ECT.

2.1 Requirements for informed consent

Key points

The requirements for obtaining informed consent are established under the Queensland Health Guidelines for the Administration of Electroconvulsive Therapy.

The Act also requires that before informed consent can be provided, the doctor proposing the treatment **must** give the person a full explanation, in a form and language able to be understood by the person, about:

- the purpose, method, likely duration and expected benefit of the treatment, and
- possible pain, discomfort, risks and side effects associated with the treatment, and
- alternative methods of treatment available to the person, and
- the consequences of not receiving treatment.

Informed consent **must be documented** on the Consent Agreement for Electroconvulsive Therapy form. Once completed, the Agreement must be uploaded on the patient's clinical record in CIMHA.

2.1.1 Individuals subject to a Treatment Authority

In making a Treatment Authority, an authorised doctor has determined that a person does not have capacity to consent to treatment for their mental illness. However, a person's lack of capacity to consent to treatment for their mental illness does not automatically apply to regulated treatments, including ECT, and an assessment as to whether the person on a treatment authority can give informed consent to ECT must be made.

If a person on a Treatment Authority is assessed by an authorised doctor as having capacity to provide informed consent to ECT, given the particular vulnerabilities that a person on a Treatment Authority may have in relation to providing consent to treatments, it is recommended that a second opinion be sought, including by clinical review. Such opinion should consider both capacity to give informed consent to ECT and whether the treatment criterion that the person does not have capacity to be treated for their mental illness continues to be met.

If an authorised doctor cannot determine that a person on a Treatment Authority has capacity, the matter should be referred to the MHRT for a decision.

If an authorised doctor determines that a patient on a Treatment Authority has capacity to consent to ECT, this assessment must be reviewed prior to each treatment of ECT and be documented on the patient record (i.e. progress note). If, within the patient's course of ECT, they are assessed as not having capacity, the matter should be referred to the MHRT for a decision prior to the next ECT treatment being given.

2.1.2 Advance Health Directives

The Act states that, for an adult patient, informed consent for ECT can be provided in an Advance Health Directive (AHD).

A patient's capacity to provide informed consent for ECT should be assessed in the first instance before consideration of consent provided in an AHD.

If the patient has lost the capacity to provide informed consent for ECT and an AHD directs that ECT **can** be performed, the doctor may still apply to the MHRT for approval to perform ECT if not satisfied consent provided in an AHD can be relied upon in the circumstances.

If the patient has lost the capacity to provide informed consent for ECT and an AHD directs that ECT **cannot** be performed, the doctor may still apply to the MHRT for approval to perform ECT.

Key points

- The MHRT in making their decisions must have regard to the directions given by the patient in the AHD.
- The doctor must inform the MHRT of the direction provided for in the patient's AHD.

The *Guardianship and Administration Act 2000* establishes ECT as 'special health care'.

- Consent for ECT **cannot** be given by a substitute decision maker or the Queensland Civil and Administrative Tribunal (QCAT).

3 Performance of ECT with MHRT approval

Key points

A doctor may apply to the MHRT for approval to perform ECT if:

- the patient is an adult and
  - the doctor is satisfied they are unable to give informed consent to the ECT, and
  - consent to ECT has not been provided in an AHD or the doctor is not satisfied consent provided in an AHD can be relied upon under the circumstances, or
- the patient is a minor.

Prior to a doctor making an application to the MHRT, a psychiatrist must prescribe ECT, having regard to the person's clinical condition, treatment history and any known views, wishes and preferences that the patient may have, or had in the past, in relation to ECT.

When making a decision about appropriateness of ECT, the patient's support person/s (see definitions) should be contacted to discuss any known views, wishes and preferences that the patient may have had in the past in relation to ECT.

It is recommended that a second opinion from another psychiatrist be obtained to inform the doctor's decision about applying for ECT.

- If obtained, the second opinion must accompany any application to the MHRT.

The doctor must complete a Treatment Application - ECT when making an application to the MHRT.

- The application form is available as a clinical note in CIMHA.

The doctor must provide the Treatment Application - ECT to the administrator of the AMHS. The administrator must forward the application to the MHRT without delay.

The doctor making the Treatment Application – ECT **must** to the extent practicable, tell the patient the application has been made and explain the application to the patient. The application **must** also be explained to the person's support person/s.

An application for ECT **must** be heard by the MHRT within **fourteen (14) days** of receiving the Treatment Application - ECT.

The MHRT requires the Treatment Application - ECT at least **seven (7) days** before a scheduled hearing date.

On receipt of the application, the MHRT **must** notify the following people of the hearing date:

- the subject of the application,
- the doctor who made the application, and
- the administrator of the treating AMHS.

4 Performance of ECT in an emergency

Key points

ECT may be performed in an emergency for a relevant patient.

A relevant patient is:

- subject to a Treatment Authority, Forensic Order or Treatment Support Order, or
- absent without permission from an interstate mental health service and detained in an AMHS.

The performance of ECT in an emergency can only occur if:

- a doctor for an AMHS and the senior medical administrator of the patient's treating health service have certified in writing (Certificate to Perform Emergency ECT) that performing ECT is necessary to:
  - save the patient's life, or
  - prevent the patient from suffering irreparable harm, and
- a Treatment Application - ECT has been made to the MHRT but is not yet decided.

The Certificate to Perform Emergency ECT must be completed electronically in CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

A Certificate to Perform Emergency ECT is in force for the period:

- starting on the day the Treatment Application - ECT to the MHRT was made, and
- ending on the day the Treatment Application - ECT is determined by the MHRT.

If a Certificate to Perform Emergency ECT is made, the MHRT must hear the Treatment Application - ECT as soon as practicable.

A Treatment Application - ECT to the MHRT may be made before, or at the time of, the Certificate to Perform Emergency ECT being made.

- There may be clinical circumstances where the Certificate to Perform Emergency ECT is completed after a Treatment Application - ECT has already been lodged with the MHRT.

The doctor must immediately provide the document/s to the AMHS administrator.

The AMHS administrator must immediately forward the document/s to the MHRT.

The doctor making the Certificate to Perform Emergency ECT must, to the extent practicable:

- tell the patient the Certificate has been made, and
- explain the Certificate to the patient.

The Certificate must also be explained to the person's support person/s.

The clinical rationale for the emergency performance of ECT must be provided on the Certificate to Perform Emergency ECT and documented in a clinical note.

Particular attention should be given to documenting the rationale and modified treatment plan in circumstances where a Certificate to Perform Emergency ECT is made after a Treatment Application – ECT was lodged with the MHRT.

5 MHRT decisions for treatment applications

Key points

The MHRT cannot approve an application to perform ECT unless satisfied:

- the performance of ECT on the patient is in their best interests, and
- evidence supports the effectiveness of ECT for the patient's particular mental illness, and
- if ECT has previously been performed on the patient – of the effectiveness of ECT for the patient, and
- if the patient is a minor – evidence supports the effectiveness of ECT for persons of the patient's age.

In deciding a Treatment Application – ECT, the MHRT **must** have regard to:

- if the Application relates to an adult – any views, wishes and preferences the adult has expressed about the therapy in an AHD.
    - In making the Application the doctor should also identify the views, wishes and preferences expressed by the adult at other times or in other documents (e.g. clinical notes) and ensure these are reflected in the Application.
- if the Application relates to a minor – the views of the minor's parents and the views, wishes and preferences of the minor.

If the MHRT decides to approve the Application, its decision must state the number of treatments that may be performed in a stated period under the approval, and any conditions the MHRT considers appropriate.

The MHRT **must** notify the following people of their decision within **seven (7) days** of the hearing:

- the person the subject of the Application
- the doctor who made the Application, and
- the Administrator of the treating AMHS.

In giving its decision, the MHRT **must** provide information about entitlements to seek reasons for the MHRT decision and to appeal the decision to the Mental Health Court.

5.1 Legal representation and support

The MHRT **must** appoint legal representation for patients at no cost for all hearings where a Treatment Application – ECT is being considered.

The MHRT website provides further information regarding the process of appointing legal representation.

A patient may also be accompanied at the MHRT hearing by a support person. Support person includes an appointed Nominated Support Person or a family member, carer or other support person. With the leave of the MHRT, more than one support person may attend the hearing.

Issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly

Chief Psychiatrist, Queensland Health

22 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
ECT	Electroconvulsive therapy
MHRT	Mental Health Review Tribunal
QCAT	Queensland Civil and Administrative Tribunal
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.
Support person	An appointed nominated support person or, if the person does not have a nominated support person, a family member, carer or other support person.

Referenced forms, clinical notes and templates
Form: Treatment Application – ECT
Form: Certificate to Perform Emergency ECT
Form: Consent Agreement for Electroconvulsive Therapy

Referenced documents and sources
The Queensland Health Guidelines for the Administration of Electroconvulsive Therapy
Mental Health Act 2016
Guardianship and Administration Act 2000

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Attachment 1 – Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone:07 3328 9899 / 1800 989 451 Email:MHA2016@health.qld.gov.au
Local Independent Patient Rights Adviser	Phone: Email:
Office of the Public Guardian	Phone: Email:
Mental Health Review Tribunal	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Mental Health Act 2016

Chief Psychiatrist Policy

Examination and assessment

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Queensland Government

General

The Act promotes the voluntary engagement of people in mental health assessment, treatment and care wherever possible. When it is not possible to provide the required examination and assessment with consent, the involuntary processes in the *Mental Health Act 2016* (the Act) may be applied.

A doctor or authorised mental health practitioner (AMHP) may examine a person to decide if a Recommendation for Assessment should be made for the person. The purpose of the assessment is to decide whether a Treatment Authority should be made to authorise involuntary treatment and care for the person during the period when they have no capacity to consent to the treatment.

Strict criteria and requirements apply to making a Recommendation for Assessment and undertaking an involuntary assessment.

Scope

This policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, AMHP, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this Policy.

This policy **must** be read in conjunction with the Chief Psychiatrist Policy – Treatment Criteria, Assessment of Capacity and Less Restrictive way of Treatment.

Clinicians should work collaboratively and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Examination and assessment

1.1 Examinations for Recommendation for Assessment

A doctor or AMHP may examine a person to decide if a Recommendation for Assessment should be made for the person.

A person may be examined by a doctor or AMHP at any location that is clinically appropriate, including in an AMHS, a public sector health service facility (PSHSF) or a person's home.

An examination may be undertaken by audio-visual link if the doctor or AMHP examining the person believes it is clinically appropriate.

1.2 Making a Recommendation for Assessment

A Recommendation for Assessment can only be made if the doctor or AMHP has examined the person within the last **seven (7) days**.

The doctor or AMHP can only make the Recommendation for Assessment if satisfied that:

- the treatment criteria may apply to the person, and
- there appears to be no less restrictive way for the person to receive treatment and care for the person's mental illness.

The *Flowchart – Determining if a Recommendation for Assessment can be made* sets out the decision-making process for making a Recommendation for Assessment.

1.2.1 Treatment Criteria

The 'treatment criteria' means all of the following:

- the person has a mental illness,
- the person does not have capacity to consent to be treated for the illness, and
- because of the person's illness, the absence of involuntary treatment or the absence of continued involuntary treatment, is likely to result in:
  - imminent serious harm to the person or others, or
  - the person suffering serious mental or physical deterioration.

The doctor or AMHP must be satisfied that the **treatment criteria may** apply to the person. A definitive conclusion is not required, however there must be sufficient evidence to support their view on each criterion.

For further information on the treatment criteria please refer to the Chief Psychiatrist Policy - Treatment Criteria, Assessment of Capacity and Least Restrictive Way and Advance Health Directives.

1.2.2 Less Restrictive Way

The 'less restrictive way' of receiving treatment and care refers to alternatives to involuntary treatment under a Treatment Authority.

A Recommendation for Assessment may only be made if there appears to be no less restrictive way for the patient to receive treatment and care.

In order to meet this requirement, the doctor or AMHP needs to consider if, after an examination of the person, it is likely that the person would not be able to receive treatment or care under one of the following less restrictive ways:

- if the person is a minor - with the consent of a parent,

- under an Advance Health Directive (AHD) - with consent provided in directions in the AHD or with the consent of an attorney appointed under the AHD,
- with the consent of a guardian appointed for the person.
- with the consent of an attorney appointed under an Enduring Power of Attorney (EPOA), or
- with the consent of a statutory health attorney.

Less restrictive ways **must** be considered in the order listed above.

The doctor or AMHP need only be satisfied that there **appears** to be no less restrictive way. This recognises the clinical circumstances in which an examination by a doctor or AMHP may occur (i.e. obtaining definitive information will not be practicable in many circumstances) and that more comprehensive information gathering of less restrictive options will occur in the involuntary assessment process.

For a complete and detailed version of the less restrictive way please refer to the Chief Psychiatrist Policy - Treatment Criteria, Assessment of Capacity, Less Restrictive Way and Advance Health Directives.

1.3 Information to be provided

If a Recommendation for Assessment is made, the doctor or AMHP **must** tell the person and their support person/s of the decision and the effect of the recommendation. This includes an explanation of the doctor's or health practitioner's view in relation to the treatment criteria. For the person, the explanation will take account of clinical considerations and minimising any potential adverse impact on the person's health and wellbeing.

Support person/s here means an appointed nominated support person or, if the person has not appointed a nominated support person, then a family member, carer or other support person.

A copy of the Recommendation for Assessment form may be requested by the person, their appointed nominated support person/s, guardian or attorney under an AHD or EPOA. A copy of the Recommendation for Assessment form **must** be provided on request. However, a copy is not required to be provided to the person if the doctor or AMHP believes that this may adversely affect the person's health and wellbeing.

1.4 Recording requirements

The Recommendation for Assessment (if made) **must** be completed electronically in CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

In addition, a record of the doctor or AMHP's examination must be documented in, or uploaded to, CIMHA clinical notes. The documentation is to include:

- a record of the examination, including information obtained from the person and other sources, and the details of the mental state examination,
- the evidence relating to mental illness, capacity to consent, and risks associated with harm or serious deterioration,
- if the person lacked capacity to consent and the doctor or health practitioner identified that the person had an AHD or alternate decision maker, the actions taken and the outcome of those actions, or the reasons why action was not taken,
- if the doctor or health practitioner determined the assessment could be conducted on the basis of consent given in an AHD or by an alternate decision maker, a clear statement of the consent provided i.e. including a record of consent for detention where this is expressly stated in the AHD or explicitly provided by the alternate decision maker, and
- the information provided to the person, and where relevant, their support person/s, or the reasons for not providing the information to the person.

If the doctor or health practitioner identifies an AHD, EPOA or Queensland Civil and Administrative Tribunal (QCAT) decision maker that is not already recorded in CIMHA, the document must be uploaded to CIMHA as soon as practicable. (Refer to CIMHA Clinician Handbook Vol 6: MHA 2016).

1.5 Detention for the purpose of making a Recommendation for Assessment

A doctor or AMHP may detain a person for a period of not more than **one (1) hour** for the purpose of making a Recommendation for Assessment if:

- the person is at an AMHS or PSHSF and has been examined on a voluntary basis (e.g. the person is not subject to detention under an Emergency Examination Authority or Examination Authority at the time),
- having examined the person, the doctor or health practitioner decides to make a Recommendation for Assessment, and
- there is a risk that the person will leave the AMHS or PSHSF before the Recommendation for Assessment is made.

Before detaining the person, the doctor or health practitioner **must** make reasonable efforts to:

- if relevant, identify themselves to the person,
- tell the person a Recommendation for Assessment will be made and the nature and effect of the document, and
- give the person an opportunity to remain while the Recommendation for Assessment is made.

If the person is to be detained for the purpose of making a Recommendation for Assessment, the doctor or health practitioner **must** make reasonable efforts to tell the person that they are detained for not more than **one (1) hour**.

The reasons for, and duration of, the detention **must** be documented on the Recommendation for Assessment form.

A doctor or AMHP may exercise these powers with help and with the force that is reasonable and necessary in the circumstances.

1.6 Revoking a Recommendation for Assessment

The doctor or AMHP who makes a Recommendation for Assessment may revoke the recommendation at any time before the start of the assessment if the doctor or health practitioner is no longer satisfied:

- the treatment criteria may apply to the person, or
- there appears to be no less restrictive way for the person to receive treatment and care for the mental illness.

The doctor or AMHP **must** complete a Revocation of Recommendation for Assessment form stating the reasons for the revocation. The Revocation of Recommendation for Assessment is to be completed electronically or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

2 Assessment under a Recommendation for Assessment

2.1 General requirements for assessment by an authorised doctor

The person's assessment under a Recommendation for Assessment **must** be undertaken within **seven (7) days** of the making of the Recommendation for Assessment.

The assessment, undertaken by an authorised doctor, is to determine if a Treatment Authority should be made to authorise involuntary treatment and care for the person during the period when they have no capacity to consent to the treatment.

The authorised doctor making the assessment must discuss the assessment with the person and their support person/s. This includes, for example, explaining the reasons for the assessment and the outcomes of the assessment.

A Treatment Authority can only be made for a person, if after undertaking an assessment the authorised doctor determines that:

- the treatment criteria apply to the person, and
- there is no less restrictive way for the person to receive treatment for the mental illness.

The assessment may occur by audio-visual technology if it is considered clinically appropriate in the circumstances.

The assessment cannot be undertaken by the doctor who made the Recommendation for Assessment, unless the doctor is a doctor for an AMHS (rural and remote) and is the **only** authorised doctor reasonably available to make the assessment

Additional information about requirements for making a Treatment Authority is provided in the Chief Psychiatrist Policy Treatment Authorities.

2.2 Location of assessment and transport

An assessment under a Recommendation for Assessment may be undertaken at:

- an authorised mental health service (AMHS),
- a public sector health service facility (PSHSF), or
- another location that the authorised doctor considers clinically appropriate e.g. the person's home.

A person subject to a Recommendation for Assessment may be transported to an AMHS or PSHSF for the purposes of the assessment. The transport must comply with the *Chief Psychiatrist Policy Transfers and Transport*.

Assessments under a Recommendation for Assessment **cannot** be made in custodial settings.
A person in custody who is subject to a Recommendation for Assessment may be transported by an authorised person to an inpatient unit of an AMHS for the assessment.
Refer to Chief Psychiatrist Policy Classified Patients.

2.3 Detention for assessment at an AMHS or PSHSF

If the assessment is to be conducted at an AMHS or PSHSF the person may be detained for the assessment.

2.3.1 Commencement of assessment period

If the assessment is conducted at an AMHS or PSHSF, the commencement of the assessment period **must** be recorded on the Recommendation for Assessment form.

The start of the assessment period is recorded as follows:

- If the person is at the AMHS or PSHSF when the Recommendation for Assessment is made, the time the Recommendation is made i.e. the date and time recorded on the declaration at section 5 of the *Recommendation for Assessment form*.
- If a person subject to a Recommendation for Assessment is transported to or presents at an AMHS or PSHSF at a later time, the assessment period will commence when the person first attends the AMHS or PSHSF for the assessment.

- A health service employee must record the date and time the person attends under the Start of assessment period at section 6 of the Recommendation for Assessment form.

2.3.2 Duration and extension of assessment period

The person may be detained for the assessment for a period of up to **twenty-four (24) hours.**

Where an extension is necessary to complete an assessment, an authorised doctor making the assessment may extend the period of detention. However, the period cannot exceed **seventy-two (72) hours** from when the detention period commenced.

The authorised doctor must record the extension of the assessment period on the *Recommendation for Assessment form*. If the recommendation was made electronically in CIMHA, the extension is to be completed electronically or, if this is not practicable, completed in hard copy and provided to the AMHS Administrator to be uploaded to MHA forms module.

2.4 Assessment at a place other than an AMHS or PSHSF

A person subject to a Recommendation for Assessment may be assessed at a location other than an AMHS or PSHSF (e.g. the person's place of residence) if the authorised doctor considers it clinically appropriate.

The person is not detained for the purposes of the assessment. The assessment period on the Recommendation for Assessment is not commenced in this instance.

If attempts to undertake the assessment at an alternate location are unsuccessful, arrangements may be made for the person to be transported to, and detained at, an AMHS or PSHSF (as provided above) within **seven (7) days** of the making of the Recommendation for Assessment.

2.5 Authorised doctor responsibilities if Treatment Authority not made

If the authorised doctor who undertakes the assessment decides not to make a Treatment Authority, they must inform the person and their support person/s of:

- the decision and the basis of the decision (i.e. the reasons the doctor determined that the treatment criteria did not apply or how treatment and care for the person's mental illness is proposed to be provided in a less restrictive way), and
- the effect of the decision (e.g. that the person is no longer subject to the involuntary processes of the Act).

The authorised doctor must make a record of the decision and the reasons for the decision on the Recommendation for Assessment form. If the recommendation was made electronically in CIMHA, the decision and reasons are to be completed electronically on the Recommendation for Assessment form or, if this is not practicable, completed in hard copy and provided to the AMHS Administrator to be uploaded to MHA forms module.

2.6 Administrator responsibilities for transport after assessment

The AMHS Administrator **must**, in specified circumstances, take reasonable steps to facilitate the person's transport following an examination or assessment (i.e. if detention is no longer required). This includes circumstances where the person was transported from a place in the community to an AMHS or PSHSF under:

- an Examination Authority, or
- a Recommendation for Assessment, or
- an Emergency Examination Authority if a Recommendation for Assessment is made.

Reasonable steps for returning the person include, but are not limited to, providing the person with means to utilise public transport such as taxi, bus, train or ferry.

A person who attends an AMHS or PSHSF under an Examination Order made by a Magistrate should also be reasonably assisted to return to a reasonable place once they are no longer required to be at the AMHS or PSHSF.

3 Providing information about rights

The Administrator of an AMHS **must** ensure appropriate arrangements are in place to provide persons admitted to an AMHS with an explanation of the Statement of Rights.

This includes persons admitted on the basis of a Recommendation for Assessment or consent (i.e. under an AHD or alternate decision maker). The arrangements **must** clearly identify who is responsible for providing the explanation and ensure that the explanation is provided in a timely way.

The explanation about rights **must** be provided to the person and their support person/s. If requested by the person or their support person/s, a copy of the Statement of Rights **must** be provided.

If the explanation is provided by a clinician and the clinician considers that the person is unable to understand the explanation (e.g. as a consequence of their mental state), the clinician should ensure that the explanation is provided at a later time.

The clinician may seek the assistance of an Independent Patient Rights Adviser to provide further explanation.

The clinician must document their actions in the person's clinical record, including the persons to whom the explanation was provided and, if relevant, further actions taken to ensure to person's understanding of their rights.

Issued under section 305 of the Mental Health Act 2016

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AHD	Advance Health Directive – A document stating the person's consent to health care that comes into effect when the person does not have capacity to make health care decisions. The directions may include consent to special health care e.g. electroconvulsive therapy[1].
Alternate decision maker	An individual/s who is/are authorised to make health care decisions for a person who lacks capacity to consent including, a parent (for a minor), an attorney appointed under an Advance Health Directive (AHD) or Enduring Power of Attorney (EPOA), a guardian, or a Statutory Health Attorney.
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
Attorney under an AHD	an individual/s appointed by the person to exercise power for a health matter in the event that directions in an AHD prove inadequate. A health matter is a matter relating to health care, other than special health care.
Attorney under an Enduring Power of Attorney	An individual/s appointed by the person to do anything in relation to personal matters that the person could have done if the person had capacity for the matter. A personal matter is a matter relating to the person's care including health care or welfare, excluding special health care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.

[1] See *Guide to Advance Health Directives, Enduring Powers of Attorney and Guardians* for further information.

Term	Definition
EPOA	Enduring Power of Attorney
Guardian	A person appointed by the Queensland Civil and Administrative Tribunal (QCAT) to do, in accordance with the terms of appointment, anything in relation to a personal matter that the individual could have done if the individual had capacity. The person may be appointed to make decisions about all personal matters or specified personal matters e.g. health care (excluding special health care), accommodation, provision of services.
HHBA	*Hospital and Health Boards Act 2011*
Minor	A person under the age of eighteen (18) years.
MHRT	Mental Health Review Tribunal
Parent	*Parent* – includes: • a guardian of the minor (under the Child Protection Act 1999), or • an individual who exercises parental responsibility for the minor, other than on a temporary basis (e.g. child minding), or • *for an Aboriginal minor:* an individual who, under Aboriginal tradition, is regarded as a parent of the minor, or *for a Torres Strait Islander minor:* an individual who, under Island custom, is regarded as a parent of the minor.
PSHSF	Public Sector Health Service Facility
Statutory Health Attorney	*For* a health matter, the first in listed order of the following people who is readily available and culturally appropriate for the matter: a spouse of the person if the relationship is close and continuing an adult (i.e. 18 years or more) who has care of the person and is not a paid carer for the person an adult who is a close friend or relation of the person and is not a paid carer for the person. If none of the above listed people is available and culturally appropriate, the Public Guardian is the person's statutory health attorney for the matter.
Support person	An appointed nominated support person or, if the person does not have a nominated support person, a family member, carer or other support person

Referenced forms, clinical notes and templates

- Recommendation for Assessment form
- Revocation of Recommendation for Assessment form

Referenced documents and sources

- Chief Psychiatrist Policy – Advance Health Directives and 'Less Restrictive Way' of Treatment
- Chief Psychiatrist Policy – Treatment Criteria and Assessment of Capacity
- Chief Psychiatrist Practice Guidelines – Transfers and Transport
- Chief Psychiatrist Practice Guidelines – Treatment Authorities
- Queensland Health Guide to Informed Decision-making in Healthcare
- CIMHA Clinician Handbook Vol 6: MHA 2016
- Flowchart – Determining if a Recommendation for Assessment can be made
- *Mental Health Act 2016*

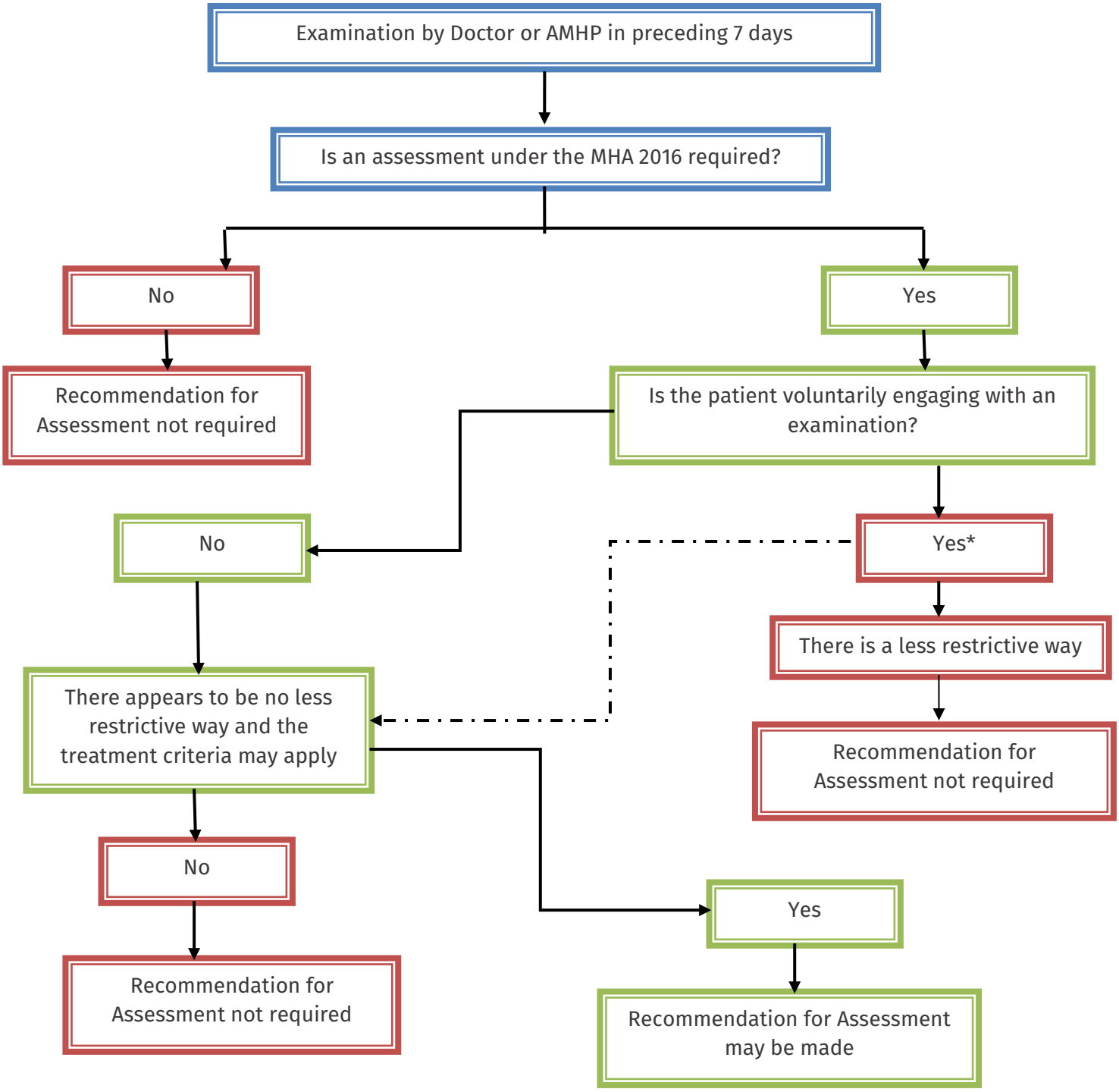
Document status summary

Date of Chief Psychiatrist approval:	15 April 2020
Date of effect:	22 April 2020
Supersedes version that took effect on:	5 March 2017
To be reviewed by:	15 March 2023

Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Statewide Coordinator Independent Patient Rights Advisers	Phone: 07 3328 9243 / 0472 846 365 Email: IPRA-Network@health.qld.gov.au
Statewide Independent Patient Rights Adviser Contact List	Available on the Act website
Local Independent Patient Rights Adviser	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Flowchart – Determining if a Recommendation for Assessment can be made.



**After a voluntary examination, the doctor or AMHP may decide there appears to be no less restrictive way and that the treatment criteria may apply*

Mental Health Act 2016
Chief Psychiatrist Policy

Examination Authorities

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General

The *Mental Health Act 2016* (the Act) promotes the voluntary engagement of people requiring mental health treatment and care. In circumstances where voluntary engagement is not successful, an Examination Authority may be required to respond to serious concerns about a person's mental health and wellbeing.

An *Application for Examination Authority* may be made by an authorised person from an authorised mental health service (AMHS) or other concerned person (e.g. a family member, friend, colleague, or other member of the person's community who has concerns about the person's wellbeing).

Examination Authorities are issued by the Mental Health Review Tribunal (MHRT).

An Examination Authority authorises a doctor or authorised mental health practitioner to examine a person without the person's consent, to determine whether a Recommendation for Assessment should be made.

Scope

This policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

Staff should work collaboratively and in partnership with individuals in their care to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. This should include the timely involvement of appropriate local supports and a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

This policy is issued under section 305 of the Mental Health Act 2016

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 October 2021

Policy

1 Alternatives to an Examination Authority – urgent circumstances

An Examination Authority may be appropriate where there is a concern that a person needs to be assessed, but it has not been possible for the person to be examined by a doctor or authorised mental health practitioner.

Where immediate risk of serious harm is indicated an Examination Authority is **inappropriate**. Instead, the Queensland Ambulance Service or Queensland Police Service should be contacted via **triple zero (000)** to arrange an urgent assessment to determine if an Emergency Examination Authority should be enacted under the *Public Health Act 2005*.

If an emergency response is required via **Triple Zero (000)**:

- the Queensland Ambulance Service should be requested in the first instance, or
- the Queensland Police Service if:
    - no less restrictive alternative is available
    - there is an actual or known risk of violence or possession of weapons, or
    - the location of the person is not known.

Further information: Queensland Health website - Emergency Examination Authorities

If the attending Queensland Ambulance Service or Queensland Police Service officers determine the person does not meet the criteria for an Emergency Examination Authority, the concerned person/AMHS should continue their efforts to engage the person with a mental health service, including for example:

- encourage the person to attend their General Practitioner, hospital or local mental health service voluntarily, or
- arrange attendance of a doctor or authorised mental health practitioner from an AMHS to examine the person to decide if a Recommendation for Assessment should be made (refer to Chief Psychiatrist Policy Examination and Assessment).

If urgent assistance is required, this should be escalated back to the Queensland Ambulance Service for a medical emergency or Queensland Police Service for a high risk or compromised safety situation via Triple Zero (000).

Otherwise, an *Application for Examination Authority* may be made to the MHRT in accordance with this policy.

2 Examination Authority criteria

Key points

The MHRT **must** consider that **all of the following apply** to the person the subject of the application:

- the person has, or may have, a mental illness, and
- the person does not, or may not, have capacity to consent to treatment, and
- either:
  - reasonable attempts at voluntary engagement have been unsuccessful, or
  - it is not practicable to engage the person voluntarily, and
- there is, or may be, an imminent risk because of the person's mental illness of either:
  - serious harm to the person or others, or
  - the person suffering serious mental or physical deterioration.

3 Voluntary engagement

Attempts **must** be made to engage the person in voluntary assessment or treatment. Every reasonable effort should be made by the AMHS to gather relevant information and try to assess the person in a voluntary capacity.

Examples of where it may not be practicable to engage a person voluntarily include:

- attempts have already been made by the applicant,
- relationships between the applicant and the subject of the application do not support attempts at voluntary engagement,
- a rapid, but not immediate, response is required, or
- entry to premises is required to enable an examination of the person.

If a concerned person contacts an AMHS in relation to making an Examination Authority, the AMHS must provide the concerned person with information about how mental health services can be accessed voluntarily. This information should include:

- contact details and avenues for support in relation to accessing public sector mental health services, and
- where relevant or appropriate, contact details for non-government services that may be appropriate for the person.

4 Person the subject of the application is known to AMHS

Key points

- Before making/supporting an application for Examination Authority, the AMHS should review the Consumer Integrated Mental Health and Addiction (CIMHA) application to check if the person, the subject of the application, is already open to another AMHS to ensure an Examination Authority is not made unnecessarily.
- If the person subject to the application is open to another AMHS:
  - the AMHS that receives the application **must** attempt to contact the patient and, if required, review as soon as possible,
  - the AMHS that receives the application should contact the patient's treating AMHS to provide information about the applicant's concerns, and
  - if the AMHS provides an outreach service to a current patient of another AMHS as a result of the concerned person's application, this **must** be documented in the patient's clinical record on CIMHA.

The fact that a person is already engaged in mental health treatment **must not** be disclosed to the applicant (exceptions apply - see Section 7 Clinician responsibilities).

5 Application for Examination Authority

If voluntary engagement is unsuccessful or not practicable, an *Application for Examination Authority* may be made to the MHRT.

Key points

- An *Application for Examination Authority* may be made by:
  - the administrator of an AMHS (or delegate),
  - a person authorised in writing by the AMHS administrator to make an application (e.g. the clinical director of an AMHS, an authorised doctor or authorised mental health practitioner), or
  - a concerned person (e.g. a family member, friend, colleague, or other member of the person's community who has concerns about the person's wellbeing).
- A concerned person making an application must seek clinical advice from a doctor or authorised mental health practitioner before an *Application for Examination Authority* may be made.

Clinical advice can be sought from any doctor (e.g. general practitioner, psychiatrist, etc.) or an authorised mental health practitioner at an AMHS.

- Where possible, the applicant should attend in person when seeking advice from a doctor or authorised mental health practitioner to enable the signed, written statement of advice (Part B to the Application for Examination Authority) to be provided with the application.
- If required, advice may be obtained over the phone and the written statement provided electronically by the doctor or authorised mental health practitioner.

The advice of the doctor or authorised mental health practitioner **must** address:

- general information about the treatment criteria under the Act, and how these criteria may apply to the person,
- whether there is a less restrictive way[1] for the person to access mental health services, including through voluntary engagement with services,
- whether the person's behaviours and other factors (e.g. treatment history, attempts already made for voluntary engagement, etc.) as described by the applicant could reasonably be considered to satisfy the Examination Authority criteria,
- options for the treatment and care of the person, and
- how the person may be encouraged to have a voluntary examination.

Any advice provided by the doctor or authorised mental health practitioner **must** be provided in a general manner and **must** not result in the disclosure of any confidential information.

If the concerned person has attended an AMHS to make the application, the AMHS should take responsibility for making an *Application for Examination Authority* if the clinical advice supports the application.

- This allows the AMHS opportunity to further engage the patient voluntarily, without disclosing to the concerned person any actions that may be taken by the AMHS. This is particularly important if the person the subject of the application is already engaged in mental health treatment.

If the concerned person continues to express a desire to make an *Application for an Examination Authority*, they should be supported to make this application.

The application can be emailed to the MHRT at enquiry@mhrt.qld.gov.au.

[1] Examples of Less Restrictive Way include consent provided via an Advance Health Directive or Substitute Decision Maker. For more information see the *Chief Psychiatrist Policy Treatment criteria, assessment of capacity, less restrictive way and advance health directives* and the *Less Restrictive Way guidelines*.

The application **must** be completed in full and **must** indicate:

- whether there are particular concerns by the applicant regarding confidentiality (see Section 5 Application for Examination Authority) and the reasons for these concerns, and
- whether the applicant agrees to be notified less than **three (3) days** prior to the MHRT hearing, and the time period to which the applicant agrees to be notified (e.g. one to two days prior).

The MHRT **must** hear an *Application for Examination Authority* as soon as practicable. The applicant will be notified in writing of the hearing date and time, **three (3) days** before it is scheduled (or a shorter period if they have agreed).

The MHRT **must** also advise the applicant of the decision of the hearing within **seven (7) days** of the decision being made. The notice will state whether or not the Examination Authority has been made and the applicant's entitlement to request reasons for the MHRT decision.

6 Limits to confidentiality

Before examining the person under an Examination Authority, the doctor or authorised mental health practitioner may give a copy of the authority to the person (if appropriate in the circumstances).

Whilst the above requirement applies to the **authority only**, the person examined can also subsequently request access to other relevant documents under Queensland's right to information and information privacy legislation[2], which may include the:

- Form – *Application for examination authority*
- Form – *Outcome of examination under examination authority*.

The applicant might express concerns about their involvement in an involuntary examination being revealed if they feel that this puts themselves or others at risk. In these circumstances, the applicant or clinicians providing advice should ensure these documents state the reasons for their concern and the need for further consultation (if the person subsequently requests access to them).

This will alert the Right to Information decision-maker to give special consideration when they review the person's request.

More information regarding the right to information process is available at: www.health.qld.gov.au/system-governance/contact-us/access-info/rti-application

[2] The *Right to Information Act 2009* governs applications for non-personal information; the *Information Privacy Act 2009* governs applications for the applicant's own personal information.

7 Clinician responsibilities

In completing an *Application for Examination Authority*, the applicant must include clinical advice from a doctor (e.g. general practitioner, psychiatrist, etc.) or an authorised mental health practitioner at an AMHS. This advice must be included on Part B of the application form.

Key points

- The doctor or authorised mental health practitioner's advice is made solely on information provided by the applicant.
  - Applicants **must** be made aware that providing false or misleading information may result in a penalty.
- A doctor or authorised mental health practitioner who is providing advice to an applicant **must not** disclose any confidential patient information about the person the subject of the application unless an exception to the *Hospital and Health Boards Act 2011* confidentiality provisions applies[3].
  - This includes, but is not limited to, confirming information provided by the applicant (e.g. the clinician **must not** confirm whether the person is already accessing mental health services).

If the doctor or authorised mental health practitioner completes Part B of the application, they may be contacted by the MHRT at a later time to verify the information made in the statement.

A copy of the application should be attached to a CIMHA clinical note documenting the concerns raised by the applicant. If the subject of the application does not have a CIMHA record, a new consumer record **must** be created to enable the document to be uploaded.

8 Examination

If an Examination Authority is issued by the MHRT, the Authority will state the AMHS responsible for carrying out an examination of the person.

A copy of the Examination Authority will be sent to the Administrator of the AMHS by the MHRT. The Authority is in force for **seven (7) days** from the date it is issued.

The Examination Authority **must** be uploaded to CIMHA.

[3] See *Queensland Health Guideline: Information sharing between mental health staff, consumers, family, carers, nominated support persons and others*

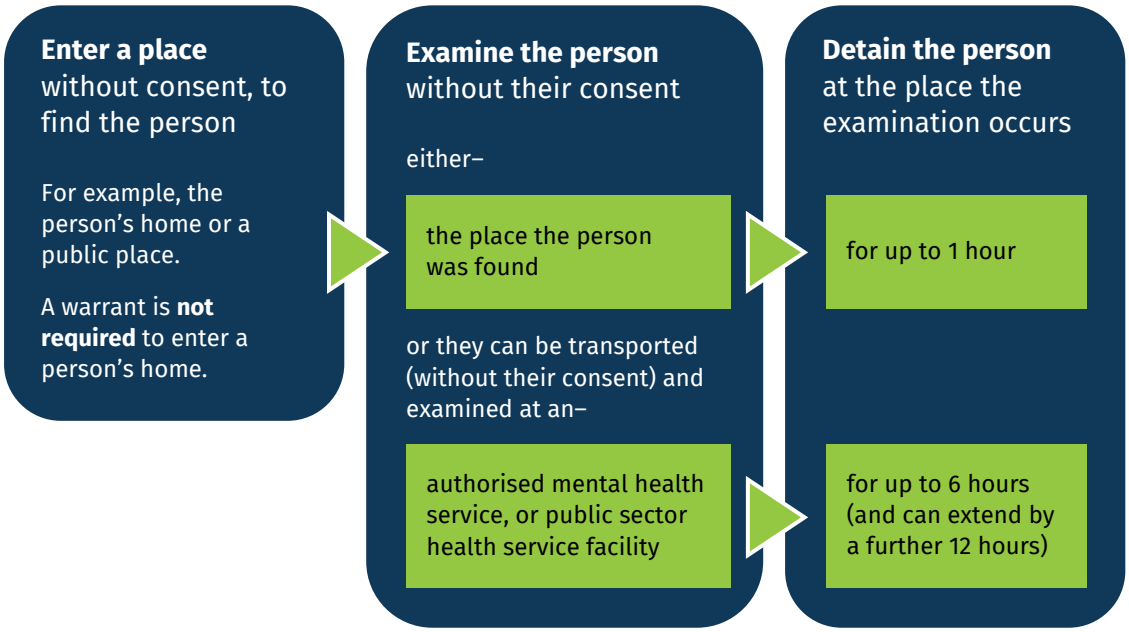
Key points

- The Administrator **must** make arrangements for a doctor or authorised mental health practitioner to examine the person within **seven (7) days**. The examination can occur without the person's consent.
  - The service should initiate contact with the person as soon as practicable after the Examination Authority is made.
  - In making the Examination Authority, the MHRT has determined imminent risk to self/others. Therefore, if unable to complete the examination within the **seven (7) day** timeframe, the service should consider whether a subsequent application to the MHRT is required to ensure the examination is completed.
  - All attempts at contacting the person should be recorded within the patient's clinical record in CIMHA.

If the examination is not completed by the AMHS, the service should consider whether it is appropriate to notify the applicant (e.g. if the concerned person is a family member or support person), including the reasons why the examination was not completed and that the Examination Authority has expired. The service should discuss with the applicant whether a subsequent application is to be made, whether by applicant or by the AMHS.

8.1 Powers under Examination Authority

A doctor or authorised mental health practitioner can with necessary and reasonable help and use of force:



As far as practicable, the use of force under an Examination Authority should be avoided. Force should not be used to enter premises unless the person has first been given an opportunity to provide consent.

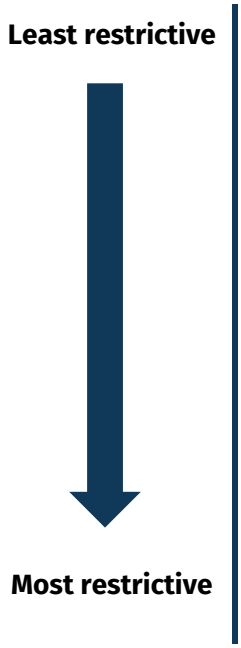
8.2 Transporting a person to an AMHS or PSHSF

If the examination of the person needs to take place in an AMHS or PSHSF, an authorised person may transport the person under the Examination Authority without their consent. An authorised person includes:

- AMHS administrator
- health practitioner
- ambulance officer
- police officer.

Transport of a person subject to an Examination Authority must comply with the *Chief Psychiatrist Policy Transfers and transport.*

Transport considerations must start from the least restrictive approach and only utilise more restrictive approaches if necessary.



Non-emergency transport

- private vehicle driven by a family member, carer or friend
- public transport such as taxi, bus, train or ferry, accompanied by a family member, carer, friend or clinician (if needed)
- non-emergency hospital or community transport service (where available)
- a health service vehicle driven by a health or mental health worker, with an additional health escort where needed

Emergency transport

- Health practitioner and QAS
- Health practitioner and QPS
- QPS acts alone (extraordinary circumstances)

The doctor or authorised mental health practitioner should remain in attendance for the duration of the transport (i.e. from the community to the inpatient unit) to provide clinical expertise and advice to the officers facilitating the safe transport of the person.

In emergency circumstances police or ambulance assistance should be requested via Triple Zero (000).

8.3 Patient rights under an Examination Authority

The doctor or authorised mental health practitioner **must** explain in general terms, the nature and effect of the Examination Authority and provide a copy of the authority to the person if requested.

Reasonable steps **must** be taken to ensure the patient understands the information. This may include use of an interpreter or other methods of communication, such as sign language, written explanations or explanation with assistance from a support person.

- This explanation is not required if the doctor or authorised mental health practitioner reasonably believes providing the explanation would prevent the clinician from completing the examination.

The doctor or authorised mental health practitioner **must** also provide a copy of the authority to the person's nominated support person/s, personal guardian or attorney upon request.

9 Examination outcomes

Key points

- Following an examination, the doctor or authorised mental health practitioner **must** decide whether to make a Recommendation for Assessment for the person.
  - The outcome must be recorded on an *Outcome of Examination Under Examination Authority form* and uploaded on CIMHA.
- If a Recommendation for Assessment is made for the person, the *Chief Psychiatrist Policy Examination and assessment* must be complied with.

Further information

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service – A health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health and Addiction (CIMHA) application – The statewide mental health database which is the designated patient record for the purposes of the Act
MHRT	Mental Health Review Tribunal
PSHSF	Public Sector Health Service Facility
QAS	Queensland Ambulance Service
QPS	Queensland Police Service

Referenced policies and resources

Chief Psychiatrist policies and guidelines

- Chief Psychiatrist Policy – Examination and assessment
- Chief Psychiatrist Policy – Transfers and transport
- Chief Psychiatrist Policy – Treatment criteria, assessment of capacity, less restrictive way and advance health directives
- Less Restrictive Way Guidelines

Mental Health Act 2016 forms and other resources

- Form: Application for Examination Authority
- Form: Outcome of Examination Under Examination Authority
- Queensland Health Guideline – Information sharing between mental health staff, consumers, family, carers, nominated support persons and others
- Queensland Health website – Emergency Examination authorities

Legislation

- Hospital and Health Boards Act 2011
- Information Privacy Act 2009
- Public Health Act 2005
- Right to Information Act 2009

Document status summary	
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Mental Health Act 2016
Chief Psychiatrist Policy

Forensic Orders and Treatment Support Orders

Amending category, conditions and limited community Treatment

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Queensland Government

General

The *Mental Health Act 2016* (the Act), outlines a number of factors that an authorised doctor **must** have regard to, in making a decision to amend the category, conditions or the Limited Community Treatment (LCT) of a patient on a Forensic Order or Treatment Support Order.

Decisions about amending the LCT, category or conditions of an order **must** consider, amongst other things, the relevant circumstances of the patient.

LCT for patients' subject to a Forensic Order (Criminal Code) **must** be approved by the Chief Psychiatrist.

Key points

Relevant circumstances, of a person, means each of the following:

- the person's mental state and psychiatric history,
- any intellectual disability of the person,
- the person's social circumstances, including, for example, family and social support,
- the person's response to treatment and care and the person's willingness to receive appropriate treatment and care, and
- if relevant, the person's response to previous treatment in the community.

Scope

This policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy should be read in conjunction with the Chief Psychiatrist Policy – Treatment and care of patients subject to a Treatment Support or Forensic Order or other identified higher risk patients.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Treatment Support Order

A Treatment Support Order can be made by the Mental Health Court following a finding that a person was of unsound mind at the time of an alleged offence or is unfit for trial. The court makes the order if it considers that a Treatment Support Order, not a Forensic Order, is necessary to protect the safety of the community (see section 2 - Forensic Order).

A Treatment Support Order may also be made by the Mental Health Review Tribunal (Tribunal) where the Tribunal has revoked a Forensic Order for the person.

The category of a Treatment Support Order must be a community category, unless it is necessary for the person to be an inpatient as a result of their treatment and care needs or to protect the safety of the person or others.

At the first appointment with the patient after a Treatment Support Order has been made, the authorised doctor **must** complete the Order/Authority Amendment form and follow the practices outlined below.

Any amendment by an authorised doctor **must not**:

- change a condition decided by the Mental Health Court or (Tribunal), or
- reduce the extent of treatment in the community contrary to a decision of the Court or Tribunal. Exceptions apply, see section 1.1.1 – Amending the category to inpatient.

Court and Tribunal decisions are recorded in CIMHA and should be checked prior to any amendment.

Key points

An authorised doctor can only amend a Treatment Support Order if the doctor is satisfied that the amendment is appropriate having regard to:

- the relevant circumstances of the patient, and
- the nature of the relevant unlawful act and the period of time that has passed since the act happened, and
- for an amendment to increase LCT, the purpose of LCT.

Consideration of victim issues should be included when planning amendments to a Treatment Support Order e.g. changing the place at which a patient resides that may bring them into contact with a victim.

The Act supports victims through Information Notice provisions which enable eligible victims to receive specific information about the patient that is relevant to their safety and wellbeing. Information Notices are recorded in CIMHA. In most cases, the existence of an Information Notice and/or the identity of the relevant victim must remain confidential from the patient.

The Queensland Health Victim Support Service (QHVSS) can provide information and advice about management of known victim issues.

Queensland Health Victim Support Service
Website: www.health.qld.gov.au/qhvss
Email: victim.support@health.qld.gov.au | Phone: 1800 208 005

1.1 Amending the category

1.1.1 Amending the category to inpatient

The authorised doctor can **only** change the category of a Treatment Support Order from community to inpatient if:

- the Court or Tribunal has decided that an authorised doctor may amend the Treatment Support Order to change the category, and
- the doctor considers, having regard to the relevant circumstances of the patient, that one (1) or more of the following cannot reasonably be met under a community category:
    - the patient's treatment and care needs
    - the safety and welfare of the patient
    - the safety of others.

If the Treatment Support Order is community category and the Court or Tribunal has determined that the extent of treatment in the community **cannot** be reduced, the following additional considerations and requirements apply:

- the category can only be amended if the authorised doctor reasonably believes there has been:
    - a material change in the person's mental state, and
    - the patient requires urgent treatment and care as an inpatient
- if the category is amended to inpatient, the AMHS administrator **must** provide a copy of the Order/Authority Amendment to the Tribunal as soon as practicable, and
- the Tribunal **must** conduct a review of the Treatment Support Order within **fourteen (14) days** of receiving the notice.

If the Treatment Support Order is subsequently amended back to a community category before the Tribunal review occurs, the AMHS administrator **must** notify the Tribunal by providing a copy of the Order/Authority Amendment as soon as practicable. The Tribunal is then not required to conduct the review.

The authorised doctor **must** tell the patient and their support person/s of their decision and explain its effects.

1.1.2 Amending the category to community

The authorised doctor **must** provide the patient and their support person/s with an explanation and written information about the patient's treatment under the community category, in particular:

- any treatment and care to be provided to the patient (e.g. fortnightly home visit, monthly appointment with authorised doctor), and
- the patient's obligations while receiving treatment under the community category (e.g. to take prescribed medication).

1.1.3 Amending category for persons in custody

Where a person is in custody and is or becomes subject to a Treatment Support Order, the category of the order **must** be community if the person is to remain in their place of custody. If the category of the order is inpatient, the person must be transferred to an inpatient unit of an AMHS under the classified patient provisions. See Chief Psychiatrist Policy – Classified Patients.

1.2 Amending conditions

An authorised doctor **must not** change a condition decided by the Court or Tribunal.

The authorised doctor **must** tell the person and their support person/s of their decision and explain the effect of the decision.

1.3 Authorising and amending Limited Community Treatment

If Limited Community Treatment (LCT) is authorised or amended, the authorised doctor **must** state:

- the type of LCT i.e. on grounds, off grounds or overnight, and whether the patient is to be escorted or supervised.
- the conditions of LCT
- the actions to be taken if the patient does not comply with conditions
- the duration of the LCT (Note that overnight leave cannot be more than **seven (7)** consecutive nights), and
- the duration of the authorisation.

The authorised doctor **must** provide the patient and their support person/s with written explanation and information about the patient's LCT, in particular:

- any treatment and care to be provided to the patient (e.g. fortnightly home visit, monthly appointment with authorised doctor), and
- the patient's obligations while receiving LCT (e.g. to take prescribed medication).

The information only needs to be provided once for each type of LCT (e.g. if the patient is authorised to have day leave for three days in the week, the information is to be given prior to the first day leave and not on each subsequent day leave).

Written information is not required to be given if the patient is only authorised to have escorted LCT, however the authorised doctor should still provide an explanation of the LCT being accessed.

If the patient accesses LCT under the authorisation, the details **must** be recorded on a Limited Community Treatment (LCT) Access and Return form. Completed forms **must** be uploaded to CIMHA.

2 Forensic Order

If the Mental Health Court finds a person is of unsound mind at the time of an alleged offence or is unfit for trial, the court must make a Forensic Order if it considers the Order is necessary to protect the safety of the community.

The court also determines the Order type:

- a Forensic Order (Mental Health) is made if the person's unsoundness of mind or unfitness for trial is due to a mental condition other than an intellectual disability, or if the person has a dual disability (a mental illness and an intellectual disability) and needs involuntary treatment and care for mental illness as well as care for the person's intellectual disability.
- a Forensic Order (Disability) is made if the person's unsoundness of mind or unfitness for trial is due to an intellectual disability and the person needs care for the person's intellectual disability but does not need treatment and care for mental illness.

In addition, the court must decide if the patient requires treatment as an inpatient of an authorised mental health service or if the person can reside in the community. The court may decide the category is community only if there is not an unacceptable risk to the safety of the community because of the person's mental condition.

In a small number of cases, a person may be receiving treatment under both a Forensic Order (disability) and a Forensic Order (mental health) to ensure their needs are met for each condition.

The following requirements apply to both Forensic Order (Disability) and Forensic Order (Mental Health). Special requirements apply to a patient subject to a Forensic Order (Criminal Code) (see section 3).

At the first appointment with the patient after a Forensic Order has been made, the authorised doctor **must** complete the Order/Authority Amendment and follow the practices outlined below.

Any amendment by an authorised doctor **must not**:

- change a condition decided by the Mental Health Court or Tribunal; or
- reduce the extent of treatment in the community contrary to a decision of the Court or Tribunal. Exceptions apply, see section 2.1.1 – Amending the category to inpatient.

Court and Tribunal decisions are recorded in CIMHA and should be checked prior to any amendment.

Key points

An authorised doctor can only increase the extent of community treatment by way of amendment to a Forensic Order if the doctor is satisfied that there is not an unacceptable risk to the safety of the community, because of the person's mental condition, having regard to:

- the relevant circumstances of the patient, and
- the nature of the relevant unlawful act and the period of time that has passed since the act happened, and
- for an amendment to increase LCT, the purpose of LCT, and
- potential impacts for victims.

Consideration of victim issues should be included when planning amendments to a Forensic Order. For example, changing the place at which a patient resides that may bring them into contact with the victim.

The Act supports victims through Information Notice provisions which enable eligible victims to receive specific information about the patient that is relevant to their safety and wellbeing. Information Notices are recorded in CIMHA. In most cases, the existence of an Information Notice and/or the identity of the relevant victim **must** remain confidential from the patient.

The Queensland Health Victim Support Service can provide information and advice about management of known victim issues.

Queensland Health Victim Support Service
Website: www.health.qld.gov.au/qhvss
Email: victim.support@health.qld.gov.au | Phone: 1800 208 005

2.1 Amending the category

2.1.1 Amending the category to inpatient

The authorised doctor can **only** change the category of a Forensic Order from community to inpatient if:

- the Court or Tribunal has decided that an authorised doctor may amend the Forensic Order to change the category.

If the Forensic Order is community category and the Court or Tribunal has determined that the extent of treatment in the community **cannot** be reduced, the following **additional** considerations and requirements apply:

- the category can **only** be amended if the authorised doctor reasonably believes there has been:
  - a material change in the person's mental state, and
  - the patient requires urgent treatment and care as an inpatient
- If the category is amended to inpatient, the AMHS administrator **must** provide a copy of the Order/Authority Amendment to the Tribunal as soon as practicable, and

- the Tribunal **must** conduct a review of the Forensic Order within **twenty-one (21) days** of receiving the notice.

If the Forensic Order is subsequently amended back to a community category before the Tribunal review occurs, the AMHS Administrator **must** notify the Tribunal by providing a copy of the Order/Authority Amendment as soon as practicable. The Tribunal is then not required to conduct the review.

The authorised doctor **must** tell the patient and their support person/s of their decision and explain its effects.

2.1.2 Amending category to community

The authorised doctor may change the category of the Forensic Order from inpatient to community only if:

- the doctor is satisfied that there is not an unacceptable risk to the safety of the community because of the patient's mental condition, including the risk of serious harm to other persons and property, and
- The amendment is not contrary to a decision of the Mental Health Court or the Tribunal.

The authorised doctor **must** provide the patient and their support person/s with an explanation and written information about the patient's treatment under the community category, in particular:

- any treatment and care to be provided to the patient (e.g. fortnightly home visit, monthly appointment with authorised doctor) and
- the patient's obligations while receiving treatment in the community (e.g. to take prescribed medication).

2.1.3 Amending category for persons in custody

Where a person is in custody and is or becomes subject to a Forensic Order, the category of the order **must** be community if the person is to remain in their place of custody. If the category of the order is inpatient, the person must be transferred to an inpatient unit of an AMHS under the classified patient provisions. See Chief Psychiatrist Policy – Classified Patients.

2.2 Amending conditions

An authorised doctor **must not** change a condition decided by the Court or Tribunal.

The authorised doctor **must** tell the person and their support person/s of their decision and explain the effect of the decision.

2.3 Authorising and amending Limited Community Treatment

An authorised doctor can only authorise LCT if it is approved by the Court or Tribunal.

If LCT is authorised or amended, the authorised doctor **must** state:

- the type of LCT i.e. on grounds, off grounds or overnight, and whether the patient is to be escorted (i.e. with a health service employee) or supervised (i.e. in the company of a person nominated by the authorised doctor),
- the conditions of limited community treatment,
- the actions to be taken if the patient does not comply with conditions,
- the duration of the LCT (Note that overnight leave cannot be more than **seven (7)** consecutive nights), and
- the duration of the authorisation.

The Order/Authority Amendment form **must** be verified by someone external to the treating team, as nominated by the AMHS Administrator.

The external person **must** complete **item 8** of the Order/Authority Amendment form, to verify that the LCT is consistent with the approval given by the Court or Tribunal.

The authorised doctor **must** provide the patient and their support person/s with written explanation and information about the patient's LCT, in particular:

- any treatment and care to be provided to the patient (e.g. fortnightly home visit, monthly appointment with authorised doctor), and
- the patient's obligations while receiving limited community treatment (e.g. to take prescribed medication).

The information only needs to be provided once for each type of LCT (e.g. if the patient is authorised to have day leave for three days in the week, the information is to be given prior to the first day leave and not on each subsequent day leave).

Written information is not required to be given if the patient is only authorised to have escorted LCT, however the authorised doctor should still provide an explanation of the LCT being accessed.

If the patient accesses LCT under the authorisation, the details must be recorded on a Limited Community Treatment (LCT) Access and Return form. Completed forms must be uploaded to CIMHA.

3 Forensic Order (Criminal Code)

A Forensic Order (Criminal Code) is an order made by the Supreme or District Court that has not yet been reviewed by the Tribunal.

The Tribunal is required to undertake the initial review within **twenty-one (21) days** of being notified of a patient subject to a Forensic Order (Criminal Code). The purpose of the review is to determine if the order will be Forensic Order (mental health) or Forensic Order (disability).

Subject to the Chief Psychiatrist's written approval, an authorised doctor may authorise, revoke or change the nature and extent of limited community treatment for a patient subject to a Forensic Order (Criminal Code).

The Chief Psychiatrist's approval is sought by completing the Chief Psychiatrist Approval - Temporary Absences and Limited Community Treatment for Particular Patients form.

This form must be completed electronically in CIMHA or, if this is not possible, completed in hard copy and uploaded to CIMHA.

Key points

If the Chief Psychiatrist's written approval is received, an authorised doctor may authorise or amend LCT if the doctor is satisfied that the amendment is appropriate having regard to:

- the relevant circumstances of the patient,
- the nature of the relevant unlawful act and the period of time that has passed since the act happened, and
- the purpose of the LCT.

An authorised doctor can only authorise or change the nature and extent of LCT if the doctor is satisfied that there is not an unacceptable risk to the safety of the community because of the patient's mental condition, including the risk of serious harm to other persons and property.

If LCT is authorised or amended, the authorised doctor **must** state:

- the type of LCT i.e. on grounds, off grounds or overnight, and whether the patient is to be escorted or supervised,
- the conditions of limited community treatment,
- the actions to be taken if the patient does not comply with conditions,
- the duration of the limited community treatment (Note that overnight leave cannot be more than **seven (7)** consecutive nights), and
- the duration of the authorisation.

The Order/Authority Amendment **must** be verified by someone external to the treating team, as nominated by the AMHS Administrator.

The external person **must** complete **item 8** of the Order/Authority Amendment, to verify that the LCT is consistent with the approval given by the Chief Psychiatrist.

The authorised doctor **must** provide the patient and their support person/s with written explanation and information about the patient's LCT, in particular:

- any treatment and care to be provided to the patient (e.g. fortnightly home visit, monthly appointment with authorised doctor), and
- the patient's obligations while receiving limited community treatment (e.g. to take prescribed medication).

The information only needs to be provided once for each type of LCT (e.g. if the patient is authorised to have day leave for three days in the week, the information is to be given prior to the first day leave and not on each subsequent day leave).

Written information is not required to be given if the patient is only authorised to have escorted LCT, however the authorised doctor should still provide an explanation of the LCT being accessed.

If the patient accesses LCT under the authorisation, the details **must** be recorded on a Limited Community Treatment (LCT) Access and Return form. Completed forms **must** be uploaded to CIMHA.

The LCT under the Forensic Order (Criminal Code) ends on the day the Tribunal determines the making of a Forensic Order (mental health) or Forensic Order (disability).

4 Documentation requirements

Key Points

Amendments made to the category, conditions or LCT of a Forensic Order or Treatment Support Order must be recorded on an Order/Authority Amendment form.

- The form must be completed electronically in CIMHA or, if this is not possible, in hard copy and uploaded to CIMHA.

Each time an amendment is made to an Order, the Involuntary Patient and Voluntary High Risk Patient Summary clinical note must be updated in CIMHA.

The authorised doctor is required to explain and provide written information to a patient who is to receive treatment in the community in particular:

- any treatment and care to be provided to the patient (e.g. fortnightly home visit, monthly appointment with authorised doctor), and
- the patient's obligations while receiving treatment under the community category (e.g. to take prescribed medication).

The AMHS Administrator **must** ensure appropriate arrangements are in place to provide patients and their support persons with information about treatment in the community. Written information may be provided in a range of ways. For example:

- for a patient undertaking LCT, providing the patient with a copy of the Order/Authority Amendment form which explains conditions and consequences for non-compliance, or
- for a patient whose category is changed to community, providing the patient with a copy of the Care Plan clinical note which makes provision for recording the treatment and care that is to be provided, as well as the patient's obligations in receiving treatment and care in the community.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
30 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act
Escorted LCT	Leave with a health service employee.
Forensic Order	Forensic Order
LCT	Limited Community Treatment, including in the grounds and buildings (other than an inpatient unit) of an authorised mental health service, for a period of not more than 7 consecutive days, as authorised under the *Mental Health Act, 2016.*
Patient	Defined in section 297 of the Act as: • an involuntary patient, or a person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under an advance health directive or with the consent of a personal guardian or attorney.
The Act	*Mental Health Act 2016*
Supervised LCT	In the company of a person nominated by the authorised doctor
Treatment Support Order	Treatment Support Order

Referenced forms, clinical notes and templates:

- Chief Psychiatrist Approval - Temporary Absences and Limited Community Treatment for Particular Patients form
- Involuntary Patient and Voluntary High Risk Patient Summary clinical note
- Limited Community Treatment (LCT) Access and Return form
- Order/Authority Amendment form

Referenced forms, clinical notes and templates:

Referenced Documents and Policies
Chief Psychiatrist Practice Guidelines – Classified Patients
Mental Health Act 2016

Document status summary

Date of Chief Psychiatrist approval:	30 April 2020
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Supersedes version that took effect on:	5 March 2017
To be reviewed by:	1 June 2023

Attachment 1 – Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Queensland Health Victim Support Service	Phone: 1800 208 005 Email: victim.support@health.qld.gov.au
Mental Health Act delegate	Phone: Email:
Mental Health Review Tribunal	Phone: Email:
Local Administrator	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Mental Health Act 2016

Chief Psychiatrist Policy

Independent Patient Rights Advisers

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General

The *Mental Health Act 2016* (Act) establishes the positions of Independent Patient Rights Advisers (IPRAs). A key function of these positions is to advise patients and their appointed nominated support persons, family, carers and other support persons of their rights under the Act. IPRAs play a very important role in liaising between clinical teams, patients and support persons.

The Act contains many important patient rights. For these rights to be effectively accessed, patients and their support persons must be aware of these rights.

The *Mental Health Act 2016* (the Act), provides that a Chief Executive of a Hospital and Health Service (HHS) **must** appoint one or more Independent Patient Rights Advisers (IPRAs).

While Independent Patient Rights Advisers play a key role in advising patients of their rights under the Act, this does not affect the obligation of other persons in authorised mental health services to advise patients of their rights and to provide information to patients about their treatment and care.

Scope

This policy is mandatory for all public sector authorised AMHSs. An authorised doctor, AMHP, AMHS administrator or other person performing a function under the Act in a public sector AMHS **must** comply with this policy.

This policy **must** be read in conjunction with the relevant provisions of the Act.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the Objects and Principles of the Act.

Policy

1 Statewide Coordinator

The IPRA Statewide Coordinator is employed within the Mental Health Alcohol and Other Drugs Branch in the Department of Health. The Statewide Coordinator reports directly to the Chief Psychiatrist.

The Statewide Coordinator's responsibilities include:

- providing advice to IPRAs on the interpretation and application of complex provisions of the Act that relate to patient rights,
- establishing and coordinating a statewide network of IPRAs,
- identifying and resolving major concerns in relation to patient rights identified by IPRAs, as reported to the Statewide Coordinator including through regular reporting processes,
- liaising with a broad range of mental health stakeholders, including mental health consumer and carer groups, advocacy organisations, non-government organisations, and staff of HHSs and AMHSs,
- advising and consulting with IPRAs in relation to performing their functions under the Act, and
- assisting the Chief Psychiatrist in ensuring compliance with the Act and protecting the rights of patients and nominated support persons, family, carers and other support persons.

2 HHS and external agency requirements

Each HHS is required to comply with this policy as a condition of the funding provided under service agreements with the Department of Health.

Key points

Where a HHS elects to perform the IPRA functions through a contract or agreement with an external agency (such as a non-government organisation), the HHS is responsible for:

- ensuring the entity and the services it provides are compliant with the service agreement and this policy.

Without limiting this, the relevant agreement **must**:

- attach this policy, and
- require compliance with the policy as part of the agreement, including, but not limited to:
    - employment under the role description,
    - remunerating staff at the level that meets the functional requirements of the position (recognising the relevant awards and organisational structures of the non-government sector),
    - working co-operatively with other IPRAs and the Statewide Coordinator,
    - complying with the record-keeping requirements,
    - participation in training and professional development sessions arranged by the Statewide Coordinator,

- providing information requested by the Chief Psychiatrist or Statewide Coordinator relevant to IPRA functions or outcomes, and
- the filling of vacancies.

3 Employment and function of IPRAs

An IPRA may be either:

- an employee of an entity that a HHS has engaged to provide services (such as a non-government organisation), or
- an employee of a HHS but not employed in the HHS's mental health service.

IPRAs are to be employed in accordance with a standard role description – **Attachment 2**.

IPRAs employed within HHSs are to be remunerated at a level equivalent to 'Administration Stream classification level AO7' in the 'District Health Services wage rates table'.

IPRAs employed in an external entity, such as a non-government organisation, are to be remunerated at a level commensurate with the required competencies for the position.

3.1 Performance management

IPRAs are accountable either to a HHS or external entity.

HHSs are to ensure that IPRAs are subject to usual HHS performance management processes and have plans developed with clear and measurable performance indicators and associated record keeping requirements.

For IPRAs employed in external entities, these performance measures are to be included in the agreement with the external entity.

The performance management process is not to interfere with or limit the independence of IPRAs.

Where the IPRA is employed in an external entity, HHSs **must** establish a point of contact within the

HHS to discuss any operational management issues, such as access to patients.

4 Coverage

HHSs **must**, as a minimum, appoint the number of IPRAs stated in **Attachment 3**.

In cases where HHSs are not large enough to warrant at least one full time position, arrangements **must** be made with another HHS to provide support, for example, through a joint appointment of IPRAs. These arrangements are to be negotiated locally between HHSs.

5 Functions

IPRA functions under s294 of the Act

- Ensure that patients and NSPs, family, carers and other support persons are advised of their rights and responsibilities under the Act,
- Help patients and NSPs, family, carers and other support persons to communicate to health practitioners the patient's views, wishes and preferences about the patient's treatment and care,
- Work cooperatively with community visitors under the *Public Guardian Act 2014*,
- Consult with AMHPs, authorised doctors, administrators and the Chief Psychiatrist on the rights of patients under the Act, the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*,
- Advise patients and NSPs, family, carers and other support persons of the patient's rights at Mental Health Review Tribunal hearings,
- If requested, help patients engage a representative for a Mental Health Review Tribunal hearing,
- Work cooperatively with any personal guardian or attorney to further the patient's interests, and
- Advise patients of the benefits of an advance health directive (AHD) or enduring power of attorney (EPOA) for a personal matter.

In performing their functions under the Act, an IPRA:

- **must** act independently and impartially, and
- is **not subject** to direction by any person in relation to the advice given to a patient or a patient's NSPs, family, carers and other support persons.

IPRAs **must** work co-operatively with the Statewide Coordinator and other IPRAs.

IPRAs may liaise as required with the Statewide Coordinator.

- For example, if an IPRA is of the opinion that an AMHS is not being sufficiently responsive to a complaint or to concerns raised about a patient's rights, or to ensure statewide consideration of patient rights issues that have been identified locally within a HHS.

In circumstances where the immediate attention of the Chief Psychiatrist may be required, IPRAs **must** contact the Statewide Coordinator for assistance.

6 Complaints management

IPRAs **must** ensure that any concerns or complaints regarding patients' rights or treatment and care, raised by a patient, their NSP, family, carers or other support person, are managed in accordance with the Chief Psychiatrist Policy - Management of Complaints and Right to a Second Opinion.

7 Assessing patient needs and prioritising provision of advice

IPRAs will need to prioritise interaction with patients, having regard to their needs and circumstances, including:

- the patient's mental condition
- the patient's social circumstances, including family and social support
- whether the patient is a child or adolescent
- whether the patient is a newly-admitted patient, involuntary or voluntary patient, inpatient or community-based patient, and
- information about the patient received from clinicians and NSPs, family, carers and other support persons.

IPRAs will also need to prioritise the provision of advice to NSPs, family, carers and other support persons, having regard to the needs and circumstances of the support person and the relevant patient.

8 Recordkeeping, communication information, disclosure and accessing records and notes

8.1 Confidentiality provisions

Key points

The requirement for 'designated persons', such as health service employees, to keep patient information confidential is outlined in the *Hospital and Health Boards Act 2011* (HHB Act).

The Act creates exceptions to this, namely:

- designated persons can disclose confidential information about a patient, including the patient's health records and written notices given under the Act, to an IPRA to enable the IPRA to perform functions under the Act, and
- an IPRA may use or disclose personal information to perform their functions.

8.2 Communicating information and disclosure

IPRAs **must** ensure proper communication of any high-risk information, such as suicidal ideation or an allegation of assault or mistreatment by a staff member, in accordance with hospital procedures.

IPRAs may use and disclose personal information to perform a function under the Act.

8.3 Recordkeeping

IPRAs **must**:

- keep a detailed record of patient interactions, including:
  - patient name,
  - date, time, duration and location of interaction,
  - nature of interaction (e.g. face-to-face, audio-visual),
  - other persons present (e.g. NSPs, family, carers or other support persons),
  - whether an interpreter was required and provided,
  - for inpatients, how long after admission the patient was seen,
  - concerns raised by the patient about their rights or their treatment and care, and whether further action is required, and
  - where follow up action is required, all action taken must be clearly documented.

These detailed notes are generally to be kept confidential from the patient's treating team.

To help ensure continuous improvement of IPRA services and to enhance patient outcomes, IPRAs **must** keep a record of common issues raised by patients or their NSPs, family, carers and other support persons in relation to patient rights.

- This information is to be provided to the Statewide Coordinator upon request.

8.4 Accessing records and notes

Key points

IPRA records **must** be accessible for the proper management of complaints about treatment and care in accordance with established HHS procedures.

- The Chief Psychiatrist Policy - Management of Complaints and Right to a Second Opinion **must** also be followed.

IPRA notes are to be accessible:

- to other IPRAs operating within the HHS, or

- if a patient is being treated in another HHS, by the IPRA working in that HHS.

The Chief Psychiatrist and the Statewide Coordinator may request access to IPRA notes at any time, for example, to investigate a serious complaint in relation to patients' rights.

An AMHS administrator may also request access to IPRA notes at any time, for example, if a patient is absent from an AMHS and there are concerns about the patient's health and well-being.

9 Skills, knowledge and training

9.1 Provision and quality of advice

IPRAs must provide advice to patients and their NSPs, family, carers and other support persons, which is consistent with the information contained in the Guide to Patient Rights under the *Mental Health Act 2016*

HHSs **must** ensure that IPRAs have sufficient skills and knowledge to allow them to capably and confidently perform their roles, prior to commencement of their employment.

9.2 Justices of the Peace and Commissioners for Declarations

One of the functions of IPRAs is to advise patients of the benefits of making an AHD or EPOA for a personal matter. AHDs and EPOAs **must** be witnessed by a person who is a Justice of the Peace, a Commissioner for Declarations, or a lawyer.

While this policy does not make it mandatory for IPRAs to be Justices of the Peace or Commissioners for Declarations, there are operational benefits in this. HHSs should consider whether to endorse IPRAs to undertake training as a Justice of the Peace or Commissioner for Declarations.

9.3 Training materials

The Statewide Coordinator is responsible for developing and disseminating training and other reference materials to the IPRA network.

IPRAs are responsible for understanding these materials and relaying relevant information to patients and NSPs, family, carers and other support persons.

9.4 Participation in the IPRA network and training

IPRAs **must** engage regularly with other IPRAs on the statewide network, and participate in any training, professional development sessions or information activities arranged by the Statewide Coordinator.

10 Coordination of statewide resources

10.1 Monitoring IPRA positions

Monitoring of IPRA positions and maintaining the network of IPRAs is the responsibility of the Statewide Coordinator.

- HHSs **must** advise the Statewide Coordinator of IPRA appointments before employment commences.
- Any subsequent changes to IPRAs **must** also be advised to the Statewide Coordinator at the earliest opportunity.

10.2 Information and assistance upon request

IPRAs and HHS representatives **must** provide any information requested by the Chief Psychiatrist or the Statewide Coordinator relevant to IPRA functions or outcomes.

IPRAs and HHS representatives **must** make every effort to assist the Chief Psychiatrist and the Statewide Coordinator to carry out their functions as they relate to IPRAs.

10.3 Filling vacancies and handovers

HHSs **must** advise the Statewide Coordinator within **five (5) business** days of an IPRA role becoming vacant, including on resignation of an IPRA.

- The HHS **must** immediately make arrangements to fill the IPRA role, ensuring uninterrupted continuity of the position.

When an IPRA is on annual leave, arrangements **must** be made to fill the position, before the period of leave commences.

If an IPRA resigns or takes annual leave for any period of time, arrangements must be made to ensure a comprehensive handover is delivered, to ensure continuity of patient care.

Policy issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service - a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
HHS	Hospital and Health Service
IPRA	Independent Patient Rights Adviser as defined under Chapter 9 Part 5 of the Act.
NSP	Nominated support person - a family member, carer or other support person **formally appointed** by a patient to be their nominated support person. NSP rights include: • must be given all notices about the patient that are required under the Act • may discuss confidential information about the patient's treatment and care • may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and • may request a psychiatrist report if the person is charged with a serious offence.
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and advance health directive or with the consent of a personal guardian or attorney.
Support person/s	Includes, a nominated support person or, if the person does not have a nominated support person, a family member, carer or other support person.

Referenced documents and sources

Statewide IPRA contact list
IPRA role description
Allocation of IPRAs across Hospital and Health Services
Chief Psychiatrist Policy – Management of complaints and right to a second opinion
Guide to Patient Rights under the *Mental Health Act 2016*
Hospital and Health Boards Act 2011

Referenced documents and sources

Public Guardian Act 2014
Guardian and Administration Act 2000
Powers of Attorney Act 1998

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To be reviewed by:	15 April 2023

Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Statewide Coordinator Independent Patient Rights Advisers	Phone: 07 3328 9243 / 0472 846 365 Email: IPRA-Network@health.qld.gov.au
Statewide Independent Patient Rights Adviser Contact List	Available on the Act website
Local Independent Patient Rights Adviser	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Attachment 2: IPRA role description

Position details			
Title	Independent Patient Rights Adviser	**Location**	Statewide
Salary range		**Classification**	AO7*
Division	N/A	**Branch/work unit**	N/A
Reports to	Depends on employment arrangement	**Direct reports**	Nil
Status	Full time and/or part time	**Success factor profile**	Supervisor

* IPRAs employed in an external entity such as a non-government organisation are to be remunerated at a level commensurate with the required competencies for the position.

Insert details of HHS

About the role

The purpose of this role is to advise patients and their nominated support persons, family, carers and other support persons of their rights under the *Mental Health Act 2016*.

The functions of Independent Patient Rights Advisers are set out in section 294 of the Act, namely:

- Ensure that a patient, and the patient's nominated support persons, family, carers and other support persons are advised of their rights and responsibilities under the Act,
- Help the patient, and the patient's nominated support persons, family, carers and other support persons to communicate to health practitioners the patient's views, wishes and preferences about the patient's treatment and care,
- Work cooperatively with community visitors performing functions under the *Public Guardian Act 2014*,
- Consult with authorised mental health practitioners, authorised doctors, administrators of authorised mental health services, and the chief psychiatrist on the rights of patients under the Act, the *Guardianship and Administration Act 2000*, the *Powers of Attorney Act 1998* and other laws,
- In relation to hearings of the Mental Health Review Tribunal:
    - advise the patient, and the patient's nominated support persons, family, carers and other support persons of the patient's rights at the hearings,
    - if requested, help the patient engage a representative for the hearings,

- Identify whether the patient has a personal guardian or attorney and, if the patient has a personal guardian or attorney, work cooperatively with the personal guardian or attorney to further the patient's interests, and
- If appropriate, advise the patient of the benefits of an advance health directive or enduring power of attorney for a personal matter.

An Independent Patient Rights Adviser, in performing the adviser's functions:

a) must act independently and impartially, and

b) is not subject to direction or control by any person in relation to advice given, or help provided, to a patient or a patient's nominated support persons, family, carers or other support persons,

c) work in accordance with the *Mental Health Act 2016* and the Chief Psychiatrist Policy Independent Patient Rights Advisers.

An Independent Patient Rights Adviser may be:

a) an employee of an entity that a Hospital and Health Service has engaged to provide services; or

b) an employee of a Hospital and Health Service but not employed in the Service's mental health service.

An Independent Patient Rights Adviser must have a commitment to patient rights, demonstrate professional integrity, and be committed to achieving results for the benefit of patients, family, carers and other support persons.

Role fit

The essential requirements for this role are:

- Demonstrated knowledge of the application and requirements of the *Mental Health Act 2016* or ability to rapidly acquire such knowledge,
- Demonstrated ability to consult with a broad range of mental health stakeholders, including mental health consumers, support persons, carers, authorised doctors and administrators of authorised mental health services,
- Demonstrated high level oral and written communications skills and ability to support people from vulnerable population groups, such as persons with a mental illness, and
- High level negotiation and conflict resolution skills.

Specific working conditions

Intra-state travel may be required.

Independent Patient Rights Advisers may be required to witness Advance Health Directives for patients. Advance Health Directives may be witnessed by a justice of the peace, a commissioner for declarations, a lawyer or a notary public.

Employee obligations – insert HHS details

Attachment 3: Allocation of IPRAs across HHSs

HHS	FTE	Comments
Cairns and Hinterland	2	Includes extra capacity to support Torres and Cape HHS
Central Queensland	2	Includes extra capacity to support Central West HHS
Central West	0	Service to be provided by Central Queensland HHS
Darling Downs	2	Includes extra capacity to support South West HHS
Gold Coast	3	
Mackay	1	
Metro North	5	
Metro South	5	
North West	0	Service to be provided by Townsville HHS
South West	0	Service to be provided by Darling Downs HHS
Sunshine Coast	2	
Torres and Cape	0	Service to be provided by Cairns and Hinterland HHS
Townsville	2	Includes extra capacity to support North West HHS
West Moreton	2	
Wide Bay	1	
Children's Health Queensland	1	
Statewide Coordinator (within the Office of the Chief Psychiatrist)	1	
Total	**29**	

Mental Health Act 2016
Chief Psychiatrist Policy

Inpatient treatment of individuals subject to Dangerous Prisoners (Sexual Offenders) Act Orders

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General

This policy is intended to assist authorised mental health services (AMHSs) in planning for the admission, treatment and discharge of patients who:

- are subject to *Dangerous Prisoners (Sexual Offenders) Act 2003* (DPSOA) supervision orders, and
- require inpatient admission to an AMHS for mental health care as part of transition from custody to the community.

Scope

This policy is **mandatory** for all AMHSs. Any AMHS admitting persons subject to DPSOA supervision orders as inpatients must do so in compliance with this policy.

Staff should work collaboratively and in partnership with individuals in their care to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. This should include the timely involvement of appropriate local supports and a recovery-oriented focus.

This policy must be implemented in a way that is consistent with the objects and principles of the *Mental Health Act 2016*.

This policy is issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly
Chief Psychiatrist, Queensland Health
28 October 2021

Policy

1 Key information

The DPSOA applies to prisoners who have committed serious sexual offences who, at the end of their sentence of imprisonment, are still considered to pose an unacceptable risk to the community of committing further serious sexual offences. The DPSOA allows the Attorney-General to apply to the Supreme Court for orders intended to manage unacceptable risk posed to the community, including:

- an order requiring ongoing detention in a correctional facility following the conclusion of a person's prison sentence (a **continuing detention order**), or
- an order requiring that on release to the community the person be subject to conditions and oversight by Queensland Corrective Services (a **supervision order)**.

Whether the Supreme Court makes either of those orders depends on the evidence that is before the court establishing that the prisoner is a serious danger to the community in the absence of either a continuing detention or supervision order. In making its assessment of a prisoner's risk, the Court is informed by evidence from expert psychiatrists.

While the DPSOA requires that certain mandatory requirements be imposed on a person subject to a supervision order, additional requirements may be added by the Supreme Court based on the person's risk to community safety. Supervision and monitoring of the person in the community is integral to the operation of the DPSOA. People subject to supervision orders will commonly be subject to requirements which include GPS monitoring, alcohol and drug testing, home visits, referral to intervention services and case management. Where a supervision order is contravened, the Supreme Court may order that the person be returned to custody.

A person's mental health treatment needs in the community are an important consideration that should be addressed prior to release from custody by the person's mental health treating team. If a supervision order is, or is likely to be, made by the Court, a person's mental health treatment needs in the community may be relevant to the Court's decision making, including recommendations related to inpatient treatment and care. In limited cases, where a person has identified inpatient treatment and care needs, admission followed by supported transition to the community may be considered appropriate by the Supreme Court.

2 Identification of person to whom the DPSOA applies

The High Risk Offender Management Unit (HROMU) is a unit within Queensland Corrective Services that is responsible for the management and oversight of people subject to orders under the DPSOA.

Key points

- The HROMU will advise the Office of the Chief Psychiatrist of individuals identified as potentially requiring supervision orders in order to facilitate the identification of shared clients.
- The Office of the Chief Psychiatrist will notify the relevant AMHS Administrator of any person who:
  - is identified as being subject to an order or application for an order under the DPSOA, and
  - has a mental illness, and
  - may require admission to an AMHS prior to transitioning to the community.
- The Office of the Chief Psychiatrist will also notify the relevant Prison Mental Health Service (PMHS) and/or Indigenous Mental Health Intervention Program (IMHIP) clinicians and the Statewide Program Coordinator – Classified Patients that a supervision order may be made, to enable appropriate planning for a person's care after release from custody.

Where a PMHS treating team or IMHIP clinician anticipates that a person may require inpatient care as part of their release from custody under a supervision order, the Office of the Chief Psychiatrist **must** be notified in writing via email at DPSOA@health.qld.gov.au.

Where appropriate, such persons may be discussed at the bi-monthly *Patients of concern in custody meeting*, however this meeting should not be relied upon as the only means of planning for potential AMHS admission.

In circumstances where the HROMU advises of the potential for an order to be made for a person with previous mental health contact who is not a current shared client, a referral to PMHS may be made by the HROMU. Based on the referral information PMHS may consider it appropriate to engage the person in a mental health assessment while the person is in custody and consider any recommendations (for example by private psychiatrists reporting for the court proceedings) related to the person's potential release under a supervision order.

3 Making a supervision order

A supervision order will include requirements that a person must adhere to which are aimed at reducing the risk of further offending. Health related requirements of the Court may stipulate that a person engage with mental health treatment and care in the community, or that a person be released from custody to an inpatient facility for treatment and care. Such requirements are informed by evidence before the Court and the Court being satisfied that the requirements are necessary to reduce risk to the community.

Key points

- The Court's power to make supervision orders and associated requirements comes from the DPSOA.
- The provisions of the *Mental Health Act 2016* are not applied by the Court when making a supervision order. The Court **cannot** order that a person be assessed or admitted under the *Mental Health Act 2016*.
- Engagement in treatment and admissions required by a supervision order, for a person with capacity, require a person's consent.
- A supervision order will not prevent the *Mental Health Act 2016* from applying where a person requires involuntary treatment and care.

4 Court proceedings

Key points

- The timeframes leading into DPSOA hearings differ depending on the type of hearing.
- Prior notice that the Court has made an order which necessitates a person's admission to an AMHS as part of their release from custody can be very limited.
  - Proceedings for initial decisions under the DPSOA must be initiated within the six months prior to the end of a person's prison sentence.
  - Hearings to review an existing supervision order (e.g. following a contravention of the order's conditions) are likely to occur at much shorter notice. These hearings may involve an examination of the requirements of an existing supervision order.
- Independent psychiatric reports addressing a person's risk of future sexual offending are considered by the Supreme Court in DPSOA hearings.

In making a decision, the Court is required to have regard to a number of matters, including the reports of independent psychiatrists which provide an assessment of the level of risk that the person will commit another serious sexual offence if released from custody. If an independent psychiatrist identifies mental health treatment needs, they may also recommend inpatient admission to an AMHS in their report to the Court.

These reports may be made available to the Chief Psychiatrist or an AMHS with the consent of the person who is the subject of the DPSOA hearings or by order of the Supreme Court. These reports, and the advice of a person's treating team if they are open to a PMHS and/or IMHIP, will be used to inform the Chief Psychiatrist's advice to the Court as to the suitability of an admission to an AMHS.

5 Allocation of authorised mental health service

Where admission to an AMHS is likely to form part of the supervision order, details about which AMHS is best placed to provide treatment and care will be communicated to the Supreme Court by the Chief Psychiatrist for the Court's consideration.

Key points

Information provided to the Court may include:

- the operation of particular units within AMHSs
- any expected wait time for admission and details of admission processes
- details of treatment available at the relevant AMHS, and
- potential transition pathways for discharge from the inpatient facilities and available community-based treatment and care.

Determining the most appropriate AMHS for a person's admission will depend on several factors, such as the person's treatment and care needs, bed availability, risk profile and plans for a person's treatment and care in the community post inpatient admission.

The Chief Psychiatrist, in consultation with the Statewide Program Coordinator – Classified Patients and relevant AMHS Administrator(s), will determine the most appropriate AMHS to provide treatment and care to a person subject to supervision order. Allocation to an AMHS will be made after consideration of all available information about a person's treatment needs and risk management requirements.

Admission to the High Security Inpatient Service or a Secure Mental Health Rehabilitation Unit for treatment may be required in some circumstances.

If the person does not require admission to the High Security Inpatient Service or a Secure Mental Health Rehabilitation Unit, the relevant AMHS will be determined after considering:

- whether the person has a Treatment Authority, Forensic Order or Treatment Support Order attached to an AMHS,
- the location of an existing open service episode (other than a service episode initiated by the PMHS or Court Liaison Service),
- the person's last known residential address prior to imprisonment,
- the proposed residential address for the person,
- where the person has recent or strong treatment links, and/or
- any relevant cultural considerations including positive strong cultural links, closeness to country or risk of cultural payback.

Where no preferred AMHS has been identified based on the above criteria, admission will be negotiated with the most appropriate AMHS. Where there is concern or dispute about whether an identified AMHS is best placed to provide treatment for a person, the matter will be reviewed by the Chief Psychiatrist. In seeking to address concerns or resolve disputes raised by the identified AMHS the Chief Psychiatrist will consult directly with the Queensland Forensic Mental Health Service, PMHS and/or IMHIP, and the Administrator and Clinical Director of the proposed AMHS.

6 Admission and Treatment

6.1. Pre-admission planning and education

Prior to a person subject to a supervision order being admitted to an AMHS, the Statewide Program Coordinator – Classified Patients will:

- provide outreach planning and education to the relevant AMHS
- support the AMHS in ensuring that staff have been provided with information about the operation of supervision orders and any impact this may have on providing treatment and care to the person, in particular, limitations on the sharing of information.

Prior to admission, a stakeholder meeting(s) should be convened between the HROMU, the treating team of the receiving AMHS, the receiving AMHSs forensic liaison officer, PMHS and/or IMHIP and the Statewide Program Co-ordinator – Classified Patients to ensure that:

- all relevant collateral information required to plan and provide treatment and care for the person has been shared,
- there is an agreed plan for transfer and admission of the individual, and
- AMHS staff are informed of the HROMU's ongoing role in providing oversight of the supervision order during the person's admission.

6.2. Treatment of person subject to a supervision order

A supervision order does not provide authority for the provision of involuntary treatment and care for a person's mental illness.

Key points

- If a person subject to a supervision order requires involuntary treatment and care for their mental illness, they **must** meet the criteria as outlined in the relevant provisions of the *Mental Health Act 2016* (see *Chief Psychiatrist Policy – Treatment Criteria, assessment of capacity, less restrictive way and advance health directives*).
- A supervision order will not impact on the application of the *Mental Health Act 2016.*
- A person with capacity retains their right to decline to engage in treatment for their mental illness. However, this may result in a breach of their supervision order.
- Whether a person subject to supervision order continues to reside in the community (including an inpatient mental health facility), may be conditional on their engagement in treatment and care for their mental illness, as well as compliance with any other condition of their supervision order.
- Support should be provided to the person in understanding the conditions of their supervision order to assist their informed decision making regarding mental health treatment.
- Careful clinical consideration should also be given to whether any risk posed by a person subject to a supervision order is based on the person's mental illness and need for treatment and care, and therefore whether the risk should be managed under the *Mental Health Act 2016.*

Support should be provided to the person in understanding the conditions of their supervision order to assist their informed decision making regarding mental health treatment. Where a person is non-adherent, or declines to consent to treatment, clinicians should work with the person to address any barriers to engagement with treatment. This should include consideration of whether the person has the capacity to consent to treatment and whether involuntary treatment under the *Mental Health Act 2016* may be appropriate.

Where attempts to engage a person with capacity in treatment are unsuccessful, careful consideration should also be given to whether declining to engage in treatment should be disclosed to the HROMU using the mechanisms for disclosure outlined in section 3 of this policy.

6.3. HROMU oversight of persons subject to supervision orders

An inpatient facility of an AMHS is considered part of the community for the purposes of a supervision order. Therefore, the HROMU remains responsible for the oversight and management of a person's supervision order when they are admitted to an AMHS.

While AMHS staff are not responsible for ensuring a person's compliance with their supervision order they should be mindful of the terms of the supervision order and how they may interact with any requirements of orders made under the *Mental Health Act 2016* to ensure the person's mental health treatment and care needs are appropriately met.

> The terms of a person's supervision order may contain references to 'treatment' provided by the HROMU or Queensland Corrective Services. This **does not** mean providing treatment and care for mental illness.
>
> 'Treatment' provided by Queensland Corrective Services under a supervision order refers to criminogenic interventions intended to reduce or prevent risk of future sexual offending and support the persons rehabilitation.

7 Information sharing with the HROMU

In limited circumstances, it may be necessary for clinicians to share appropriate and relevant information with the HROMU to support appropriate treatment and care of patients subject to supervision orders.

The conditions of a supervision order may require that a person consent to the disclosure of information about their mental health treatment and care to the HROMU, including by AMHS clinicians.

> For example, a supervision order may require that a person *'give authority to a mental health service provider to disclose to a Corrective Services officer details of their treatment'*.

A supervision order that contains a requirement that a person consents to the disclosure of such information **does not** expressly permit AMHS staff to share a patient's confidential information.

Clinicians providing treatment and care to persons subject to supervision orders are 'designated persons' for the purpose of the *Hospital and Health Boards Act 2011* and are bound by relevant provisions prohibiting disclosure of any confidential information acquired during the course of a person's treatment, unless required or permitted by law. For persons receiving involuntary treatment and care in an AMHS, the confidentiality provisions of the *Mental Health Act 2016* will also apply.

AMHS clinicians **must** ensure an appropriate mechanism is available to enable them to disclose the person's confidential health information, where appropriate and relevant.

Where disclosure occurs, the details of any confidential information disclosed, including with whom the information was shared, the purpose of the disclosure and the mechanism relied upon for disclosure **must** be recorded in the patient's clinical record.

Clinicians **must** be aware that the *Information Sharing Agreement between Queensland Health and Queensland Corrective Services* **does not** provide for information to be shared in relation to persons subject to a DPSOA order who are admitted as an inpatient in an AMHS.

7.1.Disclosure with informed consent

Key points

- Consent or authority for information disclosure given in the context of court proceedings or in relation to correctional supervision **cannot** be substituted for informed consent for disclosure of information relating to health care.
- AMHS staff **must** seek a patient's informed consent to disclose information about their health care where the patient has capacity to do so.
- If a patient lacks capacity to give informed consent for the disclosure, AMHS staff should consider whether the person has a substitute decision maker, such as an appointed guardian, who is able to give consent for them.
- If appropriate, ongoing attempts should be made to seek consent as the patient's mental health improves.

A patient who has capacity may choose not to consent to the disclosure of their confidential information, even if doing so may mean that they breach their supervision order.

For further information regarding seeking informed consent for disclosure of confidential information, staff should refer to the *Guide to Informed Decision Making in Health Care.*

7.2. Disclosure without informed consent

Prior to any disclosure of information to the HROMU in the absence of a patient's informed consent, AMHS staff should seek local advice.

Where consent to disclose information cannot be obtained (i.e. the person refuses to consent, lacks capacity or it is impracticable to obtain consent), mechanisms exist to enable the appropriate and relevant sharing of information:

7.2.1. Sharing information to facilitate treatment and care

Key points

- AMHS staff may be able to share information for the purpose of facilitating treatment and care without the patient's consent.
- Section 145 of the *Hospital and Health Boards Act 2011* permits the disclosure of confidential information that is necessary for the patient's treatment and care. Treatment in this context refers to treatment and care provided by the mental health services.
- The decision to share information regarding treatment and care under section 145 is at the discretion of the Designated Person.

AMHS staff should refer to the guidelines for *Information Sharing: Between mental health staff, consumers, family, carers, nominated support persons and others* when considering sharing information with the HROMU without a patient's consent.

7.2.2. Sharing information unrelated to treatment and care

Confidential information held by an AMHS may include information which is unrelated to a person's treatment and care for mental illness. This may include, for example, knowledge of whether a person is compliant with conditions of their supervision order.

Key points

- The *Hospital and Health Boards Act 2011* contains provisions which may permit the disclosure of confidential information, including knowledge of a person's compliance with their supervision order, in specific circumstances:
  - **Section 147** - disclosure by the relevant Hospital and Health Service Chief Executive to lessen or prevent serious risk to life, health or safety
  - **Section 148 -** disclosure for the protection, safety or wellbeing of a child, or
  - **Section 160** - disclosure by the relevant Hospital and Health Service Chief Executive (HHSCE) on the grounds the disclosure of confidential information is in the public interest.
- If an AMHS clinician is aware that a person has breached the terms of their supervision order, the matter **must** be escalated to the relevant clinical director.
- The clinical director **must** consider if disclosure should occur under a relevant section of the HHBA. If appropriate, the clinical director may then:
  - disclose the information under the relevant section of the HHBA, or
  - seek approval to disclose the information (If required) under the relevant section.

Prior to disclosing information, the clinical director **must** also give careful clinical consideration as to whether the breach arises from the person's mental illness and need for treatment and care. Where necessary, the AMHS should take steps to modify the treatment and care plan to address identified issues, including by commencing involuntary treatment under the *Mental Health Act 2016* if required.

Disclosure about a breach of supervision order requires a higher threshold in terms of authority for releasing information than disclosure for the purposes of facilitating treatment and care. Where a public interest release of information is being considered, the matter **must** be escalated to the relevant Hospital and Health Service Chief Executive for a determination about release of the information.

8 Discharge following inpatient admission

Generally, the terms of a supervision order will allow for a person to be discharged from an AMHS at a time considered appropriate by their treating psychiatrist, based on the person's treatment needs. Where a treating psychiatrist assesses that a person no longer requires inpatient treatment they **must** liaise with the HROMU to:

- effectively communicate the reasons why a person no longer requires inpatient treatment and care, and
- plans for the person's ongoing mental health treatment in the community.

The treating service should consult with the Office of the Chief Psychiatrist, in addition to liaising with the HROMU as required, if the person subject to the DPSOA order has been:

- admitted to the High Security Inpatient Service or a Secure Mental Health Rehabilitation Unit, and
- requires transfer to another AMHS for ongoing inpatient treatment and care.

Further information

Definitions and abbreviations

Term	Definition
Continuing detention order	An order made under section 13(5)(a) of the DPSOA after a person's sentence of imprisonment for serious sexual offence/s has expired, allowing for ongoing detention in custody for an indefinite term for control, care and treatment.
DPSOA	*Dangerous Prisoners (Sexual Offenders) Act 2003* (Queensland).
Designated Person	Designated person has the same meaning as in section 139A of the *Hospital and Health Boards Act 2011* and includes clinicians and employees of an HHS.
High Risk Offender Management Unit	A statewide unit of Queensland Corrective Services, responsible for the management and oversight of people subject to orders made under the DPSOA.
Indigenous Mental Health Intervention Program	The Indigenous Mental Health Intervention Program is an Aboriginal and Torres Strait Islander led, multidisciplinary, social and emotional wellbeing service for Indigenous people in custody. It provides early identification, in custody care and transitional support to connect individuals back to their community.
Patients of Concern in Custody Meeting	A bi-monthly meeting between Queensland Corrective Services and Prison Mental Health Service, chaired by the Queensland Forensic Mental Health Service, which aims to ensure effective and appropriate communication to support the mental health and risk management of people suffering complex mental health problems within or exiting custody in Queensland.
Prison Mental Health Service	Prison Mental Health Services are Hospital and Health Service in-reach mental health services that provide specialist mental health care to consumers incarcerated in Queensland Corrective Services Facilities
Shared client	A prisoner or person under the supervision of Queensland Corrective Services who is also receiving health services provided or contracted by a Hospital and Health Service.
Supervision order	An order of the court made under section 13(5)(b) of the DPSOA after a person's sentence of imprisonment for serious sexual offence/s has expired, allowing for continuing supervision and monitoring in the community by Queensland Corrective Services.

Referenced policies and resources

Policies, guidelines and other resources

- Chief Psychiatrist Policy – Treatment Criteria, assessment of capacity, less restrictive way and advance health directives
- Guide to Informed Decision-Making in Health Care
- Information Sharing Between mental health staff, consumers, family, carers, nominated support persons and others guidelines

Legislation

- *Mental Health Act 2016*
- *Dangerous Prisoners (Sexual Offenders) Act 2003*

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Mental Health Act 2016

Chief Psychiatrist Policy

Judicial Orders

Examination Orders, Court Examination Orders and Other Judicial Orders

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General

A Judicial Order is an order made by a Court authorising the detention of a person in an authorised mental health service (AMHS) and generally, authorises the examination of the person by an authorised doctor or a specified examining practitioner (determined by the Court).

A Judicial Order means:

- an Examination Order
- a Court Examination Order, and
- another order made by a Court under the *Mental Health Act 2016* (the Act), requiring or permitting a person to be detained in an AMHS for a particular purpose (e.g. while court proceedings are underway).

Under certain circumstances, they may authorise ongoing detention in an AMHS or public sector health service facility (PSHSF).

A Judicial Order does not authorise involuntary treatment.

Scope

This Policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner (AMHP), AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this Policy.

This Policy **must** be implemented in a way that is consistent with the Objects and Principles of the Act.

Policy

1 Magistrates Court

The *Magistrates Examination Order flowchart* provides an overview of the Examination Order process.

1.1 Examination Orders

A Magistrate can make an Examination Order for a person charged with a simple[1] offence, if they are concerned about the mental condition of the person.

Key points

An Examination Order authorises an authorised doctor of the AMHS (or PSHSF) stated in the order, to examine the person without their consent and determine whether:

- the person requires treatment and care for a mental illness,
- to make a Treatment Authority for the person,
- to make a recommendation for the person's treatment and care, or
- change the patient's treatment and care if the person is already subject to a Treatment Authority, Treatment Support Order or Forensic Order under the Act.

Once the Examination Order is made, if the charges have not already been dismissed, the magistrate may adjourn the hearing until after the examination is completed.

- Where available, the Queensland Health Court Liaison Service (CLS) should assist the Magistrate in determining the nearest or most appropriate AMHS or facility for the order. See Chief Psychiatrist Policy Court Liaison Service.
- However, it is not the role of CLS clinicians to conduct examinations under an Examination Order. These **must** be undertaken by an authorised doctor of the AMHS or PSHSF stated in the order.

In a PSHSF, the person in charge of the facility **must** ensure there is access to an authorised doctor to conduct the examination under an Examination Order.

- The Act does not place restrictions on the use of audio-visual technology for undertaking an examination.

The Registrar of the court **must** give written notice of the Examination Order to the administrator of the AMHS, or to the person in charge of the PSHSF, stated in the order.

A copy of the Examination Order **must** be uploaded to the Consumer Integrated Mental Health Application (CIMHA).

[1] ***simple offence*** means any offence (indictable or not) punishable, on summary conviction before a Magistrates Court, by fine, imprisonment, or otherwise.

1.1.1 Transportation under an Examination Order

Key points

An Examination Order may:

- direct an authorised person (see definitions) to transport the person immediately to an AMHS
- direct the person to attend an AMHS or PSHSF within a specific time, of not more than **twenty-eight (28) days**, after the order is made.
    - An order to attend may be made for a person who has had their charges dismissed, or who is granted bail to remain in the community.

A person who is directed to attend an AMHS immediately may be transported by an authorised person (see definitions).

Where available, the CLS should assist with arrangements for immediate transportation.

If the person is in police, court or corrective services custody at the time the Examination Order is made (e.g. remanded in custody), the relevant custodian should transport the person to the AMHS as required.

If the person is not in custody at the time the Examination Order is made, the least restrictive way of transporting the person, having regard to clinical and risk matters, should be utilised. Transport options may include:

- family, carer or support networks
- non-emergency hospital or community transport services
- ambulance
- a health service vehicle driven by a health service employee, with additional escort where needed, or
- police, with health service employee escort where needed.

The Interagency agreement between Queensland Health, Queensland Ambulance Service and Queensland Police Service, Safe transport of People with Mental Illness, outlines factors that should be considered when determining transport options.

If police assistance is required for the transportation, a Request for Police Assistance form **must** be completed by an authorised doctor, AMHP or the administrator of an AMHS.

This requirement does not apply if the Court has ordered police to assist, or the person would otherwise be in police custody.

An authorised person transporting a person under an Examination Order **must** comply with the Chief Psychiatrist Policy Transfers and Transport.

If the Court ordered that a person be immediately transported to an AMHS, the Examination Order also authorises an authorised person to transport the person from the AMHS to appear before the Court following the examination.

1.1.2 Attendance and non-attendance

Key points

If a person has been ordered to attend the AMHS or PSHSF within **twenty-eight (28) days** under an Examination Order, the AMHS or PSHSF will receive a copy of the order and should:

- contact the person named in the order,
- schedule an appointment for the examination within the required timeframe, and
- update CIMHA to reflect that the person has an Examination Order.

The person's Examination Order status in CIMHA will show as 'pending'. The patient is not 'opened' under the Examination Order until they present for the examination.

If a person does not follow the directions of an Examination Order (i.e. does not attend the service within 28 days or absconds while being taken to an AMHS), the Chief Psychiatrist Policy Involuntary Patient Absences applies.

Notification of the person's failure to comply with the Examination Order **must** be sent by email to the Registry of the Magistrates Court that made the Examination Order.

- A copy of the Examination Order should be included in the email.

1.2 Examination

Key points

A person may be detained for up to **six (6) hours** under an Examination Order, starting from when the person arrives at the relevant facility.

- An authorised doctor can extend the examination period for a further **six (6) hours** (the total examination period **must** not exceed **twelve (12) hours**).

The Chief Psychiatrist Policy Examination and Assessment **must** be complied with when undertaking the examination.

1.2.1 Examination Report

Key points

The authorised doctor completing the examination **must** complete the Examination Report form. This form includes providing advice on the following:

- details of the examination carried out,
- the recommendation or decision reached regarding treatment, and
- if a recommendation for treatment has been made, details of the explanation given to the patient regarding the benefits of being treated voluntarily.

The Examination Report **must not** provide commentary on the person's offence, criminal responsibility or fitness for trial.

The Examination Report **must** be completed on the patient's clinical record on CIMHA.

A copy of the Examination Report **must** be emailed to the registry of the relevant Magistrates Court as soon as practicable, but within **twenty-one (21) days.**

The Examination Report is admissible at the hearing related to the charges for which the order was made, and any future proceedings to allow the Court:

- to decide whether to make an Examination Order for a person at a future proceeding, or
- to decide whether to refer to the matter to the Mental Health Court.

Although the Examination Report may be used by the Court, statements made by the person in the process of an examination are not admissible in any criminal or civil proceedings.

- The exceptions to this are where the proceedings relate to charges of contempt of court or an offence relating to the administration of justice (Chapter 16 of the Criminal Code). If the report is received into evidence, it can only be used with permission from the Court.

1.3 Outcomes of Examination Order

If an authorised doctor makes a Treatment Authority for the person, they **must** comply with the *Chief Psychiatrist Policy Treatment Criteria, Assessment of Capacity, 'Less Restrictive Way' and Advance Health Directives* and the *Chief Psychiatrist Policy Treatment Authorities*.

A Recommendation for Assessment is not required prior to a Treatment Authority being made as a result of an Examination Order.

If an authorised doctor makes a recommendation for a person's treatment and care, the doctor **must** explain to the patient the benefits of being treated voluntarily in accordance with the doctor's recommendation.

1.3.1 Classified admissions

A person with a custodial status (e.g. a person on remand or sentenced prisoner) may require an admission to an AMHS beyond the time allowed under an Examination Order to enable treatment to be provided to the person.

See section 4 of this policy for requirements for classified admissions.

2 Mental Health Court

2.1 Court Examination Orders

Key points

References to the Mental Health Court are usually accompanied by a psychiatric or other clinical report. The Mental Health Court may order further examination/s (a Court Examination Order - CEO) of a person whose matter has been referred to the Mental Health Court.

A CEO requires the person to be assessed by the stated examining practitioner. The Mental Health Court will determine the matters which are required to be addressed in the CEO.

If the Court makes a CEO, the registrar of the Court **must** give written notice of the order to the parties and the stated examining practitioner.

The specified examining practitioner **must** provide a written report back to the Court.

2.1.1 Recommendation and request for CEO

An assisting clinician may recommend to the Mental Health Court that a CEO be made.

The Director of Public Prosecutions may ask the Mental Health Court to make a CEO.

If a recommendation or request is made, the registrar of the Court must give written notice to the parties to the proceedings of the request or recommendation, with a time frame for providing submissions related to this request.

The Court will consider any submissions made by the parties to the proceedings in relation to the recommendation or request when determining whether to make a CEO.

2.1.2 Detention under a CEO

Key points

If the Court cannot find another way of ensuring a thorough examination of the person's mental condition, the Court may order that the person be detained in an inpatient unit of an AMHS for:

- the period of time stated in the CEO, or

- a maximum of **three (3) days**, starting from when the person arrives at the AMHS.

If detention is ordered, an authorised person may transport a person who is the subject of a CEO to an inpatient unit of an AMHS for the examination.

If the CEO does not state that police can transport the person (i.e. it authorises a health practitioner or ambulance officer), and police assistance is required, a Request for Police Assistance form **must** be completed by an authorised doctor, authorised mental health practitioner or the administrator of an AMHS.

An authorised person transporting a person under CEO **must** comply with the Chief Psychiatrist Policy Transfers and Transport.

If the CEO requires the person to be detained for the examination, and they are not already in an AMHS when the order is made, the authority to transport absent person provision of the Act can be applied. In this case, an authorised person transporting a person **must** comply with the Chief Psychiatrist Policy Involuntary Patient Absences.

2.1.3 Examination under a CEO

The examining practitioner may examine the person without the consent of the person or anyone else.

- If the person is detained in an AMHS for the examination, the specified examining practitioner and anyone lawfully helping the practitioner may use the force that is necessary and reasonable in the circumstances to examine the person.

2.1.4 Ending of a CEO

After the examination time period has elapsed, or the examination has been completed (if earlier) an authorised person may transport the person back to lawful custody (e.g. if the person was transported from another AMHS, prison, or the Forensic Disability Service).

If the person was transported for the CEO from a community setting (e.g. the person is not in lawful custody), the administrator of the AMHS **must** ensure arrangements are made to:

- transport the person back to the place from which the person was taken for the examination, or
- transport the person to another reasonable location the person has asked to be taken.

This does not apply if the person is, or becomes, an involuntary patient requiring detention in the AMHS (e.g. on an inpatient-category authority or order) or a voluntary classified patient.

2.1.5 Classified admissions

A person with a custodial status (e.g. a person on remand or sentenced prisoner) may require an admission to an AMHS beyond the time allowed under an Examination Order to enable treatment to be provided to the person.

See section 4 of this policy for requirements for classified admissions.

3 Other Judicial Orders

3.1 Magistrate, District and Supreme Court

Key points

A Magistrate, District or Supreme Court may order the detention of a person in an AMHS if court proceedings are adjourned and the Court is satisfied that the person should be detained in an AMHS due to the person's mental condition.

If a person has pleaded guilty, a District or Supreme Court may:

- order a plea of not guilty be entered and refer the matter of a person's mental state or condition to the Mental Health Court for further examination, and
- order that the person be detained in an AMHS during an adjournment of the District or Supreme Court proceedings.

3.1.1 Detention in an AMHS

Key points

A person may only be detained in an AMHS under a Judicial Order made by the Magistrates, District or Supreme Court if written agreement has been given by the administrator of the relevant AMHS or the Chief Psychiatrist.

The administrator can only agree to the detention of the person if they are satisfied the AMHS has the capacity to detain the person for treatment and care. The administrator **must** be satisfied the person's detention in the AMHS does not pose an unacceptable risk to the person or others having regard to:

- the person's mental state and psychiatric history
- the person's treatment and care needs, and
- the security requirements for the person.

If the administrator of the AMHS has not given agreement to the person's detention in the service, the Chief Psychiatrist may provide this agreement having regard to the same criteria outlined above.

- The Chief Psychiatrist's agreement has the same effect as the administrator's agreement.
- Prior to making a decision, the Chief Psychiatrist will contact the administrator of the relevant AMHS to discuss the matter.

If the Chief Psychiatrist gives agreement to the detention, a copy of the written agreement will be provided to the relevant administrator.

If a Judicial Order is for a minor and relates to the High Security Inpatient Service, the administrator of the AMHS cannot provide agreement for the detention unless the Chief Psychiatrist has provided written approval.

3.1.2 Mental Health Court

If the Mental Health Court orders that proceedings are to continue against the person, the Court can order that the person be detained in a stated AMHS until the person is granted bail or brought back to the Court to continue proceedings.

If an appeal has been made to the Mental Health Court, the Court can stay (postpone) that decision to secure the effectiveness of the appeal.

- The Court can order that the person subject to the appeal be detained in a stated AMHS for the duration of the stay.

If an appeal is made to the Court of Appeal against a decision of the Mental Health Court, and the Court of Appeal returns the matter to the Mental Health Court, the Court of Appeal may order the person to be detained in a stated AMHS.

3.1.3 Transportation

An authorised person may transport a person the subject of a Judicial Order under this section to an AMHS.

If the order does not state that police can transport the person (i.e. it authorises a health practitioner or ambulance officer), and police assistance is required, a Request for Police Assistance form **must** be completed by an authorised doctor, authorised mental health practitioner or the administrator of an AMHS.

At the end of the period of detention specified in the order, an authorised person may transport the person back to lawful custody if required (e.g. if the person was transported from another AMHS, prison, or the Forensic Disability Service).

This does not apply if the person is, or becomes, an involuntary patient requiring detention in the AMHS (e.g. on an inpatient-category authority or order) or a voluntary classified patient.

An authorised person transporting the person **must** comply with the Chief Psychiatrist Policy Transfers and Transport.

If the person is not already in an AMHS when the order is made, the authority to transport absent persons provision of the Act can be applied. In this case, an authorised person transporting a person **must** comply with the Chief Psychiatrist Policy Involuntary Patient Absences.

4 Classified admissions

A person with a custodial status (e.g. a person on remand or sentenced prisoner) requiring an admission to an AMHS beyond the time allowed under an Examination Order or CEO to enable treatment to be provided to the person, is a classified patient.

Key points

The person can remain in the AMHS as a classified patient provided:

- the person either:
  - consents to receiving treatment and care in an AMHS, or
  - is subject to a Treatment Authority, Forensic Order (mental health) or a Treatment Support Order
- a Transfer Recommendation is made by an authorised doctor
- an Administrator Consent form is signed by the administrator of the AMHS where the patient is admitted, and
- a Custodian Consent form is signed by the relevant custodian.

If the authorised doctor undertaking the examination decides the person requires admission as a classified patient following an Examination Order or CEO, the person may be detained under section 74 of the Act for up to seven (7) days in the AMHS to enable the relevant forms to be completed.

The AMHS is responsible for the person's detention.

If a person absconds from the AMHS during this period, an Authority to Transport Absent Patient form may be issued and the processes set out in the Chief Psychiatrist Policy Involuntary Patient Absences **must** be followed.

If a person is to be detained as a classified patient, the Chief Psychiatrist Policy Classified Patients **must** be complied with including notification to the Statewide Coordinator – Classified Patients of the patient's classified status.

Statewide Coordinator – Classified Patients
Email: ClassifiedPatientsMHA2016@health.qld.gov.au
Phone: 3837 5820

5 Leave from an AMHS for persons subject to Judicial Orders

5.1 Limited Community Treatment

A patient subject to a Judicial Order can access limited community treatment (LCT) under certain circumstances.

Key points

An authorised doctor may authorise LCT for a patient if:

- the Chief Psychiatrist has given written approval for the LCT, and
- the authorised doctor is satisfied the patient is unlikely to abscond from the AMHS while receiving LCT.

Leave **must** be:

- escorted (i.e. in the physical presence of a health service employee), and
- limited to the grounds and buildings of the AMHS.

The authorised doctor **must** request the Chief Psychiatrist's written approval by completing the Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients form.

- This form is to be completed electronically or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

To authorise LCT the authorised doctor must complete the Order / Authority Amendment form detailing:

- the conditions of LCT
- the actions to be taken if conditions are not adhered to
- the duration of LCT and the duration of the authorisation

LCT taken by the patient must be recorded on the Limited Community Treatment Access and Return form and must be recorded in, or uploaded to, CIMHA.

5.2 Temporary Absences

The Chief Psychiatrist may approve a temporary absence for a person subject to a Judicial Order.

Key points

Temporary absence from an AMHS may be approved:

- to receive medical, dental or other health treatment
- to appear before a court, tribunal or other body
- to look for accommodation for the patient for when the patient is discharged from the service
- for a purpose based on compassionate grounds, or
- for another purpose the Chief Psychiatrist is satisfied is justified.

The authorised doctor **must** request the Chief Psychiatrist's written approval by completing the Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients form.

- This form is to be completed electronically or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

The Chief Psychiatrist will make a determination on the request as soon as practicable and provide the outcome to the administrator on the Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients form.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
Authorised Person	Means a health practitioner, an ambulance officer, a police officer, a corrective services or youth detention officer, the administrator of an AMHS, and a health service employee appointed by the administrator[2].
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Court Examination Order (CEO)	An order made by the Mental Health Court requiring a person to be assessed by a specified examining practitioner.
Examination Order	An order made by a magistrate for a person charged with a simple offence which requires examination in an AMHS for the purposes of determining treatment and care needs.
Examination Report	A report prepared by an authorised doctor subsequent to an examination under an Examination Order.
Judicial Order	Means: • A CEO • An Examination Order, and • Another order made by a court under the Act, requiring or permitting a person to be detained in an AMHS for a particular purpose (e.g. while court proceedings are underway).
Specified examining practitioner	Means the health practitioner nominated by the Mental Health Court to undertake a CEO. The specified examining practitioner may be a psychiatrist, medical officer, or other health practitioner such as a psychologist.

[2]The administrator may appoint a specific health service employee, or a class of health service employees (for example all consumer consultants employed in the AMHS) as authorised persons.

Referenced forms, clinical notes and templates

Form – Administrator Consent
Form – Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients
Form – Authority to Transport Absent Patient
Form – Custodian Consent
Form – Examination Report
Form – Limited Community Treatment Access and Return
Form – Order/Authority Amendment
Form – Request for Police Assistance
Form – Transfer Recommendation

Referenced documents and sources

Chief Psychiatrist Policy – Classified Patients
Chief Psychiatrist Policy – Court Liaison Service
Chief Psychiatrist Policy – Involuntary Patient Absence
Chief Psychiatrist Policy – Treatment Criteria, Assessment of Capacity, **'Less Restrictive Way' and** Advance Health Directives
Chief Psychiatrist Policy – Transfers and Transport
Chief Psychiatrist Policy – Treatment Authorities
Queensland Interagency Agreement – Safe transport of people with mental illness
Mental Health Act 2016

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Document status summary	
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Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Statewide Coordinator – Classified Patients	Phone: 3837 5820 Email:ClassifiedPatientsMHA2016@health.qld.gov.au
Court Liaison Officer	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Mental Health Act 2016

Chief Psychiatrist Policy

Management of complaints and right to a second opinion

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Queensland Government

General

A complaint is any expression of dissatisfaction or concern, by or on behalf of a patient or group of patients, regarding the provision of a health service.

Complaints and feedback mechanisms allow authorised mental health services (AMHSs) to identify areas for improvement, with the goal being to improve patient outcomes. Complaints and feedback processes also strengthen the accountability of staff, and provide oversight in the administration of AMHSs, which increases patient and public confidence.

Scope

This Policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner (AMHP), AMHS administrator, or other person performing a function or exercising a power under the Act must comply with this Policy.

This Policy applies if a patient or someone on the patient's behalf, such as a nominated support person, family, carer or other support person, wishes to make a complaint about any aspect of the patient's treatment or care. This may include a complaint about the quality or standard of mental health treatment or care, or an alleged failure to provide appropriate treatment and care by an AMHS or particular staff member.

Section 2.5 of this policy only applies to public sector AMHSs.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1. Management of complaints

Key points

Complaints **must** be received, acknowledged and assessed in accordance with established Hospital and Health Service (HHS) procedures or, for a private sector AMHS, in accordance with the hospital's complaints management procedures.

Independent Patient Rights Advisers (IPRAs) and staff of AMHSs **must** provide assistance to patients and their support persons in making a complaint, if requested.

- Where a patient requires specific help to make a complaint, such as with the assistance of an interpreter, personal guardian, support person or community visitor, every reasonable effort must be made by the AMHS to organise the appropriate support.

In assessing any complaint, regard must be given to section 2 of this policy in relation to the right of a patient or interested person to request a second opinion. This section only applies if an AMHS has not been able to resolve a complaint made by a patient, or an interested person for the patient, about the patient's treatment and care.

The *Hospital and Health Boards Act 2011* (HHBA) provides that there should be openness to complaints from users of the public sector health services and a focus on dealing with the complaints quickly and transparently. This legislated principle applies only to public authorised mental health services. However, the National Safety and Quality Health Service Standards Clinical Governance Standard requires that all health services have complaint management systems which encourage and support reporting of complaints and timely resolution.

1.1. Notifying the Chief Psychiatrist

Key points

A primary function of the Chief Psychiatrist is to protect the rights of patients and ensure compliance with the Act.

The AMHS administrator **must** notify the Chief Psychiatrist of complaints relating to significant non-compliance with the Act and for specified critical incidents.

The Chief Psychiatrist has powers under the Act to investigate these matters.

- Investigative powers also exist under the *Hospital and Health Boards Act 2011* and *Private Health Facilities Act 1999.*

Further information is provided in the Chief Psychiatrist Policy - Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with Act.

This Policy applies whether or not a complaint has been made about a matter.

2. Right to request a second opinion

The Act provides patients and 'interested persons' a right to request a second opinion about a patient's treatment and care. This ensures there is accountability and oversight for the clinical decision-making by authorised doctors.

The right to request a second opinion also aims to strengthen the confidence that patients and patients' support persons have in the quality of mental health services

2.1. Application of the provision to request a second opinion

The right to request a second opinion applies where an AMHS has been unable to resolve a complaint made by a patient or an 'interested person' for the patient, about the patient's treatment and care. See section 1 Management of Complaints.

A health practitioner may separately request a second opinion about a particular patient, on their own initiative or at the request of the patient or an interested person for the patient.

For example, this may apply where a patient wishes to confirm a clinical diagnosis.

The patient, or 'interested person' for the patient, **must** be kept informed of steps taken to arrange a second opinion.

Key points

The patient, or an 'interested person' for the patient, may request the administrator of the AMHS to obtain a second opinion from another health practitioner about the patient's treatment and care.

- A health practitioner also includes another psychiatrist.

An interested person for a patient includes:

- the patients nominated support person; or
- another person or individual who has a sufficient interest in the patient.

The administrator **must** make arrangements to obtain the second opinion:

- from a health practitioner who is independent of the patient's treating team, and
- in the way required under this policy.

Wherever possible, discussion **must** have occurred between the patient and/or their interested person, and the treating team. The AMHS administrator or clinical director must also have attempted to resolve any complaint about a person's treatment and care.

The *Process for obtaining a second opinion* flowchart outlines how a request for a second opinion should be managed to ensure compliance with this Policy.

Any complaint about a patient's treatment and care must first be dealt with in accordance with the relevant HHSs complaints management processes and this policy.

- For private sector AMHS, action must be taken in accordance with the hospital's complaint management procedures.

2.2. Documentation

A request for second opinion **must** be documented in the patient's health records and include:

- any specific concerns about treatment and care provided to the patient, or
- any other matter expressed by the patient or interested person for the patient.

2.3. Administrator obligations and timeframe

The administrator **must** ensure that necessary arrangements are made for a second opinion to be obtained.

Timeframes for obtaining a second opinion will vary on a case-by-case basis (due to factors such as AMHS size and availability of clinicians). However good practice is for a second opinion to be obtained within **seven (7) days.**

2.4. Credentialing and expenses

Key points

A second opinion may be obtained from another health practitioner who is either within the AMHS or external to it.

The health practitioner **must** be independent of the patient's treating team.

If a health practitioner external to the AMHS is engaged:

- the credentialing process for the practitioner (where required) must be expedited by the AMHS, and
- the AMHS requesting the second opinion must pay all reasonable expenses incurred by the health practitioner engaged to provide the second opinion.
  - e.g. travel and accommodation costs.

Arrangements for obtaining a second opinion in a private sector AMHS should be made according to local processes and procedures.

2.5. Health Practitioner Obligations

The request for a second opinion about a patient's treatment and care **must** be sufficiently clear on the particulars of the request.

Key points

The health practitioner providing the second opinion must:

- Respond to the concerns outlined in the request,
- Consider any other matters they believe relevant to the patient's treatment and care, and
- After examining the patient, provide an independent and professional opinion on these matters.

The health practitioner providing the second opinion **must** document the opinion in the patient's health records and advise the treating team, and the patient or interested person, of the opinion.

The patient's treating team **must** consider the opinion and discuss it with the patient or interested person for the patient.

2.6. Outcomes following second opinion

The patient's authorised doctor **must**, to the extent practicable, provide the patient with appropriate information about the outcome of any second opinion.

If a second opinion suggests that a patient should be receiving different treatment or care, the health practitioner who prepared the second opinion **must** consult with the patient's treating team, to resolve the appropriate course of action.

If a resolution cannot be reached, the relevant clinical director of the AMHS **must** be contacted for advice.

Administrators and Clinical Directors may also contact the Chief Psychiatrist for advice as necessary.

2.7. Escalation to the Chief Psychiatrist

If provision of a second opinion and the AMHS response to it does not resolve the patient's or interested person's concerns, the matter may be escalated to the Chief Psychiatrist for consideration.

Escalation to the Chief Psychiatrist can only occur with endorsement of the relevant clinical director and where all other avenues for resolution are exhausted.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service - a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Clinical Director	A senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the clinical director functions and responsibilities
HHBA	*Hospital and Health Boards Act 2011*
HHS	Hospital and Health Service
IPRA	Independent Patient Rights Adviser as defined under s293 of the Act
MHRT	Mental Health Review Tribunal
NSP	Nominated support person - a family member, carer or other support person **formally appointed** by a patient to be their nominated support person. NSP rights include: • must be given all notices about the patient that are required under the Act • may discuss confidential information about the patient's treatment and care • may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and • may request a psychiatrist report if the person is charged with a serious offence
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.
Support person/s	Includes, a nominated support person (a family member, carer or other support person **formally appointed** by a patient to be their nominated support person) or, if the person does not have a Nominated Support Person, a family member, carer or other support person

Term	Definition
The Act	*Mental Health Act 2016*

Referenced documents and sources

Chief Psychiatrist Policy – Patient Records
Chief Psychiatrist Policy – Notification to Chief Psychiatrist of Critical Incidents and Non-Compliance with Act
Flowchart – Process for obtaining second opinion
The Hospital and Health Boards Act 2011
Private Health Facilities Act 1999.

Document status summary

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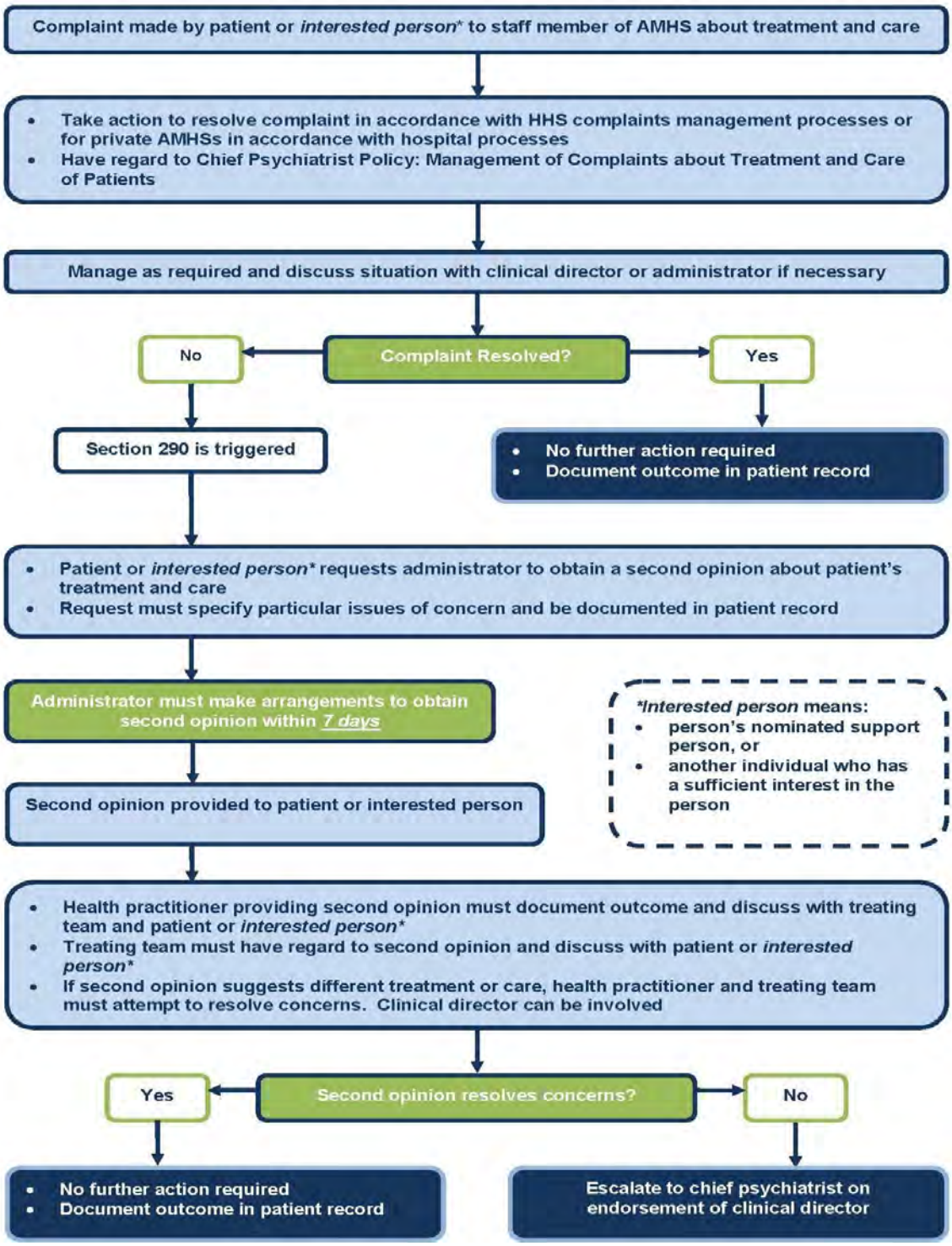
Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Office of the Health Ombudsman	Ph: 133 OHO (133 646) Email: info@oho.qld.gov.au
Local Clinical Director	Ph: Email:
Local Independent Patient Rights Adviser	Ph: Email:
Local complaints liaison officer	Ph: Email:
	Ph: Email:
	Ph: Email:
	Ph: Email:
	Ph: Email:
	Ph: Email:

Flowchart – Process for Obtaining a Second Opinion



Mental Health Act 2016
Chief Psychiatrist Policy

Managing involuntary patient absences

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General

Arrangements may be made under the *Mental Health Act 2016* (the Act) for particular patients who are absent without approval (AWA) to be returned to an authorised mental health service (AMHS) or a public sector health service facility (PSHSF).

Patients who are AWA may represent a risk to their own life, health or safety or the safety and wellbeing of others.

All AMHS must ensure governance and reporting structures are in place to facilitate the oversight of AWA events within their service.

This Policy promotes:

- preventing and reducing the risk of patients becoming AWA from an AMHS or PSHSF as part of the clinical governance of the relevant service or facility
- implementation of evidence-based, recovery-oriented strategies to reduce the risk of patients becoming AWA from the AMHS or PSHSF and working towards a least restrictive model of care, and
- the active inclusion of patients, their families, other support persons and service providers, in comprehensive care planning, problem solving and identifying strategies to reduce the risk of patients becoming AWA from the AMHS or PSHSF.

See flowchart Absent Without Approval Pathway for further information outlining the steps when responding to an AWA event.

Scope

This Policy is mandatory for all Authorised Mental Health Services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act must comply with this Policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

This policy does not apply in relation to a person who absconds while being detained under the Emergency Examination Authority (EEA) provisions of the *Public Health Act 2005*.

Further information can be located on the *Public Health Act 2005* website.

Policy

1 Minimising risk and responding to patient absence

A risk assessment **must** be conducted on a patient's initial contact with a service or facility and be reviewed at regular intervals throughout the service episode.

Individual patient strategies must be based on assessment of the patient's risk of becoming AWA.

Particular attention must be given to patients who may be at increased risk of becoming absent without approval, for example:

- recently admitted patients
- patients voicing thoughts about wanting to leave
- patients with repeated AWA events
- patients with a history of violence
- patients with a history of trauma
- young patients, and
- patients who, because of their ethnic, social or cultural background, are at increased risk of becoming AWA.

2 AWA Prevention and Response Plan

An AWA Prevention and Response Plan (Prevention and Response Plan) is a locally developed plan that sets out the clinical strategies to mitigate the risk of an absence and the actions to be taken by the service if the patient becomes AWA.

Consideration should also be given to whether a Police and Ambulance Intervention Plan (PAIP) is required for the person.

Key Points

- The initiation of any process to return a patient following an AWA event must have regard to the strategies outlined in their Prevention and Response Plan.
  - A Prevention and Response Plan is intended to supplement clinical judgement at the time of an AWA event.
- A Prevention and Response Plan is mandatory for involuntary inpatients.
  - It is recommended for involuntary patients being treated in the community.
- The plan must be developed by the treating team in consultation with the patient's treating psychiatrist.
- The Prevention and Response Plan must be incorporated into general mental health care planning and review processes.
- The treating team must ensure the plan is accessible in CIMHA to ensure ready access by clinicians, along with any other relevant clinical record.

The patient and their support person/s **must**, to the greatest extent practicable, be involved in the development of the Prevention and Response Plan and assisted to understand the actions that will be taken if the patient becomes AWA.

3 Application of the absent patient transport provisions

Key Points

The absent patient transport provisions of the Act may be applied when an involuntary patient is absent without approval (AWA) from an AMHS or a PSHSF. An involuntary patient for this purpose means a person:

- detained under a Recommendation for Assessment or detained for the purposes of making a Recommendation for Assessment
- subject to:
  - an Examination Authority
  - a Treatment Authority
  - a Treatment Support Order (TSO)
  - a Forensic Order (FO)
  - a judicial order, or
- detained for the purposes of making arrangements to return the person to an interstate mental health service.

The absent patient transport provisions also apply to classified patients (involuntary) and classified patients (voluntary).

The absent patient transport provisions also apply if:

- a person becomes subject to a Treatment Authority, FO, TSO or judicial order requiring detention in an AMHS and the person is not in an AMHS when the authority or order is made, or
- a person subject to Chapter 4, Part 2 of the Act (request for psychiatrist report) or an order of the MHRT does not attend a scheduled appointment.

For involuntary patients and classified patients (voluntary), the provisions encompass the following circumstances:

- absconding or leaving:
  - an inpatient mental health unit or facility without approval
  - a community mental health facility without approval
  - an emergency department, non-mental health unit or facility, or a PSHSF without approval, where the patient has been detained under the Act

- absconding or not returning from limited community treatment including where the limited community treatment has been suspended or revoked
- absconding while being transported (i.e. during a transfer or while moving between units)
- not returning from an approved temporary absence, including when approval has been revoked
- not attending an AMHS or PSHSF as required (e.g. attending a scheduled appointment or review, to comply with conditions of an order or authority, or due to a change in category from community to inpatient).

4 Process for returning patients who are AWA

If a patient is AWA, the least restrictive option appropriate to the level of risk should be exercised to return the patient.

Key Points

Unless there is a risk that the patient may harm themselves or others, reasonable attempts must be made to contact the person and encourage them to return to the AMHS voluntarily prior to completing an Authority to Transport Absent Person (ATAP) form.

In all cases, the treating psychiatrist (or on-call psychiatrist) must be notified without delay of the patient's absence. The purpose of this is to ensure the treating psychiatrist is aware of the absence.

- This requirement does not prevent another health practitioner taking action to return the patient

Notification of relevant support persons (e.g. nominated support person, guardian, parent) should also occur consistent with clinical appropriateness and local processes.

If a patient is on a community category order or authority, there is no automatic requirement to change the category to 'inpatient' prior to authorising the patient's return.

- If the patient is on a community category order when they present or are taken to an AMHS following the AWA event, an authorised doctor must review the patient to determine whether the category of order should be changed to inpatient.

4.1 Authorisation to transport patients who are AWA

If the patient is unable to be located or returned voluntarily, or there are concerns regarding risk of harm to the patient or others, an Authority to Transport Absent Person form (ATAP) **must** be initiated.

- The ATAP form is required for all AWA events where the patient cannot be returned voluntarily.

Key Points

The return of an absent person to an AMHS or PSHSF can be authorised by a responsible person using the ATAP form. A responsible person in this context is:

- an AMHS administrator
- an authorised doctor
- an AMHP, or
- a person in charge of a PSHSF.
    - the person in charge may delegate this power to an appropriately qualified health service employee.

A responsible person may:

- authorise an authorised person, other than a police officer, to transport an absent person to a stated AMHS or PSHSF, or
- ask a police officer to transport an absent person to a stated AMHS or PSHSF (act alone or assist another authorised person with the transport of an absent patient).
    - An authorised person in this context is:
        - an AMHS administrator,
        - an ambulance officer,
        - a health practitioner,
        - a police officer,
        - a corrective services officer, if a person is to be transported to or from a corrective services facility or court,
        - a youth detention employee if the person is to be taken to or from a youth detention centre or court.
    - The administrator of an AMHS may appoint, in writing, an employee of the AMHS as an authorised person.

4.1.1 Administrator responsibilities

The AMHS administrator **must** ensure that, where appropriate, health service employees are appointed as authorised persons to enable them to return patients who are AWA.

In rural and remote AMHS, it is particularly important that the administrator or person in charge of a PSHSF ensures that processes are in place to enable action to be taken in response to an AWA event.

- These processes **must** ensure, at all times, that there is an authorised doctor or authorised mental health practitioner available to commence an ATAP process if required.

4.2 Authorising transport of an absent person

Key points

The ATAP form must include:

- the name of the AMHS or PSHSF where the patient is to be transported
- the category or categories of authorised person able to return the patient
- a summary of risk issues relevant to the patient and others
- any actions taken to locate the person, and
- where a Police and Ambulance Intervention Plan (PAIP) is in place, the checkbox on the ATAP form must be marked and the form should include any relevant information from the PAIP.

Unless there is serious and imminent risk to the individual or others, or it is clearly unsafe for an authorised person other than police to return the patient, an ATAP form should at first instance authorise a health practitioner or appointed health service employee to return the patient.

The person completing the ATAP form **must** provide a copy to all categories of persons authorised under the form.

- Phone contact **must** also be made, particularly if ambulance officers or police are to be involved in the transport.

A copy of the ATAP form **must** be recorded on CIMHA.

Where there is a change in risk status or patient whereabouts, consideration should be given to completing a Request for Police Assistance or a new ATAP to enable police to act alone (See sections 4.3.2 and 4.3.3 below).

4.3 Determining least restrictive method for transport

Decisions regarding who should be authorised to transport a person who is AWA should be made, as far as possible, in consultation with the patient's treating psychiatrist or on-call psychiatrist.

The interagency agreement between Queensland Health, Queensland Ambulance Service (QAS) and Queensland Police, Safe transport of people with mental illness outlines factors that should be taken into account when considering the mode of transport required.

Consideration should be given to the least restrictive means for safely transporting the patient. Transport options include, but are not limited to:

- a health practitioner (AMHS/ QAS) returning the patient without police assistance
- a request for police assistance is completed and a health practitioner returns the patient with the assistance of police, or
- the police acting alone to return the patient.

Although the least restrictive method should be used to transport a patient who is AWA, in some cases it may be necessary for police to act alone to ensure the safe transportation and return of the patient.

4.3.1 Requesting ambulance assistance to transport an absent person

The primary role of the Queensland Ambulance Service (QAS) is to assist the community with acute healthcare emergencies; this includes emergencies related to mental illness.

QAS are a less restrictive transport option in situations where circumstances prevent transport by the mental health service (e.g. co-morbid physical health concerns).

Key points

- QAS assistance can be requested by health service staff or police where there is a healthcare emergency requiring ambulance transport.
- Health service staff should request ambulance assistance by calling '000'.
- When requesting ambulance assistance to transport an absent patient, the ATAP form should be completed and the 'Authorised person other than police' box should be selected in section 5 of the form.
- If an ambulance officer has been authorised to transport a person who is AWA, regular liaison by the AMHS with the ambulance officers should occur to provide updated information if required and to coordinate joint action.
- A copy of the ATAP form should be provided to QAS in person or as locally negotiated.

4.3.2 Requesting police assistance (AMHS clinician attending)

QAS do not provide a search and rescue service and as such, are unable to assist in locating consumers whose whereabouts are unknown.

A health practitioner or appointed employee who has been authorised to act under an ATAP form may request police assistance for transporting a patient who is AWA.

Requesting police assistance allows the health practitioner or appointed employee and police officer/s to work together to return a person who is AWA.

Key points

When requesting police assistance, the Request for Police Assistance form must be completed.

- The form must include a statement outlining why it is necessary for police to assist with the transport (see example forms in Attachments 2-6).
  - Generally, police should be involved in transport only where their assistance is required for the management of serious risk to the individual or others.
- Local police must be contacted by phone if being requested to assist in transporting a patient who is AWA to establish collaborative transport arrangements.
- A health practitioner must attend with police when using the Request for Police Assistance process.
  - When requesting assistance, the police do not require a copy of the ATAP form.
  - A copy of the Request for Police Assistance form must be sent to the AMHS administrator and kept on the patient's clinical record in CIMHA.

A QCAD (Queensland Computer-Aided Dispatch) number (police communications ID) is **not required** where a Request for Police Assistance is being made under local arrangements agreed to by the relevant QPS district (and not via the regional police communications centre).

A QCAD number **must** be obtained by the AMHS when a Request for Police Assistance is being made via the relevant regional police communications centre (e.g. where local processes are not in situ or outside business hours).

The QCAD number **must** be recorded on the Request for Police Assistance form before it is provided to police.

- See section 4.3.3.1 below for full requirements for issuing of QCAD numbers.

4.3.3 Requesting police to act alone

Prior to making a request for police to act alone, every reasonable attempt to locate the person **must** be made, and detailed actions and outcomes are to be recorded on the ATAP form.

Circumstances in which it may be appropriate for police to act alone to transport a patient include, for example:

- for the management of serious and imminent risk to the individual or others, and/or
- where it is unsafe for the patient to be returned by an authorised person other than a police officer.

Using the ATAP form, a police officer may be requested to transport a patient who is AWA to an AMHS or PSHSF without a health practitioner.

Key points

If requesting police to act alone, the ATAP form must include:

- a statement outlining why it is necessary for police to transport the person including the serious and imminent risk to self or others
- the name of the AMHS or PSHSF where the patient is to be transported
- a summary of risk issues relevant to the patient and other persons, including risk to the authorised person transporting the patient, and
- all actions taken to locate the person, and
- any relevant information from a patient's PAIP (see Attachments 2-6).

The ATAP form should be completed electronically on CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

- The police must be contacted to be notified of the AWA event. Where a situation is assessed as urgent, consideration should be given to informing police via a '000' call.

A QCAD number **must** be obtained by the AMHS by contacting the relevant regional police communications centre. The QCAD number must be recorded on the ATAP form before it is sent to the local police and Warrant Bureau. See section 4.3.3.1 below for full requirements for issuing of QCAD numbers.

The ATAP form **must** be sent to:

- Regional Police Communications Centre, and/or
- Local Police station (if required by local protocol), and
- Police Information Centre (Warrant Bureau) once QCAD provided and ATAP accepted by the Regional Police Communications Centre.

Where an ATAP form has been accepted by QPS, ongoing communication and information sharing should be maintained to facilitate patient return.

Information sharing should be as per the 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 2016.

4.3.3.1 QCAD number (police communications ID number)

A QCAD number is the police communications ID number issued by the Queensland Police Service and must be obtained by contacting the relevant regional police communications centre (dependent on local protocols).

If adequate information is not provided to establish that police involvement is required, a QCAD number will not be issued.

Forms without a QCAD number will not be actioned by the police and **must not** be sent to the local police and Warrant Bureau.

To determine whether involvement of police is required the police communications centre will request the following information:

- whether the clinician considers there is:
  - a recent history of violence towards self or others
  - a history of violence or vulnerability when not taking medication or engaging in treatment
  - threats to self or others when the Queensland Health staff contacted the patient
  - a history of vulnerability which may put the patient or others in imminent danger, and
- what the clinician considers to be the current level of these risks

Assessment of risk should be based on the most recent examination of the person, collateral information and/or longitudinal historical information including from the patient's clinical record.

If historical risks are identified, these should be conveyed to the police in the context of the person's current situation.

Where police advise that their involvement is not required and decline to provide a QCAD number, the escalation process detailed at section 4.3.4 should be followed.

4.3.4 Escalation of matter where police have indicated their involvement is not required

If the request meets the threshold for police attendance and the local Communications Centre have advised that their involvement is not required, the treating psychiatrist (or on-call psychiatrist) should be notified to review the circumstances of the absence and the ATAP documentation.

- The psychiatrist should consider whether the risks can be managed without the involvement of the police, and
- if the risks can be safely managed without the involvement of police, then further attempts by a health practitioner to return the patient should be made.

If the psychiatrist considers the involvement of the police is required, phone contact with the Duty Officer, Brisbane Police Communications Centre should be made by the treating psychiatrist/ psychiatrist on call to clarify the current risk issues for the matter to be reconsidered.

QPS Duty Officer, Brisbane Communications Centre
Available 24 hours 7 days per week
Landline: 3364 3512
Mobile: 0428 712 829

Where police continue to advise that their involvement is not required, the matter is to be referred to the AMHS Clinical Director (or appropriately delegated person) for resolution at a local level.

In circumstances where the Clinical Director is unable to resolve the matter locally and the AMHS require police involvement to return a patient, the Clinical Director (or appropriately delegated person) may contact the Office of the Chief Psychiatrist.

Office of the Chief Psychiatrist, Mental Health Act Liaison Service
8.30am - 4.30pm Monday – Friday
Landline: 3328 9899
After hours/public holidays: 0408 750 369

5 Transportation

Key points

If authorised to transport a patient following an AWA event, the authorised person may take the patient to the AMHS or PSHSF stated in the ATAP form.

- If it is not reasonable or practicable to transport the patient to the stated AMHS, the patient may be transported to the nearest AMHS or PSHSF.
- In determining where the patient should be transported to, the authorised person should consult the treating or on-call psychiatrist.

While acting to transport a patient who is AWA, the authorised person may act with the help, and using the force, that is necessary and reasonable in the circumstances.

- This includes the ability to detain the person if required.

While transporting a patient following an AWA event, an authorised person must comply with the Chief Psychiatrist Policy – Transfers and Transport.

6 Notifications

All AWA events and ATAP forms **must** be recorded on CIMHA.

The AMHS administrator or person in charge of a PSHSF **must** ensure the AMHS or PSHSF has clearly established notification processes for patients who become AWA.

6.1 Notification of AWA events

6.1.1 AWA events – Inpatient category, classified patients and judicial order

Key points

A copy of the ATAP form must be provided to the treating psychiatrist and the Clinical Director (or appropriately delegated person) at the time of issuing for all AWA events involving patients subject to a:

- Treatment Authority (inpatient)
- TSO (inpatient)
- FO (inpatient)
- Classified Patients, and
- patients subject to a Judicial Order (excluding non-attendance for an Examination Order).

Notification to the Clinical Director is mandatory for all of the above patients, regardless of the type of AWA event.

Email notification to the Clinical Director must be followed with a phone call for all Forensic patients (inpatient), classified patients, or Judicial Order patients (excluding non-attendance for an Examination Order).

6.1.1.1 Clinical Director responsibilities

Key points

The Clinical Director (or appropriately delegated person) must notify the Chief Psychiatrist, by phone and email, as soon as practicable of AWA events involving:

- forensic patients (inpatient)
- classified patients, and
- patients subject to a judicial order (excluding non-attendance for an Examination Order).

A copy of the ATAP form must be provided to the Chief Psychiatrist at the time of notification.

6.1.2 AWA events – Patients other than inpatient category, classified and judicial order

This section includes AWA events involving patients subject to any of the following authorities or orders:

- an Examination Authority
- detention under a Recommendation for Assessment, or detained for the purposes of making a Recommendation for Assessment
- Treatment Authority (community)
- TSO (community)
- FO (community), and
- individuals subject to:
  - an Examination Order, who have failed to attend an appointment,
  - chapter 4, part 2 of the Act (request for psychiatrist report initiated by the Chief Psychiatrist), or
  - an order of the MHRT and who have not attended for an appointment.

6.1.2.1 Clinician responsibilities

Key points

Where the treating psychiatrist (or on-call psychiatrist) considers there is a significant risk related to an AWA event involving a patient identified in section 8.1.2, they should notify the Clinical Director (or appropriately delegated person) as soon as practicable.

Factors that may be relevant for notifying the Clinical Director include, for example:

- clinically significant risks
- serious or controversial events
- known victim issues, and
- events that may attract media attention.

If an AWA matter is escalated to the Clinical Director, a copy of the ATAP form **must** be emailed to the Clinical Director and must be followed with a phone call.

6.1.2.2 Clinical Director responsibilities

If required, the Clinical Director may notify the Chief Psychiatrist as soon as practicable of AWA events involving patients identified in section 6.1.3.

Key points

Escalation to the Chief Psychiatrist for AWA events not involving a forensic patient (inpatient), classified patient or judicial order patient is at the discretion of the Clinical Director (or appropriately delegated person).

- Escalation should only include matters where the Clinical Director considers additional oversight beyond the AMHS governance structures is warranted.

Notifications to the Chief Psychiatrist must be made via phone and email. A copy of the ATAP form must be provided to the Chief Psychiatrist at the time of notification.

6.1.3 Notification of the return of patient absent without approval

Key points

The treating psychiatrist and clinical director (or appropriately delegated person) must be notified as soon as practicable of the return of a patient who, at the time of the AWA event, was:

- on an inpatient category authority or order, or
- a classified patient, or
- subject to a judicial order.

The clinical director must also be notified for any other matters that were significant either at the time of the AWA event, or on the patient's return.

If the Chief Psychiatrist is notified of any AWA event, they must be notified as soon as practicable, via phone and email, of the patient's return and any relevant issues.

For patients with repeated AWA events, or who are assessed as being high risk of further absences, the treating psychiatrist **must** provide the Clinical Director with relevant information about the patient including:

- an assessment of risk issues
- proposed future management to minimise risk, and
- actions or recommendations to address any systemic issues identified in relation to the patient's absence.

The Clinical Director has discretion to notify the Chief Psychiatrist in other circumstances where a patient's return from an AWA event is deemed to warrant additional involvement and oversight from the Chief Psychiatrist.

The Clinical Director may also determine that an Assessment and Risk Management Committee (ARMC) should be arranged to discuss the circumstances of the AWA event and review the patient's treatment and care (For further detail see Chief Psychiatrist Policy – Treatment and Care of Forensic Order, Treatment Support Order and other Particular Patients).

6.1.4 Notifications to MHRT

Key points

The MHRT must be notified of a patient AWA event in the following circumstances:

- the patient is on a Treatment Authority or TSO and is absent within seven (7) days of their MHRT hearing, or
- the patient is on a FO and is absent within Fourteen (14) days of their MHRT hearing.

Notification is provided on the Written Notice of Relevant Patient's Absence – Mental Health Review Tribunal Clinical Report template.

Once notified, the MHRT may determine whether to adjourn the hearing due to the patient's absence.

- The MHRT may proceed in the patient's absence (if for example, the patient wilfully absents themselves from the hearing).
- The treating psychiatrist's advice provided in the Written Notice of Relevant Patient's Absence - Mental Health Review Tribunal Clinical Report template will be used to inform the decision of the MHRT.

If the hearing is adjourned, the AMHS administrator will be advised by the MHRT.

The administrator **must** notify the MHRT as soon as practicable of the patient's return using the Written Notice of Relevant Patient's Return - Mental Health Review Tribunal Clinical Report template.

The MHRT must schedule a new hearing within **twenty-one (21) days** after receiving notification of the patient's return.

All Written Notices of Relevant Patient's Absence and Return **must** be uploaded to CIMHA as soon as practicable.

7 Ending an authority to transport absent person

Key points

An ATAP event ends:

- when the patient returns or is returned to the AMHS; or
- after three (3) days if:
  - the patient was subject to a recommendation for assessment and absconded before the assessment period ended
  - the patient was being detained for a one-hour period to make a recommendation for assessment, or
  - the patient was subject to an Examination Authority; or
- when the person is no longer subject to an order or authority (e.g. their order or authority is revoked or ends).

A Revocation of Authority to Transport Absent Person form must be issued to end the effect of an ATAP form.

The Revocation of Authority to Transport Absent Person should be completed electronically in CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

When an ATAP form has been issued to police (see section 4.5.3):

- if the patient returned without direct involvement of police, contact local police or relevant regional Police Communications Centre to notify of the patient's return, and
- send a copy of the Revocation of Authority to Transport Absent Person form (by email preferably) to the Police Information Centre (Warrant Bureau).

A copy of the Revocation of Authority to Transport Absent Person form must also be sent to:

- the authorised person/s who were authorised to transport the patient, and
- the relevant AMHS administrator.

8 Monitoring AWA events

Key points

All AMHS administrators must ensure there are sufficient governance and reporting structures in place to facilitate oversight of AWA events.

Regular case reviews to re-assess risk and, review attempts made to locate the patient, are essential to the governance of all AWA events. A number of AWA events will remain the sole responsibility of the AMHS.

Frequency of reviews will be determined based on clinical circumstances, with more regular reviews recommended for AWA events considered high risk and requiring notification to the Chief Psychiatrist.

Governance and reporting structures can be determined by the AMHS however must ensure:

- clinical and reporting oversight is provided for all AWA events that occur in inpatient or community settings and, if applicable, PSHSF where patients of the relevant AMHS are involuntarily detained
- reporting structures comply with notification and reporting requirements of the Chief Psychiatrist, and
- all AWA events are recorded in CIMHA.

Data relating to AWA events is auditable and published annually at a state and national level (in de-identified formats). AWA data is utilised by the Chief Psychiatrist and AMHSs to support continuous clinical improvement.

Issued under section 305 of the Mental Health Act 2016

Dr John Reilly

Chief Psychiatrist, Queensland Health

21 May 2021

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
AWA	Absent Without Approval
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
EEA	Emergency Examination Authority
HHS	Hospital and Health Service
NSP	Nominated support person - a family member, carer or other support person **formally appointed** by a patient to be their nominated support person. NSP rights include: • must be given all notices about the patient that are required under the Act • may discuss confidential information about the patient's treatment and care • may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and • may request a psychiatrist report if the person is charged with a serious offence.
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.
PSHSF	Public Sector Health Service Facility
QCAD	Queensland Computer-Aided Dispatch
Relevant AMHS Administrator	The relevant AMHS Administrator is: • the Administrator of the AMHS currently providing clinical services to the person, or • if the person is not currently receiving mental health services (i.e. no open service episode), the Administrator of the AMHS for the location where the person resides.
Support person/s	Includes, a Nominated Support Person or, if the person does not have a Nominated Support Person, a family member, carer or other support person.

Referenced Documents and Policies

Chief Psychiatrist Policy – Transfers and Transport
Chief Psychiatrist Policy – Treatment and Care of Forensic Order, Treatment Support Order and Other Identified Higher Risk Patients
Public Health Act 2005
Mental Health Act 2016
Authority to Transport Absent Person form
Request for Police Assistance
Written Notice of Relevant Patient's Absence – Mental Health Review Tribunal Clinical Report Template
Revocation of Authority to Transport Absent Person

Document Status Summary

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To be reviewed by:	1 June 2024

Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
AMHS Administrator	Phone: Email:
Clinical Director	Phone: Email:
Queensland Police Service Duty Officer **Brisbane Communications Centre** QCAD Escalations	Available 24 hours 7 days per week Landline: 3364 3512 Mobile: 0428 712 829
Queensland Police Service **Local communications centre**	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Absent Without Approval (AWA) Pathway

For further information see *Chief Psychiatrist Practice Guidelines – Involuntary Patient Absences*

Action 1 – Assessment of Urgency

Step 1 Patient AWA

In an emergency call '000'
Notify treating psychiatrist/on-call psychiatrist

Imminent Risk/ Dangerous situation — YES → **Call 000** ← YES — Classified Patient

NO → Immediate Actions ← NO

Action 2 – Immediate Actions

Step 2 Least Restrictive Option

Unless there is a risk that the patient may harm themselves or others, reasonable attempts must be made to contact the person and encourage them to return to the AMHS voluntarily

Patient returned voluntarily — NO → ATAP Required

Patient returned voluntarily — YES → No further action required. Continue treatment as usual.

Action 3 – ATAP

Step 3 Commence Authority to Transport

Authorised doctor, Authorised Mental Health practitioner or Administrator to complete Authority to Transport Absent Person form

Who will return the patient

- Health Practitioner (AMHS/QAS/Otheragency) return patient without police assistance
- Request for Police Assistance is required to assist AMHS staff to return the patient
- Police to act ALONE to return the patient

Action 4 – Notification requirements

Step 4 Notification Requirements

Notification requirements depend on the MHA2016 status of the patient. Consideration must also be given to relevant clinical risk factors.

High Priority Patient Notifications

Mandatory reporting:

- Forensic Order (Inpatient)
- Classified Patients
- Judicial order (excluding non-attendance for an Examination Order).

Reporting based on risk (dynamic and static factors) contextualised to current circumstancesapplies to all person subject to the Mental Health Act 2016

High or Low Priority Notification

Low Priority Patient Notifications

Mandatory reporting:

- Forensic Order (community),
- Treatment Support Order
- Treatment Authority
- Detention under a Recommendation for Assessment, or detained for the purposes of making a Recommendation for Assessment
- Examination Authority
- Individuals subject to an Examination Order; Chapter 4, Part 2 of the MHA 2016 (request for psychiatrist report); or an order of the MHRT and who have not attended for an appointment.

Action 5 – Patient Return

Step 5 Patient Return

An *Authority to Transport Absent Person* event ends when the patient returns or is returned to the AMHS OR after 3 days in certain circumstances. A ***Revocation of Authority to Transport Absent Person*** form must be issued to the end the effect of an ***Authority to Transport Absent Person*** form.

Patient Returned to Treatment

YES → High Priority Patient Return / Low Priority Patient Return

NO → **Step 6 Review of Absent Without Approval**

Action 6 - Review

Change in risk status?

YES → Action 3 – ATAP

NO → Action 5 – Patient Return

Mental Health Act 2016

Chief Psychiatrist Policy

Mechanical restraint

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Queensland Government

General

The *Mental Health Act 2016* (the Act) makes provision for a range of safeguards and restrictions in relation to the use of mechanical restraint in an authorised mental health service (AMHS) that promote the national and state priority of reducing and eliminating mechanical restraint.

Mechanical restraint is to be used as a last resort to prevent imminent and serious risk of harm to patients and staff, where less restrictive interventions have been unsuccessful or are not feasible.

It is an offence to use mechanical restraint in an AMHS other than in accordance with the Act.

The use of mechanical restraint for the transport and transfer of patients is governed by separate provisions of the Act and is outlined in the *Chief Psychiatrist Policy - Transfer and Transport*.

The following principles **must** be applied in the use of mechanical restraint:

- maintaining the safety, wellbeing and dignity of the patient is essential
- protecting the safety and wellbeing of staff is essential
- mechanical restraint should only be used for the minimum period of time necessary, and
- all staff actions should be justifiable and in proportion to the patient's behaviour and broader clinical context.

Scope

This policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

This policy applies to the use of mechanical restraint in an AMHS. Separate provisions of the Act apply to the use of mechanical restraint to transport a person.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Application of the mechanical restraint provisions

Key Points

Mechanical restraint is the restraint of a person by the application of a device to the person's body, or a limb of the person, to restrict the person's movement.

Mechanical restraint **does not** include:

- the appropriate use of a medical or surgical appliance in the treatment of physical illness or injury, or
- restraint that is authorised or permitted under another law

The mechanical restraint provisions of the MHA 2016 may **only** be applied to a **relevant patient** in an AMHS.

A relevant patient is:

- An involuntary patient in an AMHS, subject to a Treatment Authority, Forensic Order or Treatment Support Order, or
- A person who is absent without permission from an interstate mental health service and who has been detained in an AMHS.

Mechanical Restraint under the Act **cannot** be applied to anyone who is **not** a **relevant patient**. For example:

- patients who are detained for examination or assessment,
- patients accessing services voluntarily, or
- with the consent of a substitute decision maker.

Mechanical restraint may only be used in an AMHS if:

- the AMHS is a high security unit, or
- the AMHS has been approved by the Chief Psychiatrist as a service that is authorised to use mechanical restraint

The mechanical restraint device to be used **must** also be approved by the Chief Psychiatrist.

Any use of mechanical restraint on a relevant patient in an AMHS, including use under another authorising law, **must** be recorded in CIMHA. The Administrator of the AMHS **must** ensure that procedures are in place within their service to ensure these records are maintained.

Movement in and out of restraint must be documented in the Restraint Record which must be attached to the Authorisation of Mechanical Restraint**.**

Mechanical restraint **must not** be used:

- as a substitute for other less restrictive interventions
- as a form of discipline or punishment
- as a substitute for adequate staffing levels
- as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours, or
- when seclusion is being used simultaneously.

In determining whether the use of mechanical restraint is to be administered under the Act or permitted under another law (e.g. in complex cases where both psychiatric and medical treatment are required) consideration should be given to:

- if the person's impaired capacity is a result of their mental illness,
- whether mechanical restraint is required to administer a treatment for the person's mental illness or to address another medical issue or condition.

If the decision to use mechanical restraint is made under other legislation or alternate decision-making processes, evidence of the rationale for action taken **must** be well documented.

Hospital and Health Services should have local policy and procedures available for restraint provisions under other legislation or alternate decision-making processes.

1.1 Application and approval of mechanical restraint

Note: An Application for Approval of Mechanical restraint is considered on a case-by-case basis with consideration given to the facility, device and appropriateness of use under the individual circumstances.
Each use of mechanical restraint under an approval requires authorisation by an authorised doctor (see section 4).

Key Points

The Chief Psychiatrist **must** approve all authorisations of mechanical restraint.

The Clinical Director of the service should notify the Chief Psychiatrist by phone that the use of mechanical restraints is proposed.

An Application for Approval to Use Mechanical Restraint must then be sent to the Chief Psychiatrist. The application **must** be completed by an authorised doctor and include:

- the name of the relevant patient
- details of the person's mental condition, including diagnosis and current treatment
- the purpose of mechanical restraint
- reasons that the authorised doctor believes there is no other reasonably practicable way to protect the patient or others from physical harm
- the way in which the patient will be continuously observed
- any proposed limitations on the use of mechanical restraint (for example, maximum time periods proposed by the doctor)
- the name of the AMHS in which the mechanical restraint will be applied
- a description of the mechanical restraint device to be applied
- the proposed period for which the approval is sought (not more than **seven (7) days**).

The Chief Psychiatrists approval is provided on the Application for Approval to Use Mechanical Restraint.

Approval provided is specific to the matter outlined in the application and is assessed on a case-by-case basis. The approval provided covers:

- the AMHS facility,
- the device specified in the application, and
- its use on the relevant patient the subject of the application.

The maximum period of approval provided by the Chief Psychiatrist is **seven (7) days.**

An application to the Chief Psychiatrist may be made verbally in certain circumstances. The Chief Psychiatrist may give verbal approval if urgently required.

- An application **must** be sent to the Chief Psychiatrist **as soon as practicable** after verbal approval is granted.
- The application **must** note that verbal approval was given.

1.1.1 Approved devices

The Chief Psychiatrist does not pre-approve any devices for mechanical restraint. Approval for a device will only be given if it is the safest way to protect the patient or any other person from harm.

Under **no circumstances** will handcuffs be approved as a device for the purposes of mechanical restraint under the Act.

Key Points

The Chief Psychiatrist will consider the following, at a minimum, when determining approval of a device:

- the device is appropriate for the purpose
- the device is safe (e.g. no hard/abrasive/sharp edges)
- relevant staff have been provided specific training in relation to the use of the device, and
- the device is in good working order (e.g. not dated, dirty or broken).

1.1.2 Approved Facilities

Key Points

The Chief Psychiatrist will, at a minimum, consider the following factors about a facility in providing approval for mechanical restraint:

- appropriately trained staff are available within the facility
- continuous observation requirements can be met,
- immediate medical treatment can be provided if there is a concern,
- sufficient bedding, clothing, food and drink is available, and
- there is access to toilet facilities.

2 Authorisation of use of mechanical restraint

Key Points

Where the Chief Psychiatrist has approved the use of mechanical restraint, an authorised doctor may then authorise the use of the mechanical restraint on the patient.

- Authorisation for mechanical restraint is given by completing the Authorisation of Mechanical Restraint form. This form **must** be recorded on CIMHA.

An authorised doctor's authorisation for mechanical restraint **must** be based on a face-to-face medical review of the patient.

This review **must** occur even if consecutive authorisations are made by the same authorised doctor.

Services must adopt evidence-based and best practice approaches to safely reduce and, where possible, eliminate the use of mechanical restraint.

The use of mechanical restraint can cause significant and lasting distress and injury to both patients and staff. The potential harmful effects of mechanical restraint must be balanced against the risk of harm of the behaviour in question.

2.1 Context for appropriately introducing mechanical restraint

When using mechanical restraint under the Act, staff **must** do all of the following:

- use verbal strategies, de-escalation techniques and other evidence-based strategies such as sensory modulation to help the patient safely gain control of their behaviour.
- be appropriately trained to protect the welfare, dignity and safety of the patient (training must include de-escalation strategies, trauma-informed care, recovery-oriented practice, de-briefing strategies and the use of relevant mechanical restraint devices).
- as far as practicable in the circumstances, explain to the patient the reason for mechanical restraint, what will happen during the mechanical restraint (such as clinical observations, access to food and drink, access to the toilet), and the circumstances in which the restraint may be removed.

2.2 Safety during restraint

- Ensure that no more physical force is used to apply mechanical restraint than is necessary and reasonable in the circumstances.
- Ensure the patient is in a safe body position at all times; a prone (face down) position must not be used, airways must not be obstructed and there must not be prolonged compression of the chest or abdomen.
- Ensure the patient is in safe clothing and that personal items do not compromise the safety of the patient or staff; where reasonable to do so, staff should also ensure the patient has access to physical aids they normally would use such as glasses, hearing aids or oxygen apparatus.
- Continuously observe the patient for indications of physical or mental distress; monitoring airway, breathing, circulation, skin integrity, body alignment and level of consciousness; for patients at additional risk, such as those who have been sedated, appropriate recording of oxygen saturation, pulse and blood pressure should be undertaken.
    - the use of CCTV is **not** a sufficient way to continuously observe a patient.
- Monitor patients where intramuscular or intravenous medication was administered within **one (1) hour** prior to the use of mechanical restraint or during the mechanical restraint and seek immediate medical treatment if there is a concern.
- Use added caution for patients with an underlying medical or neurological condition, who are intoxicated or have acute behavioural disturbance or 'excited delirium'.
- Be aware of heightened vulnerability to significant psychological trauma from restraint, especially for minors, patients with a history of trauma, abuse or detention, and patients of Aboriginal and Torres Strait Islander backgrounds.

2.3 Post restraint

See section 4.2 for post restraint requirements.

2.4 Authorised doctor responsibilities

Key Points

The authorised doctor must be satisfied that:

- there is no other reasonably practicable way to protect the patient or others from physical harm
- the authorisation complies with the approval given by the Chief Psychiatrist
- the mechanical restraint complies with this policy, and
- the mechanical restraint complies with an approved Reduction and Elimination Plan (R&E Plan) (where a R&E Plan is in place).

The *Authorisation of Mechanical Restraint form* must include:

- the duration of the mechanical restraint, including start and finish times, which must not exceed **three (3) hours**
- specific measures to ensure the health, safety and comfort of the patient
- how the patient will be continuously observed while in mechanical restraint, and
- whether the health practitioner in charge of the unit may remove the patient from the mechanical restraint before the authorised period ends.

When authorisation for a period of mechanical restraint has expired, any further mechanical restraint requires a new authorisation.

A patient's total hours in mechanical restraint **must not** exceed **nine (9) hours** in a **24-hour period** unless an approved Reduction and Elimination Plan is in place (see section 3).

Each authorisation must be completed on the Authorisation of Mechanical Restraint form and recorded on CIMHA.

2.5 Health Practitioner in charge of unit responsibilities

The health practitioner in charge of the unit must ensure that the application of mechanical restraint is documented on the Restraint Record which must be attached to the Authorisation of Mechanical Restraint.

The health practitioner in charge of the unit also has responsibilities to ensure the mechanical restraint authorisation is complied with. This includes:

- meeting observation requirements,
- ensuring any specific measures required by the authorised doctor for the patient's health and safety are carried out, and

- ensuring that a process is in place for tracking the amount of time a person is in mechanical restraints.

2.6 Restrictions on authorisation

Mechanical restraint **must not** be used on a patient in seclusion.

The **maximum** period for an authorisation of mechanical restraint is **three (3) hours.**

Consecutive authorisations may be made; however mechanical restraint may be applied for **no more than nine (9) hours** in a **24-hour period,** unless a Reduction and Elimination Plan is in place (see section 3).

3 Reduction and Elimination Plan

A Reduction and Elimination Plan (R&E Plan) outlines measures to be taken to reduce and eliminate the use of mechanical restraint on a patient and to reduce the potential for trauma and harm.

The plan reinforces efforts to proactively reduce the use of mechanical restraint on a patient by ensuring clinical leadership, monitoring, accountability and a focus on safe, less restrictive alternatives to mechanical restraint.

3.1 Requirements for R&E Plan

Key Points

It is recommended practice for a R&E Plan to be in place in all instances where a patient is mechanically restrained, in particular where multiple instances of restraint occur.

An approved Plan must be in place for any patient who is mechanically restrained for more than **nine (9) hours** in a **24-hour** period.

- Development of a R&E Plan should be initiated in advance if it is considered likely that the mechanical restraint of a patient could exceed nine **(9) hours** in a **24-hour** period.
- An authorised doctor must apply to the Chief Psychiatrist for approval of a R&E Plan.
    - The Office of the Chief Psychiatrist will review the proposed Plan and make a recommendation to the Chief Psychiatrist about its approval.
    - The Office of the Chief Psychiatrist may contact the authorised doctor making the application for further information.
    - The Clinical Director and authorised doctor will be advised in writing of the Chief Psychiatrist's decision as soon as possible, but within **two (2) working days** of receiving the Plan

The Chief Psychiatrist may also direct, on his/her own initiative, that a R&E Plan be prepared for a patient.

- Where a direction is made, the treating doctor and relevant Clinical Director will be advised of this requirement via telephone and email

The R&E Plan form is available within the MHA module in CIMHA.

- If the form is not completed on CIMHA, it must be completed manually and uploaded onto the patient's CIMHA profile.

In urgent circumstances the Chief Psychiatrist may provide initial approval via email following a telephone discussion with the authorised doctor and receipt of an email from the authorised doctor containing:

- relevant clinical details regarding the patient,
- the reasons for use of mechanical restraint,
- the planned use of mechanical restraint and strategies for the reduction and elimination of use.

A full R&E Plan **must** be provided to the Chief Psychiatrist within **twenty-four (24) hours** of the email approval being provided.

A R&E Plan must not be approved for longer than **seven (7) days.**

- The timeframe for an approved plan cannot be extended.
- If a patient requires mechanical restraint over a period longer than **seven (7) days**, a new R&E Plan must be submitted to the Chief Psychiatrist for approval.

Key Points

A R&E Plan must be recorded on the patient's clinical file and must include the following details:

- the name and date of birth of the patient
- the name of the AMHS
- any previous use of mechanical restraint on the patient
- any strategies previously used to reduce the use of mechanical restraint on the patient and the effectiveness of the strategies
- a description of the behaviour that has led to the proposed mechanical restraint
- a description of significant risks to the patient or others
- the reasons that the authorised doctor believes there is no other reasonably practicable way to protect the patient or others from physical harm
- the proposed frequency and duration of mechanical restraint
- the strategies proposed to reduce and eliminate the use of mechanical restraint.

The approval of a R&E Plan does not replace authorisation of each individual period of mechanical restraint.

- An Authorisation of Mechanical Restraint form and a medical review must be completed by an authorised doctor every **three (3) hours.**

A single R&E Plan may apply to **both** mechanical restraint and seclusion.

Only the Chief Psychiatrist may approve a R&E Plan that covers both seclusion and mechanical restraint, or mechanical restraint alone.

Seclusion and mechanical restraint **must not** be used simultaneously.

4 Removal from mechanical restraint

Key Points

The authorised doctor **must** remove a patient from mechanical restraint prior to the end of an authorisation period if satisfied the mechanical restraint is no longer necessary to protect the patient or others from physical harm.

A health practitioner **must** remove a patient from mechanical restraint if:

- the authorised doctor has stated that a health practitioner may remove the patient from mechanical restraint before the authorised period ends in the Authorisation of Mechanical Restraint form, and
- the health practitioner is satisfied the mechanical restraint is no longer necessary to protect the patient or others from physical harm.

If the patient is removed from mechanical restraint prior to the authorisation ending, the restraints may be reapplied under the same authorisation if necessary, to protect the patient or others from physical harm.

- This movement in and out of restraint must be documented in the Restraint Record which must be attached to the Authorisation of Mechanical Restraint.

4.1 Removal from mechanical restraint on Chief Psychiatrist direction

The Chief Psychiatrist may also direct an authorised doctor or health practitioner in charge to remove a patient from mechanical restraint if satisfied the mechanical restraint is no longer necessary to protect the patient or others from harm.

- The authorised doctor or health practitioner in charge **must** comply with this direction.
- Reuse of mechanical restraint in these circumstances will require a new authorisation by an authorised doctor.

4.2 Requirements following mechanical restraint

Key Points

A medical review of the patient, including a physical examination if clinically appropriate and safe to do so, **must** be undertaken by an authorised doctor at the end of the mechanical restraint.

A review (or debrief) with the patient, and where appropriate their support person/s, **must** be undertaken as soon as is clinically appropriate after the mechanical restraint ends, in order to:

- enable open discussion about the restraint and the events leading to it,
- allow the patient to ask questions, and
- provide an opportunity to identify strategies that may assist in preventing the need for restraint in the future.

A review (or debrief) for all staff involved in the mechanical restraint of the patient **must** also be undertaken as soon as practicable after the mechanical restraint ends to evaluate:

- the triggers which resulted in the need to use mechanical restraint, and
- the methods used to respond to the need for mechanical restraint.

5 Notifications and recording

5.1 Notifications

Key Points

The administrator of the AMHS **must** ensure that processes are in place within the AMHS to ensure compliance with the notifications and recording requirements outlined in this policy.

The Chief Psychiatrist **must** be notified immediately where mechanical restraint results in, or is associated with:

- the death of a patient during or within **24-hours** following mechanical restraint of the patient, or
- significant harm to a patient or other person during mechanical restraint or within **24-hours** following mechanical restraint of the patient.

This notification process is in addition to the notification requirements contained in the Chief Psychiatrist Policy – Notification of Critical Incidents and Non-compliance under the Mental Health Act 2016.

Community visitors under the *Public Guardian Act 2014* may request information about the use of mechanical restraint on minors in an AMHS.

- AMHS staff **must** provide information as recorded under section 5.2 of this policy when requested by a community visitor (whether or not it is during or connected with a visit).

5.2 Recording

Key Points

Each time a patient has mechanical restraints applied, the health practitioner in charge of the unit **must** ensure the following information is recorded in the patient's clinical record on CIMHA:

- any current R&E Plan approved by the Chief Psychiatrist,
- the start and end times of each mechanical restraint event,
- the Authorisation of Mechanical Restraint form, and
- the Application for Approval to Use Mechanical Restraint.

Movement in and out of restraint **must** be documented in the Restraint Record which must be attached to the Authorisation of Mechanical Restraint.

In addition, the following information **must** be recorded in the patient's clinical record in CIMHA:

- the reasons for the mechanical restraint, including the events that led to the mechanical restraint,
- why there was no other reasonably practicable way to protect the patient or others from physical harm, including any strategies used to prevent the need for mechanical restraint,
- the patient's health at the time of the mechanical restraint, including signs of alcohol or other drug intoxication or withdrawal,
- the patient's behaviour during the mechanical restraint,
- whether physical restraint or seclusion directly preceded a mechanical restraint event,
- medications administered up to **one (1) hour** prior, during and immediately after the mechanical restraint,
- any adverse events related to the mechanical restraint (for example, injury to the patient or staff),
- the examinations that took place during and immediately after the mechanical restraint,
- the results of all medical reviews of the patient as required, and
- post-event review details.

Issued under section 273 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
Approved device	A device approved by the Chief Psychiatrist that may be used under the MHA 2016 for mechanical restraint.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Clinical Director	Means a senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the clinical director functions and responsibilities.
Health Practitioner in Charge	A health practitioner in charge is any health practitioner with oversight, in control of or with responsibility for a given unit in an AMHS.
HHS	Hospital and Health Service
NSP	Nominated support person - a family member, carer or other support person **formally appointed** by a patient to be their nominated support person. NSP rights include: • must be given all notices about the patient that are required under the Act • may discuss confidential information about the patient's treatment and care • may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and • may request a psychiatrist report if the person is charged with a serious offence.
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.

Term	Definition
Relevant AMHS administrator	The relevant AMHS Administrator is: • the Administrator of the AMHS currently providing clinical services to the person, or • if the person is not currently receiving mental health services (i.e. no open service episode), the Administrator of the AMHS for the location where the person resides.
Support person/s	Includes, a Nominated Support Person or, if the person does not have a Nominated Support Person, a family member, carer or other support person.

Referenced documents and policies

- Chief Psychiatrist Policy – Management of complaints and right to a second opinion
- Chief Psychiatrist Policy – Notification of Critical Incidents and Non-compliance under the Mental Health Act 2016
- Chief Psychiatrist Policy - Transfer and Transport
- Guide to Patient Rights under the *Mental Health Act 2016*
- Form - Authorisation of Mechanical Restraint
- Form - Application for Approval of Mechanical restraint
- Form - Reduction and Elimination Plan (R&E Plan)
- *The Hospital and Health Boards Act 2011*
- *Mental Health Act 2016*
- *Public Guardian Act 2014*
- *Guardian and Administration Act 2000*
- *Powers of Attorney Act 1998*

Document status summary

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Document status summary

To be reviewed by:	15 April 2023

Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Clinical Director	Phone: Email:
Mental Health Administration Delegate	Phone: Email:
Independent Patient Rights Adviser	Phone: Email:
Local Aboriginal and Torres Strait Islander Cultural or Case work unit	Phone: Email:
Multicultural Mental Health	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Mental Health Act 2016

Chief Psychiatrist Policy

Notifications to the Chief Psychiatrist of critical incidents and non-compliance with the Mental Health Act 2016

Contents

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Queensland Government

General

The Chief Psychiatrist promotes adherence to clinical standards and best practice in the administration of the *Mental Health Act 2016* (the Act) and is responsible for accountability and transparency as an essential part of governance arrangements and continuous quality improvement.

The Chief Psychiatrist's core functions under the Act include:

- protecting the rights of patients,
- ensuring the involuntary examination, assessment, treatment, care and detention of persons under the Act complies with the Act,
- facilitating the proper and efficient administration of the Act, and
- monitoring and auditing compliance with the Act.

The Act also provides that the Chief Psychiatrist may, by written notice, require the administrator of an authorised mental health service (AMHS) to provide the Chief Psychiatrist with a stated document or information about a patient who is, or has been, examined, assessed or treated in the service, or any other matter relevant to the Chief Psychiatrist's functions. The administrator must comply with the notice.

AMHS administrators must ensure that the Chief Psychiatrist is notified as soon as practicable of any critical incident involving a patient, or any incident involving significant non-compliance or suspected non-compliance by the AMHS with the Act.

Scope

This Policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner (AMHP), AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this Policy.

For public sector AMHSs, notifying the Chief Psychiatrist of the events specified in this Policy is in addition to any requirements under other legislation such as the *Hospital and Health Boards Act 2011*.

Public sector AMHS are required to comply with the requirements of the Patient Safety Health Service Directive (QH-HSD-032:2014) and the Health Service Directive Patient Safety Guideline for Clinical Incident Management (QH-HSDGDL-032-2).

For private sector AMHSs, notifying the Chief Psychiatrist of the events specified in this Policy is in addition to the requirements specified in any other legislation such as the *Private Health Facilities Act 1999*.

This Policy **must** be implemented in a way that is consistent with the Objects and Principles of the Act.

Policy

1 Critical incidents, significant and suspected non-compliance

AMHS administrators **must** ensure notification to the Chief Psychiatrist of a 'critical incident' or incident involving significant non-compliance or suspected non-compliance with the Act, involving a patient of the service.

The administrator **must** ensure notification to the Chief Psychiatrist as soon as practicable[1] after becoming aware of the incident.

Key Points

Critical incidents include:

- Clinical incidents requiring mandatory reporting under existing legislation:
  - the death, or injury resulting in likely permanent harm, of a person receiving treatment or care for a mental illness in an AMHS
  - the death, or injury resulting in likely permanent harm, of a person who, within thirty (30) days preceding their death, received treatment or care for a mental illness as a patient of an AMHS, if the AMHS becomes aware of the person's death or injury.
- Additional clinical incidents to be notified:
  - an incident resulting in significant mental or physical harm to an inpatient
  - allegations of sexual assault or sexual safety incidents resulting in significant mental or physical harm involving an inpatient
  - a serious adverse clinical incident such as the incorrect administration of medication to a patient which could have resulted in serious harm.
- Additional incidents outside of existing legislative reporting requirements:
  - any incident (clinical or non-clinical) affecting the health, safety or well-being of a patient or another person which could attract public attention or adversely affect the organisational reputation of the AMHS (see section 2.1.2).

[1] Under the Chief Psychiatrist Policies for Seclusion, Physical Restraint and Mechanical Restraint, the Chief Psychiatrist must be notified **immediately** if seclusion, physical restraint or mechanical restraint results in, or is associated with, the death of a patient, or significant harm to a patient or other person, during the seclusion or restraint or within **24 hours** of the seclusion or restraint.

Significant non-compliance means:

- detention of a person other than in accordance with the Act, or
- provision of a regulated treatment (e.g. electroconvulsive therapy) other than in accordance with the Act, or
- the use of seclusion, mechanical restraint, physical restraint or administration of medications other than in accordance with the Act, or
- a breach of any offence provision of the Act (e.g. ill-treatment of patients, contravention of the confidentiality obligations, assisting a patient to unlawfully absent themselves, giving false or misleading information to an official, and obstructing of an official).

Suspected non-compliance means:

- a matter involving possible non-compliance which has yet to be determined as non-compliance with the Act and may require formal investigation at service level and/or by the Chief Psychiatrist.

2 Notification process

2.1 Critical incidents

2.1.1 Critical incidents that relate to a clinical incident

Key Points

The Chief Psychiatrist is notified of critical incidents which relate to a clinical incident as follows:

- Public sector AMHS:
  - Notification is made through the Queensland Health clinical incident reporting system. The Office of the Chief Psychiatrist receives notification reports from the Department of Health Patient Safety and Quality Improvement Service generated from the Queensland Health clinical incident reporting system.
- Private sector AMHS:
  - Notification is made with the Notification of Critical Incidents (Private Sector Authorised Mental Health Services) form.

AMHS administrators must provide the Chief Psychiatrist with a copy of any local clinical incident analysis within **ninety (90) days** of the notification of the incident.

Notification under other Chief Psychiatrist Policies should also be provided in line with notification requirements in those policies.

In addition to the above notification process, AMHSs should use their discretion as to the need to also advise the Office of the Chief Psychiatrist directly of critical incidents via MHA2016@health.qld.gov.au or via phone contact with the Chief Psychiatrist.

2.1.2 Critical incidents relating to organisational, public and media risks

Key Points

The Chief Psychiatrist must be notified, by phone contact, as soon as practicable of any incident (clinical or non-clinical) affecting the health, safety or well-being of a patient or another person which could attract public attention or adversely affect the organisational reputation of the AMHS.

Written notification must also be made via MHA2016@health.qld.gov.au and must include:

- person details (who)
- incident details (what, when and where)
- facility/service type
- RiskMan reference number (if applicable), and
- outcome (including facility/service response and planned actions).

AMHS staff should refer to the relevant HHS or organisational media relations policy and local procedures to ensure legislative requirements, patient privacy obligations and community expectations are met.

2.2 Significant legislative non-compliance or suspected non-compliance

AMHS administrators **must** notify the Chief Psychiatrist of significant or suspected non-compliance, by completing the Notification to the Chief Psychiatrist of Significant Non-compliance form in the Consumer Integrated Mental Health Application (CIMHA), as soon as practicable. The Office of the Chief Psychiatrist receives an automatic notification once the form is completed.

This notification **must** occur whether or not the significant or suspected non-compliance results in harm to the patient.

2.2.1 Notification process when matter is subject to another investigation process

If the Administrator of an AMHS is concerned about confidentiality and privacy issue surrounding a significant or suspected non-compliance event, due to other ongoing investigative process within the service, the Administrator of the AMHS **must** notify the Chief Psychiatrist of the matter by phone and email.

The email **must** contain the following:

- details of the incident, and
- why the non-compliance event cannot be recorded on the patients CIMHA profile, including details of the ongoing review or investigation process.
- A copy of the Notification to the Chief Psychiatrist of Significant Non-compliance form.

The form **must not** be uploaded against the patients CIMHA profile until notification of the outcome of the other investigation/review is provided to the Chief Psychiatrist.

3 Chief Psychiatrist actions

The Chief Psychiatrist will review notifications of critical incidents and significant or suspected non-compliance, and any associated incident analysis, with a view to identifying clinical governance and systemic issues in relation to the assessment and treatment and care of patients.

Key Points

The Chief Psychiatrist may:

- require the AMHS Administrator to provide specific information about the treatment and care of a patient or patients of the service. The Administrator must comply with the notice.
- require remedial actions and/or system improvements at local service or state-wide levels.
- undertake an investigation under the Act into any incident, legislative breach or suspected legislative breach involving the mental health assessment, treatment and care of a patient/s in an AMHS.
- inform the Private Health Regulation Unit, Office of the Chief Health Officer regarding any actions taken by the Chief Psychiatrist that may be relevant to licensing of private health facilities.

4 Recording

The AMHS Administrator **must** ensure that the details of the incident or significant legislative non-compliance/suspected non-compliance are recorded in the patient's clinical record. Wherever possible, this should be recorded on CIMHA.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.

Referenced documents and solicies

- Notification to the Chief Psychiatrist of Significant Non-compliance form
- *Hospital and Health Boards Act 2011*
- Patient Safety Health Service Directive (QH-HSD-032:2014)
- Health Service Directive Patient Safety Guideline for Clinical Incident Management (QH-HSDGDL-032-2).
- *Private Health Facilities Act 1999*

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Mental Health Act 2016
Chief Psychiatrist Policy

Overnight confinement for security purposes at high security units

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Queensland Government

General

The *Mental Health Act 2016* (the Act) makes provision for a range of safeguards and restrictions in relation to the use of seclusion in an authorised mental health service (AMHS) that promote the national and state priority of reducing and where possible eliminating seclusion.

This policy sets out requirements for the overnight confinement for security purposes of a patient detained in a high security unit who is subject to an approved Reduction and Elimination Plan (R&E Plan) under the Act.

All requirements set out in the Act and the Chief Psychiatrist Policy – Seclusion apply to patients in AMHS including those in a high security unit.

Additional guidelines in relation to the use of overnight confinement apply to patients in a high security unit with an approved R&E Plan in circumstances where seclusion under an approved R&E Plan is being utilised as part of the patient's ongoing management plan.

Scope

This policy is mandatory for all authorised doctors, authorised mental health practitioners, administrators, or other persons or staff of a high security unit exercising a power or function under the Act.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy is to be read in conjunction with the relevant provisions of the Act (Chapter 8) and the Chief Psychiatrist Policy – Seclusion.

Policy

1 Application

A high security unit provides treatment and care to patients with significantly challenging behaviours whose risk of harm to self or others cannot be safely managed in a less secure environment. Some patients may require extended periods of seclusion to ensure their own or others' safety. Consistent with national priorities, the aim is to minimise the use of seclusion for these individuals while ensuring a safe environment for the patient and others.

All requirements set out in the Act and the Chief Psychiatrist Policy – Seclusion apply to patients in AMHS including those in a high security unit.

Additional guidelines in relation to the use of overnight confinement apply to patients in a high security unit with an approved R&E Plan in circumstances where seclusion under an approved Plan is being utilised as part of the patient's ongoing management plan.

Key points

The administrator of a high security unit may approve overnight confinement for a period of not more than **ten (10) hours**, between 8pm and 8am, during which a patient may be confined for security purposes.

Overnight confinement for this purpose is not captured within the definition of seclusion.

This additional guideline does not apply to patients of a high security unit who are:

- authorised to be in seclusion to manage an acute risk, or
- subject to an Extension of Seclusion.

2 Reduction and elimination plans

R&E Plans outline measures to be taken to proactively reduce, and where possible, eliminate the use of seclusion. In general, R&E Plans are not required to include information about the use of overnight confinement.

Key points

- Where the use of seclusion and overnight confinement is being utilised as part of the patient's management within a high security setting, this must be reflected in the R&E Plan.
- One of the effects of including overnight confinement within an approved R&E Plan is that during the hours of overnight confinement, there is no legislative requirement for an Authorisation of Seclusion form and a medical review by an authorised doctor to be undertaken every **three (3) hours**.
- A R&E Plan submitted to the Chief Psychiatrist (or delegate) must therefore outline whether, and how, overnight confinement is being utilised for a patient as part of their management plan.

Information provided in the proposed R&E Plan in relation to the use of overnight confinement **must** be patient-specific.

Examples of information in a R&E Plan may include but are not limited to:

- detailing how seclusion is being utilised as part of an ongoing management strategy to address high and persistent risk, rather than an acute situation
- explaining why **three (3) hourly** reviews are not clinically required during overnight confinement, for example:
  - risks may increase if patient is reviewed overnight
  - risks are decreased overnight due to less activity on the ward as other patients are also confined.
- providing strategies to escalate concerns about risks / intervene early in the event that a medical review is required overnight, and
- outlining observation requirements and how these are consistent with the decision not to require 3 hourly medical reviews during overnight confinement (e.g. patient is on constant observations and escalation pathways have been established).

Information provided in relation to overnight confinement **must** address the patient's current presentation, psychiatric history, risk assessment, and management strategies employed to date.

2.1 Approval process for reduction and elimination plans

Key points

Delegation of authority to approve R&E Plans:

The Chief Psychiatrist may delegate the authority to approve a R&E Plan for seclusion to the clinical director (or another senior clinician of the AMHS).

- The clinical director (or delegate) may only approve the **first** R&E Plan required for a patient.
- Subsequent plans **must** be approved by the Chief Psychiatrist.

Where a R&E Plan that includes use of overnight confinement is submitted to the Chief Psychiatrist, the process for approval outlined in the Chief Psychiatrist Policy - Seclusion applies.

- Prior to submitting the R&E Plan to the Chief Psychiatrist, an authorised doctor must have the plan approved by the clinical director.
  - The Office of the Chief Psychiatrist will review the proposed plan and make a recommendation to the Chief Psychiatrist about its approval.
  - The Office of the Chief Psychiatrist may contact the authorised doctor making the application for further information.
  - The clinical director and authorised doctor will be advised in writing of the Chief Psychiatrist's decision as soon as possible, but within two (2) working days of receiving the plan.

The process for seeking urgent approval (e.g. via phone and email) does not apply as the inclusion of overnight confinement may only occur as part of a patient's ongoing management plan.

3 Monitoring and review

As part of the ongoing monitoring and review of the use of seclusion, the authorised doctor completing the Authorisation of Seclusion form which immediately precedes the commencement of overnight confinement (e.g. the last **Authorisation** prior to 10pm) **must** confirm that the plan outlined in the approved R&E Plan should continue for the patient. If there are any acute changes in the patient's presentation, these should be documented on the Authorisation of seclusion form.

The Clinical Director **must** also review the appropriate use of overnight confinement, at least **weekly**, and updated information must be provided each time a R&E Plan is submitted for approval.

4 Notifications and recording

Key points

The authorised doctor or clinical director of a high security unit **must** enter the R&E Plan into CIMHA for approval.

If the clinical director of a high security unit approves the R&E Plan, the AMHS administrator **must** ensure that the R&E Plan is recorded in CIMHA.

If overnight confinement forms part of a patient's R&E Plan, the AMHS administrator **must** ensure that CIMHA reflects that:

- seclusion is ended for the person at the commencement of the period of overnight confinement (e.g. 10pm), and
- seclusion is authorised for the person at the end of the period of overnight confinement (e.g. 8am).

Issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly
Chief Psychiatrist, Queensland Health
30 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Overnight Confinement	The administrator of a high security unit may approve a period of not more than 10 hours, between 8pm and 8am during which a patient may be confined for security purposes. Overnight confinement for this purpose is not captured within the definition of seclusion.
Reduction and Elimination Plan (R&E Plan)	Outlines measures to be taken to reduce and where possible eliminate the use of seclusion on a patient, and to reduce the potential for trauma and harm as a result of seclusion.
Seclusion	The confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented. It does not include overnight confinement for security purposes in a high security unit or another unit approved by the Chief Psychiatrist for this purpose.

Referenced forms, clinical notes and templates
Authorisation of seclusion form
Reduction and elimination plan
Return to and release from seclusion form

Referenced documents and sources
Chief Psychiatrist Policy: Seclusion.
Mental Health Act 2016

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Attachment 1 – Key contacts

Key contacts	
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Mental Health Act 2016

Chief Psychiatrist Policy

Patient records

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Queensland Government

General

The *Mental Health Act 2016* (the Act) requires that the Chief Psychiatrist **must** establish and maintain a system for keeping electronic records of, advance health directives (AHD's), Enduring Powers of Attorney for a personal matter (EPoA) and appointment of Nominated Support Persons (NSPs).

The Consumer Integrated Mental Health and Addictions (CIMHA) application is a statewide electronic mental health database in Queensland and is the designated patient record for the purposes of the Act.

CIMHA **must** contain information stating the name of the person who made the AHD, EPoA or appointment, the date that it was made, and an electronic copy of the document.

The Act also requires the administrator of an authorised mental health service (AMHS) to keep a record containing specified information for involuntary patients and classified patients (voluntary) for the AMHS.

An accurate, comprehensive and up to date patient record management system supports mental health clinicians and administrators in delivering high quality treatment and care and upholding the rights of involuntary patients.

Scope

This Policy is mandatory for all Authorised Mental Health Services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act must comply with this Policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Legislative requirements for record keeping

All records created or received by Queensland Health are governed by the *Public Records Act 2002* (PR Act), which applies to all public authorities. Retention and disposal of Queensland Health records **must** comply with the relevant schedules issued under the PR Act.

All patient information created or received by Queensland Health is subject to the confidentiality provisions of the *Hospital and Health Boards Act 2011* (HHB Act).

The *Private Health Facilities Act 1999* (PHF Act) provides for the Chief Health Officer to make standards about patient records. Private facility AMHS administrators **must** ensure that all local recordkeeping arrangements align with the standard issued by the Chief Health Officer for information management.

1.1 Record management systems

Key Points

CIMHA functionality enables information in relation to a person's assessment, treatment and care in an AMHS to be managed and viewed in one location.

- This information comprises data and documents, including forms, clinical notes, clinical reports, medico-legal documents and non-clinical information.

Limited mental health information from CIMHA is also available via 'The Viewer', to enable non-mental health clinicians to access up-to-date and accurate information about mental health patients. Information available via 'The Viewer' includes:

- patient demographic and clinical information,
- status under the Act,
- AHDs and documents relating to appointment of an EPoA,
- alerts, and
- certain clinical notes such as assessments and discharge summaries.

AMHS administrators **must** ensure that CIMHA data entry relevant to the assessment, treatment and care patients under the Act is accurate and up-to-date.

All Act-related documents (e.g. reports, forms, advance health directives and documents relating to the appointment of a guardian or attorney) **must** be electronically entered or uploaded to CIMHA.

For private sector AMHS, it will also be necessary for a copy of these documents to be stored on the relevant patient's clinical record to ensure that they are readily accessible to staff.

1.2 Medico-legal documents

Key Points

Documents which are both medico-legal and clinical in nature must be saved in the CIMHA clinical notes module to allow clinicians access to timely clinical history and to support comprehensive risk management and treatment planning. Such documents include:

- a psychiatrist report to inform decisions about criminal responsibility and fitness for trial, and
- an expert report provided to a court.

Other medico-legal documents and non-clinical information such as police reports, QP9 forms, witness statements and court materials must be scanned and saved in the Mental Health Act forms module.

- Access to these documents is restricted to AMHS administrators, administrator delegates, Court Liaison Service staff, Forensic Liaison Officers, Psychiatrists completing Chapter 4 reports and the Office of the Chief Psychiatrist.

This functionality removes the requirement for a separate administrator paper record to be retained. The necessity to retain an administrator paper record for historical information which is not scanned and saved in CIMHA will remain pending the development of functionality to manage this information.

Public facility AMHS Administrators **must** ensure that clinical documentation relevant to the assessment, treatment and care of patients under the Act is recorded in CIMHA clinical notes.

This documentation may also be located in other patient recordkeeping systems (paper or electronic), according to local Hospital and Health Service (HHS) requirements.

Original paper records **must** be retained until the accuracy of the digitised (scanned) image has been verified and quality checks have been conducted on the digitised image according to local arrangements.

AMHS Administrators are responsible for ensuring that they have processes in place to manage the integrity of scanned information so that it remains accessible as required.

1.3 Retention and disposal

The retention and disposal of Queensland Health records is determined by their class under the PR Act and the relevant retention and disposal schedule.

- Different retention and disposal schedules apply for clinical, medico-legal and administrative records.
- Digitised records **must** be retained for the full retention period required by the relevant schedule.

1.4 Access to CIMHA

The level of access by mental health staff to CIMHA **must** be in accordance with their roles and functions, and the relevant information security classifications and levels.

AMHS administrators **must** ensure that all relevant staff are trained and competent in the use of CIMHA.

The Office of the Chief Psychiatrist undertakes regular data quality activities in conjunction with AMHSs as part of compliance mechanisms to ensure the accuracy and consistency of data in CIMHA.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Relevant AMHS Administrator	The relevant AMHS Administrator is: • the Administrator of the AMHS currently providing clinical services to the person, or • if the person is not currently receiving mental health services (i.e. no open service episode), the Administrator of the AMHS for the location where the person resides.

Referenced documents and sources

Public Records Act 2002
Private Health Facilities Act 1999
Private Health Facilities (standard) Notice 2016
Queensland State Archives Glossary of Archival Recordkeeping Terms
Queensland State Archives (QSA) Digitisation Disposal Policy
Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1
General Retention and Disposal Schedule: QDAN 249
General Retention and Disposal Schedule for Original Paper Records that have been digitised: QDAN 656 v.2
Clinical Records Management Policy: QH-POL-280:2014
Managing Paper Records Standard: QH-IMP-424-1:2015
Recordkeeping Policy: QH-POL-424:2015

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Mental Health Act 2016

Chief Psychiatrist Policy

Physical restraint

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General

The *Mental Health Act 2016* (the Act) makes provision for a range of safeguards and restrictions in relation to the use of physical restraint in an authorised mental health service (AMHS) that promote the national and state priority of reducing, and where possible, eliminating physical restraint.

Physical restraint generally refers to the use by a person of his or her body to restrict the patient's movement. However, physical restraint does not include the giving of physical support or assistance reasonably necessary to enable the patient to carry out daily living activities, or to redirect the patient because the patient is disoriented.

Physical restraint is to be used as a last resort where less restrictive interventions are insufficient to protect a patient, or others, from physical harm, provide necessary treatment and care to a patient, prevent serious damage to property, or prevent a patient detained in an AMHS from leaving the service without approval.

It is an offence to use physical restraint on a person in an AMHS other than in accordance with the Act, except where the restraint is authorised under another law.

The following principles **must** be applied in the use of physical restraint:

- maintaining the safety, wellbeing and dignity of the patient is essential
- protecting the safety and wellbeing of staff is essential
- physical restraint should only be used for the minimum period of time necessary, and
- all staff actions should be justifiable and in proportion to the patient's behaviour and broader clinical context.

Scope

This policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator or other person performing a function or exercising a power under the Act **must** comply with this policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Application of the physical restraint provisions

Key points

Physical restraint of a patient is the use, by a person, of his or her body to restrict the patient's movement.

Physical restraint under the Act does not include:

- the giving of physical support or assistance reasonably necessary to enable a patient to carry out daily living activities or to redirect a disorientated patient, or
- physical restraint authorised under another law, or
- physical restraint required in urgent circumstances.

The physical restraint provisions of the Act and this policy apply to any person who is a patient.

- A patient is defined as:
  - an involuntary patient (see definitions), or
  - a person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient (including under an AHD or with the consent of an attorney or guardian)

Physical restraint may be used in any unit within an AMHS, including an emergency department, provided that sufficient resources are available to safely meet the needs of the patient and staff.

Any use of physical restraint on a patient in an AMHS, including restraint used in urgent circumstances, **must** be recorded on the physical restraint clinical note template in CIMHA. This applies to:

- physical restraint in a mental health inpatient or other specialist mental health unit within a hospital or in an AMHS community facility, or
- physical restraint in another area of an AMHS (for example, Emergency Department) where mental health service staff are involved in the decision or process of the person's physical restraint.

This includes, for example, where physical restraint is applied in order to move a patient to a seclusion room, or to administer medication.

The administrator of the AMHS must ensure that procedures are in place within their service to ensure these records are maintained.

Where physical restraint is planned, prior authorisation **must** be sought from an authorised doctor or health practitioner in charge (for example to transfer a patient to, or from, a seclusion room).

Authorisation may be given for the use of physical restraint on a patient for one or more of the following purposes:

- to provide treatment and care to the patient,
- to protect the patient or others from physical harm,
- to prevent the patient from causing serious damage to property, or

- for a patient detained in an AMHS, to prevent the patient from leaving the service without permission.

The authorising doctor or health practitioner in charge **must** be satisfied that there is no other reasonably practicable way to achieve the purpose of the physical restraint.

Authorisation of physical restraint may be provided verbally.

Physical restraint must not be used:

- as a substitute for other less restrictive interventions,
- as a form of discipline or punishment,
- as a substitute for adequate staffing levels, or
- as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours.

As far as is practicable and safe, verbal strategies, de-escalation techniques and other evidence-based strategies such as sensory modulation **must** be used to help the patient safely gain control of their behaviour.

Medication may assist to prevent the need for the use of physical restraint.

- Additionally, if other strategies have been ineffective or are not appropriate, acute sedation may also need to be considered as part of a treatment strategy to prevent harm to the patient and others (refer to Chief Psychiatrist Policy – Clinical need for medication).

Authorisation under the Act is not required where physical restraint is:

- required in urgent circumstances (e.g. to restrain a patient who is physically aggressive), or
- authorised under another law, or
- for the giving of physical support or assistance reasonably necessary to enable the patient to carry out daily living activities or redirect a disorientated patient.

1.1 Requirements for the use of physical restraint

1.1.1 Procedures

Key points

Administrators must ensure that all units that may use physical restraint have procedures clearly outlining a standard approach to the use of physical restraint within the unit.

- This will include a team-based approach to be used for planned (i.e. non-urgent) and unplanned physical restraint.

The following should be outlined for a team-based approach:

- the individual tasks required, including overall leadership of the physical restraint, responsibility for physical monitoring of the patient and for specific tasks associated with physical restraint, and
- the intended staffing and allocation of roles, with consideration for situations in which intended staffing may not be available or where staff may have a different skillset, including clinicians with different levels of training, health security staff and other operational staff.

If health security officers, staff from other clinical areas within the HHS or other service providers such as first responders use different approaches to physical restraint, local procedures should clarify which takes priority in case of any areas of overlap.

The approach taken to physical restraint must be supported by a structured occupational violence prevention and management training package for staff, approved by the Hospital and Health Service (HHS). Where possible this should include scenario-based training to improve live responses.

Staff carrying out a restraint under the Act **must** be appropriately trained to protect the welfare and dignity of the patient. This training must include de-escalation strategies, physical restraint techniques, trauma-informed care, recovery-oriented practice and de-briefing strategies.

Administrators should ensure appropriate mechanisms are in place to enable review of all physical restraint events within the unit, as part of established quality and safety processes.

1.1.2 Preparation and planning

Emergency situations can and will arise unexpectedly, and not every physical restraint event can be prevented or planned. However, practice which is consistent with clear, specific procedures and aligns with associated training may protect patients and staff and may reduce the likelihood of prolonged physical restraint.

In situations where an intervention with an individual patient includes a need for physical restraint as a possible contingency, the treating team and relevant team members trained in the use of restraint should develop a specific plan for the intervention, including any possible physical restraint.

To the greatest extent possible, preparation and planning should be undertaken collaboratively with the patient and family/carers and should lead to an agreed plan for the prevention of physical restraint (wherever possible) and for the safe management of any necessary physical restraint, including minimising the duration of the restraint.

1.1.2.1 Prevention of physical restraint

Situations that may trigger distress, anger and aggression should be identified, such as:

- refusing a patient's request (e.g. for leave or for a personal item),
- administration of treatment not wanted by the patient at that time (e.g. medication, electroconvulsive therapy (ECT)), or
- a planned transfer to a more restrictive environment (e.g. a high dependency unit).

Individualised strategies and less restrictive alternatives to prevent the need for physical restraint should be identified, for example:

- verbal strategies, de-escalation techniques, and the use of sensory items and/or a quiet room or sensory room, in addition to use of medication, to reduce distress.

1.1.2.2 Factors to consider for the safe management of physical restraint

- Identification of the risks associated with the behaviour/s of concern, along with the objectives of physical restraint and the risks associated with the restraint and associated care.
- The management of specific risks associated with the restraint plan.
- The most appropriate timing of any required physical restraint.
- Individual patient risk factors, including degree of cooperation, possible intoxication, any medications given, age, obesity, and the presence of respiratory, neurological or musculoskeletal disorders.
- Any heightened vulnerability to significant psychological trauma, especially for minors, patients with a history of trauma, abuse and/or detention.
- The identification of persons from Aboriginal and Torres Strait Islander backgrounds and strategies to address cultural needs.
- Mechanical and postural factors which may increase the risk of harm to the patient during physical restraint, including restraint positions likely to restrict breathing or venous return.

To meet the goal of minimising duration of physical restraint, staff should make any necessary preparations for subsequent management of behaviour prior to initiating the intervention.

- This may include preparation of medications, seclusion rooms, oxygen and any other necessary requirements.

1.1.3 Use of physical restraint in an AMHS

Staff carrying out the restraint **must** complete the following.

Prior to physical restraint (or as soon as possible during emergency restraint):

- adhere to any plan in place to prevent and/or safely manage the use of physical restraint on the patient, to the extent possible.
- Wherever possible, avoid or mitigate mechanical and postural factors which may increase the risk of harm to the patient during physical restraint.
    - This includes restraint positions that restrict breathing or venous return, for example prone restraint, and any position in which the patient's head or trunk is bent towards their knees.

During restraint:

- Use no more physical force than is necessary and reasonable in the circumstances.
- Ensure that the patient's airway, breathing, consciousness and body alignment are monitored by a clinician at all times.
    - This should include continuous consideration by all involved staff of the physical risks associated with extended duration of restraint, in particular by the clinician responsible for monitoring and the clinician leading the restraint.
- There should be no direct pressure on the neck, thorax, back or pelvic area.
- Observe for indications of physical or mental distress, and ensure that clinical concerns are appropriately escalated, and that appropriate treatment and care is provided.
- Monitor patients where intramuscular or intravenous medication was administered within **one (1) hour** prior to the use of physical restraint or during the restraint and seek immediate medical treatment if there is a concern.
- If necessary, change physical restraint positions where it is safe to do so.
- Cease physical restraint as soon as it is no longer required.
    - The assessment of risks of continuing the restraint needs to be continuously balanced against the risks associated with ceasing it.

1.1.4 Medical review of the patient

A medical review of the patient, including a physical examination if clinically appropriate and safe to do so, must be undertaken by an authorised doctor as soon as practicable after the use of physical restraint. The patient must be closely monitored for as long as clinically necessary.

Consideration should be given to the person's ongoing clinical management, including whether involuntary treatment under the Act is required.

Relevant information **must** be recorded in the patient's clinical record on CIMHA regarding the use of physical restraint (refer to section 2).

1.1.5 Post-event debriefing

A review (or debrief) with the patient involved in the physical restraint (with the patient's consent), and with other patients involved in any event that led to the physical restraint, must be undertaken as soon as is clinically appropriate after the physical restraint ends, in order to:

- enable open discussion about the physical restraint, the events leading to it and the patient's experience of it,
- allow the patient to ask questions, and
- provide an opportunity to identify strategies that may assist in preventing the need for physical restraint in the future. This may include a written plan or list of strategies that can be shared with and utilised by the patient, their support person/s and staff.

The review (or debrief) should include support persons such as a family member or peer worker where possible and appropriate.

A review (or debrief) for all staff involved in the physical restraint of the patient **must** also be undertaken as soon as practicable after the physical restraint ends, to:

- enable open discussion about the physical restraint, the events leading to it and the staff's experience of it,
- identify the triggers which resulted in the need to use physical restraint,
- evaluate the methods used to respond to the need for physical restraint, and
- identify measures to reduce, and where possible, prevent future use of physical restraint.

2 Notifications and recording

The health practitioner in charge of the unit must ensure that each time a patient is physically restrained, the information listed in section 2.1 is recorded on the Physical restraint clinical note template in CIMHA.

- The Physical restraint clinical note template includes sections for all items listed, with the exception of post-event review.

Key points

The Clinical Director (or appropriately delegated person) must notify the Chief Psychiatrist **immediately** where physical restraint results in, or is associated with:

- the death of a patient during or within **24-hours** following physical restraint of the patient, or
- significant harm to a patient or other person during physical restraint or within **24-hours** following physical restraint of the patient.

Notification must be made via phone or email to the Chief Psychiatrist.

This notification process is in addition to the requirements contained in the Chief Psychiatrist Policy – Notification of critical incidents and non-compliance with the *Mental Health Act 2016*.

2.1 Recording physical restraint events

The following information **must** be recorded in the patient's clinical record on CIMHA:

- the actual times and duration of physical restraint by AMHS staff, the type of physical restraint used, and the number of staff involved in the physical restraint event,
- the reasons for the physical restraint, including the events that led to the physical restraint,
- why there was no other reasonably practicable way to protect the patient, others or property, to provide treatment or to prevent the patient from leaving the service,
- clinically relevant details regarding the patient's health at the time of the physical restraint, including signs of alcohol or other drug intoxication or withdrawal,
- the patient's behaviour during the physical restraint,
- whether seclusion or mechanical restraint directly preceded or followed the physical restraint,
- medications administered up to one hour prior to, during or immediately after the physical restraint (including medication name, dosage, frequency and route of administration),
- any adverse events relating to the physical restraint, including injury to patients or staff,
- the results of the clinical review of the patient that took place immediately after the physical restraint, and
- post-event review with the patient, staff and any other relevant persons.

Community visitors under the *Public Guardian Act 2014* may request information about the use of physical restraint on minors in an AMHS.

AMHS staff **must** provide information as recorded under section 2 of this policy when requested by a community visitor (whether or not it is during or connected with a visit).

3 Monitoring and reporting

Monitoring physical restraint rates, the types of events that result in physical restraint, the types of physical restraint used, and any adverse events is a necessary part of minimising the use of physical restraint.

Data will be publicly reported in the Chief Psychiatrist Annual Report in accordance with national standards.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly

Chief Psychiatrist, Queensland Health

22 May 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service - a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Clinical Director	means a senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the Clinical Director functions and responsibilities outlined in this Practice Guideline.
HHS	Hospital and Health Service
Health Practitioner	Means a person registered under the Health Practitioner Regulation National Law, or another person who provides health services, including, for example a social worker.
Health Practitioner in Charge of a Unit	Means the health practitioner who has clinical responsibility for the unit where the patient will be physically restrained (e.g. the nurse unit manager, or senior registered nurse in charge).

Involuntary Patient	Means:
	• A person subject to any of the following:
	  ○ An examination authority,
	  ○ A recommendation for assessment,
	  ○ A treatment authority,
	  ○ A forensic order,
	  ○ A treatment support order,
	  ○ A judicial order, or
	• A person detained in an AMHS or PSHSF under section 36, or
	• A person from another state detained in an AMHS under section 368(4).

NSP	Nominated support person - a family member, carer or other support person formally appointed by a patient to be their nominated support person. NSP rights include: • must be given all notices about the patient that are required under the Act • may discuss confidential information about the patient's treatment and care • may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and • may request a psychiatrist report if the person is charged with a serious offence.

Term	Definition
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.
Physical restraint	Generally, refers to the use by a person of his or her body to restrict the patient's movement. However, physical restraint does not include the giving of physical support or assistance reasonably necessary to enable the patient to carry out daily living activities or to redirect the patient because the patient is disoriented.
Relevant AMHS administrator	The relevant AMHS administrator is: • the administrator of the AMHS currently providing clinical services to the person, or • if the person is not currently receiving mental health services (i.e. no open service episode), the administrator of the AMHS for the location where the person resides.
Support person/s	Includes, an appointed Nominated Support Person or, if the person does not have a Nominated Support Person, a family member, carer or other support person.

Referenced documents and sources
Physical Restraint clinical note template (in CIMHA)
Chief Psychiatrist Policy – Clinical need for medication
Chief Psychiatrist Policy – Notification of Critical Incidents and Non-compliance under the Mental Health Act 2016
Public Guardian Act 2014

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Attachment 1 – Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Local Independent Patient Rights Adviser	Phone: Email:
Community visitor	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Mental Health Act 2016
Chief Psychiatrist Policy

Psychiatrist reports for persons charged with a serious offence

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General

A criminal case can be referred to the Mental Health Court if it is believed that the alleged offender was of unsound mind or there is a question relating to the alleged offender's fitness for trial. The Mental Health Court is responsible for deciding the state of mind of persons charged with criminal offences.

Under Chapter 4 of the *Mental Health Act 2016* (the Act), the Chief Psychiatrist may direct that a psychiatrist report for a person charged with a serious offence be prepared by an authorised psychiatrist:

- at the request of the person charged or other specified persons (Part 2), or
- on the Chief Psychiatrist's own initiative (Part 3).

Psychiatrist reports for persons charged with a serious offence are used to inform decisions about further action in relation to a charge. This includes decisions by the person or the Chief Psychiatrist about whether a reference should be made to the Mental Health Court to determine matters of unsoundness of mind and fitness for trial.

Once a direction for a psychiatrist report has been given by the Chief Psychiatrist, proceedings against the person in relation to the serious offence in the criminal courts are suspended.

The suspension ends generally if a reference to the Mental Health Court is not made within twenty-eight (28) days of the report being received or when the Mental Health Court makes a decision on the reference.

Psychiatrist reports under Chapter 4 of the Act do not impact on the person's right to seek a psychiatrist report from a private sector psychiatrist. A private sector psychiatrist report will be at the person's own cost and initiative.

Scope

This policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

This policy **must** be read in conjunction with the relevant provisions of the Act (Chapter 4).

Staff should work collaboratively with and in partnership with individuals in their care to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. This should include the timely involvement of appropriate local supports and a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

This policy is issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 October 2021

Policy

1 Psychiatrist report on request

For an overview of processes that apply for a psychiatrist report made on request, refer to

- Flowchart – *Psychiatrist reports 2(a): Report on request*, and
- Flowchart – *Psychiatrist reports 2(b): Direction for report (Report on request).*

1.1 Identifying persons eligible to make request

A psychiatrist report may be requested if all of the following apply:

- a person is charged with serious offence[1],
- the person was subject to a Treatment Authority, Forensic Order or Treatment Support Order at the time of the offence, or any subsequent time, regardless of whether the authority or order remains in place, and
- a court has not yet made a final decision on the offence.

Under the Act, any of the following persons may make a request to the Chief Psychiatrist for a psychiatrist report:

- the person,
- their appointed nominated support person,
- an appropriately authorised guardian or attorney,
- a parent of the person, if the person is a minor, or
- the person's legal representatives (if instructed by the person).

> Once an AMHS administrator becomes aware that a person is eligible for a psychiatrist report, they have an obligation under the Act to advise that person, and other relevant persons, of this entitlement.

A clinician who becomes aware that a person may be entitled to request a psychiatrist report **must**, notify the relevant AMHS administrator as soon as practicable.

The relevant AMHS administrator is:

- the administrator of the AMHS currently providing clinical services to the person, or
- if the person is not currently receiving mental health services (i.e. no open service episode), the administrator of the AMHS for the location where the person resides.

[1] Serious offence means an indictable offence, other than an offence that is a relevant offence under the Criminal Code, section 552BA(4).

If the AMHS administrator considers the person may be eligible to request a psychiatrist report, the administrator **must** notify the Office of the Chief Psychiatrist.

Within **seven (7) days** of receiving the request the Chief Psychiatrist will confirm whether the person's criminal charges are eligible for a psychiatrist report and notify the AMHS administrator of the outcome.

The AMHS administrator **must** inform the notifying clinician of the outcome as soon as practicable.

1.2 Information to be provided when a person is eligible

1.2.1 Administrator responsibilities

Key points

- On receiving confirmation that a person is eligible to request a psychiatrist report, the administrator must as soon as practicable, prepare information to be provided to the person including:
  - a letter advising the person of their entitlement to request a report (A template letter is available in the Consumer Integrated Mental Health and Addiction (CIMHA) application),
  - Factsheet – *Psychiatrist reports*, and
  - Form – *Request for psychiatrist report*.

The administrator **must** determine the clinician responsible for providing the information to the person. For example:

- the health practitioner in charge of the inpatient unit if the person is an inpatient
- the case manager if the person is not an inpatient, or
- the Forensic Liaison Officer.

If the person does not have an open service episode, the administrator will determine if the person is to be provided the information by mail or in person.

> **Example:** it may be appropriate for the information to be provided in person if the person is well known to the service or has had a recent service episode. If the information is given by mail, contact details for a clinician are to be provided in the letter.

The administrator will also advise the person's treating authorised psychiatrist of their eligibility to request a psychiatrist report. This enables the psychiatrist to consider whether there are public interest considerations in relation to preparing a report (see Section 2.1 Chief Psychiatrist's consideration of public interest issues).

1.2.2 Clinician responsibilities

The nominated clinician is responsible for providing and explaining the information to the person and their support person/s (see definitions).

The information is to be provided as soon as practicable, within **fourteen (14) days** of the administrator's letter.

If the person is a minor the clinician **must** also provide and explain the information to one or more of the person's parents.

However, the information is not required to be given to a parent if the clinician determines that giving the information is not in the minor's best interests.

The clinician's role is limited to helping the person understand the information provided. The clinician should be mindful to not influence the person's decision about whether to request a report.

If the person requires assistance to make the decision, they should be encouraged to discuss the matter with their support person/s or a lawyer. If the person does not have a lawyer, contact details for legal advice are provided in the *Factsheet - Psychiatrist reports*.

> If the person is unable to understand the explanation due to their mental state at the time, the clinician may provide the information at a later time. Timely provision of information to the support person/s and any personal guardian or attorney is vital.

The clinician may seek assistance from an Independent Patient Rights Adviser (IPRA) if they consider the person or their support person may benefit from further explanation.

The clinician **must** make a record of the information in a CIMHA clinical note, including:

- who the information was provided to, or
- if information was not provided, the reasons the information was not provided, and
- any other relevant actions including referral to the IPRA.

> All clinicians have a responsibility to ensure the person understands their entitlement to request a psychiatrist report. Further information/explanation can be provided by any member of the person's treating team or any other clinician who has contact with the person e.g. Court Liaison Service or Prison Mental Health Service clinician.
>
> This is also one of the functions of IPRAs under the Act. For more information, refer to the *Chief Psychiatrist Policy Independent Patient Rights Advisers*.

1.2.3 Provision of information before eligibility to request a report confirmed

In certain circumstances, it may be necessary for a clinician to provide information to the person, prior to confirmation of their eligibility to request a report, to ensure the person receives timely advice about their possible entitlement.

For example, it may be appropriate for a Court Liaison Officer to inform a person who is to appear in the Magistrates Court in relation to a charge.

The clinician should explain the entitlement and the process that may apply (e.g. confirmation and letter of entitlement from administrator).

> Where appropriate, the *Psychiatrist reports factsheet* may be provided to explain the entitlement.

The clinician **must** advise the relevant administrator without delay. A record of the information provided, and actions taken, should be recorded in a CIMHA clinical note.

1.3 Chief Psychiatrist decision if request for report is made

Key points

- The Chief Psychiatrist **must** decide any request for a psychiatrist report within **seven (7) days**.
- A direction for a psychiatrist report will be issued in the vast majority of circumstances. However, the Chief Psychiatrist will not issue a direction for a psychiatrist report if:
  - the charges have been withdrawn by the prosecution,
  - the charges have already been determined by a court,
  - a direction for a psychiatrist report has already been issued by the Chief Psychiatrist following a request from another person or on the Chief Psychiatrist's own initiative,
  - the person who made the request is not eligible to make the request e.g. the person makes the request as a nominated support person, or guardian or attorney for the person and the person's standing cannot be verified, or
  - a direction for a psychiatrist report in relation to the offence has been previously revoked by the AMHS administrator and the Chief Psychiatrist is not satisfied that the circumstances have changed.

The Chief Psychiatrist may seek further information from the administrator, authorised psychiatrist or other relevant clinician to determine the standing of the person who made the request or to understand the current circumstances if a direction for a psychiatrist report has previously been revoked by the administrator.

If the Chief Psychiatrist does not make a direction for a report, the Chief Psychiatrist will give written advice to the person who made the request and will provide the reasons for not making the direction.

2 Psychiatrist reports on the Chief Psychiatrist's own initiative

Key points

- A direction for a psychiatrist report on the Chief Psychiatrist's own initiative is intended to apply in **exceptional circumstances**. The Chief Psychiatrist **must** be satisfied:
  - the person may have a mental illness, and
  - the person may have been of unsound mind at the time of the offence or may be unfit for trial, and
  - the preparation of a psychiatrist report is in the public interest.

2.1 Chief Psychiatrist's consideration of public interest issues

Consideration of public interest is relevant to the Chief Psychiatrist's decision to:

- direct a psychiatrist report on the Chief Psychiatrist's own initiative, and
- refer the matter of the person's mental condition to the Mental Health Court.

Determination of public interest requires consideration of the individual circumstances of the case and a balanced assessment of competing interests.

The decision will take account of the policy intent for individuals to, as far as possible, make their own decisions about how their legal matters are dealt with.

A decision to direct a report on the Chief Psychiatrist's own initiative or make a reference to the Mental Health Court will only be made in **exceptional circumstances** where necessary for the protection of the individual or the community.

The Chief Psychiatrist will take account of available expert clinical advice from an authorised psychiatrist to inform matters relating to protection of individual or community interests.

An authorised psychiatrist may make an *Advice to Chief Psychiatrist – Public Interest Consideration* if they consider the individual circumstances require the Chief Psychiatrist's attention. Prior to providing this advice, the service should ensure all avenues for the individual to progress an application on request have been exhausted.

- The authorised psychiatrist should contact the Mental Health Act Administration Team by phone on 07 3328 9899 to discuss the circumstances before giving written advice for a Chief Psychiatrist public interest consideration.
    - For example, information about whether the person's nominated support person, legal representative, or public guardian has been engaged to ensure the person is aware of the importance of this process.
- Advice may be given by the person's treating authorised psychiatrist or another authorised psychiatrist who has assessed the person e.g. authorised psychiatrist for the Court Liaison Service.
- In exceptional circumstances, the advice may be given by a senior clinician who is not a psychiatrist (where circumstances prevent referral to a psychiatrist).
    - For example, where a Court Liaison Officer identifies a public interest concern and considers that immediate advice needs to be provided to ensure timely consideration by the Chief Psychiatrist (e.g. there is a risk that the matter will be determined by a court).

The advice may be provided in relation to a person who is eligible to make a request for a psychiatrist report or another patient of an AMHS who is charged with a serious offence i.e. a patient who was not, and has not been, subject to a Treatment Authority, Forensic Order or Treatment Support Order at the time of, or following, the date of the offence.

Written advice of the Chief Psychiatrist's decision will be provided to the authorised psychiatrist.

2.1.1 Individual interests

Key points

- All members of the community are entitled to a fair legal process and ensuring this occurs is in the public interest.
- Protection of the individual's interests will usually arise where the person's current mental condition significantly impacts their capacity to represent their own interests in relation to the offence (i.e. where it appears the person is not currently fit for trial).

In making the determination, the Chief Psychiatrist will consider whether the person's interests can be adequately protected through other mechanisms, such as the person's appointed nominated support person, guardian or attorney (who may seek a psychiatrist report on the person's behalf).

The decision-making will take account of any likely improvement in the person's mental condition. The Chief Psychiatrist's decision to direct a report may be delayed if early improvement to the person's mental condition and their capacity to represent their own interests is anticipated.

2.1.2 Community interests

Appropriate treatment of a person's mental illness, particularly where there is a strong association between offending and the illness, is an effective means of reducing the risk of further offending.

Minimising risk of recidivism is fundamental to protecting the interests of the community, as well as being in the best interests of the individual. Management of this risk needs to take account of community interests and individual rights.

Key points

- The Chief Psychiatrist will, taking account of the individual circumstances, determine whether a report is required to inform the circumstances of offending behaviour. The following considerations apply:
  - the nature and, if known, the circumstances of the offence
  - evidence to indicate that the person may have been mentally ill at the time of the offence
  - history of offending behaviour including any previous findings that the person was of unsound mind in relation to an offence, and
  - treatment history, including engagement in treatment and whether potential risks can be appropriately ameliorated through existing treatment arrangements.

3 Chief Psychiatrist direction for a psychiatrist report

For an overview of processes that apply when the Chief Psychiatrist has given a direction for a psychiatrist report, refer to *Flowchart – Psychiatrist reports 3: Direction for Report (Chief Psychiatrist Initiative)*.

3.1 Chief Psychiatrist direction

The Chief Psychiatrist's direction is given by way of a *Chief Psychiatrist direction for psychiatrist report* form. This form identifies whether the direction is given on:

- a request for a psychiatrist report, or
- the Chief Psychiatrist's own initiative.

The Chief Psychiatrist's direction is provided to the relevant AMHS administrator. If the person is a prisoner, the Chief Psychiatrist will determine the most appropriate AMHS on a case by case basis.

A direction for a psychiatrist report on the Chief Psychiatrist's own initiative may specify the authorised psychiatrist required to provide the report and, in some instances, will provide appointment details for the person to be examined by the specified authorised psychiatrist.

The Chief Psychiatrist's direction will identify the serious offence and, where relevant, any associated offences.

> If a direction for a psychiatrist report is made, the proceedings against the person in relation to the serious offence and any associated offences are suspended. The Chief Psychiatrist will provide notice of the suspension to the Chief Executive for Justice.

3.2 Giving effect to the Chief Psychiatrist's direction and providing information about the direction

3.2.1 Administrator responsibilities

The administrator **must** request relevant information about the charges from the prosecuting authority. The administrator may seek assistance from the Office of the Chief Psychiatrist to facilitate timely access to relevant information about the charges.

Key points

The Administrator **must**:

- for a direction made on a **request**:
  - determine the authorised psychiatrist to make the report and provide the authorised psychiatrist with a copy of the direction,
  - make arrangements for the person to be examined by the authorised psychiatrist as soon as practicable.
- for a direction made on the **Chief Psychiatrist's own initiative** that does not specify an authorised psychiatrist:
  - determine the authorised psychiatrist to make the report and provide the authorised psychiatrist with a copy of the direction,
  - ensure an appointment is made for the person to be examined by the authorised psychiatrist **within twenty-eight (28) days** of the direction.

  Note: If the direction is on the Chief Psychiatrist's own initiative and the person is not an inpatient, the person **must** attend the appointment as arranged. Failure to attend the appointment may result in the person being transported to the authorised mental health service (see Section 3.5.2 Direction made on the Chief Psychiatrist's own initiative). The potential consequences of non-attendance are stated in the direction.

In all circumstances, the administrator **must** determine the clinician responsible for informing the person of the direction and provide the nominated clinician with:

- a copy of the direction to give to the person, and
- the details of the psychiatrist appointment to be provided with the direction.

3.2.2 Clinician responsibilities

The nominated clinician is responsible for providing and explaining the Chief Psychiatrist's direction to the person and their support persons.

The information is to be provided as soon as practicable and **must** be provided within **fourteen (14) days** of the Chief Psychiatrist's direction. Earlier communication may be required depending on the date of appointment with the authorised psychiatrist.

The person is to be provided with a copy of the direction and details of their appointment with the authorised psychiatrist.

The extent of explanation required will depend on the circumstances.

For example: Minimal explanation will be required if the person made the request or is aware that the request was made on their behalf. A more comprehensive explanation will be required if the person is unaware of a request on their behalf or if the direction is on the Chief Psychiatrist's own initiative.

In all circumstances, the clinician should explain the potential consequences of the person not participating in the psychiatrist's examination or not attending the appointment as arranged; in particular:

- for a direction made on a request, the administrator may revoke the Chief Psychiatrist's direction, or
- for a direction made on the Chief Psychiatrist's own initiative, the administrator may make arrangements for the person to be taken to the AMHS (by health practitioners or police) for the psychiatrist's examination (see section 3.5.2 Direction made on the Chief Psychiatrist's own initiative).

In all circumstances, the clinician should advise the person of their entitlement to have a support person present at the appointment with the authorised psychiatrist.

3.3 Requirements for preparing psychiatrist report

Key points

- Psychiatrist reports must be prepared in accordance with the *Chief Psychiatrist Guidelines for preparing psychiatrist reports*.
- The template for psychiatrist reports is available in CIMHA clinical notes.
- The administrator is to provide the authorised psychiatrist with information received from the prosecuting authority as soon as possible.
  - If the authorised psychiatrist is based at another AMHS, the administrator is also required to facilitate access to relevant clinical information e.g. hard copy records.

The Office of the Chief Psychiatrist will review all psychiatrist reports received to ensure the report meets the requirements set out in this policy and the Guidelines for preparing psychiatrist reports.

- Further information may be requested from the authorised psychiatrist if the requirements are not met.
- The time frame for receipt of psychiatrist reports will be the date the Chief Psychiatrist determines the report is finalised.

3.4 Timeframe for psychiatrist reports

Key points

- The psychiatrist report **must** be provided within **sixty (60) days** of the Chief Psychiatrist's direction. The due date is specified in the Chief Psychiatrist's direction.
- If the psychiatrist report cannot be provided within the **sixty (60) day** time frame, a request to the Chief Psychiatrist to extend the time frame by **thirty (30) days** must be made:
  - for a direction on the Chief Psychiatrist's own initiative that specifies the authorised psychiatrist – by the authorised psychiatrist specified, or
  - in any other circumstance – by the administrator of the AMHS.
- A request for extension may be made via the *Request to extend timeframe for psychiatrist report* and must be made as close to and no less than **seven (7) days** prior to the expiry of the **sixty (60) day** time frame.
- Only **one (1)** extension may be given.
- The administrator **must** ensure that any extension to the time frame, and the reasons for the extension, are explained to the person and their support persons.

If the administrator has determined the authorised psychiatrist to prepare the report, the administrator is responsible for ensuring the timeliness of the psychiatrist report.

3.5 Person not participating in psychiatrist examination or non-attendance at appointment

The administrator is responsible for ensuring reasonable efforts to engage the person (and where relevant, their support person) in the process.

Consideration should be given to the extent to which the person's non-attendance or non-participation is impacted by their mental illness. In this circumstance, all reasonable efforts **must** be made to facilitate attendance and engagement prior to instituting the actions set out below.

Actions that may be taken will depend on whether the Chief Psychiatrist's direction was made on a request for a psychiatrist report or on the Chief Psychiatrist's own initiative.

3.5.1 Direction made on request for psychiatrist report

Key points

- The authorised psychiatrist is responsible for advising the administrator of non-attendance or non-participation in the interview process, via a *Notice to administrator - Person Not Participating in Good Faith*.
- If satisfied that all reasonable efforts have been made to engage the person, the administrator **must** inform the person in writing of their intention to revoke the Chief Psychiatrist's direction. A template letter is available for this purpose.
- Consideration should be given to whether the letter needs to be provided and explained by a clinician.
- The person **must** be given a reasonable opportunity to respond to the administrator's letter. If the person indicates intention or willingness to attend and participate, they are to be given further opportunity to do so.

If the person does not respond to the administrator's letter or further attempts to examine the person are unsuccessful, the administrator may advise the person in writing that the Chief Psychiatrist's direction for a report is revoked. A template is available in CIMHA for this purpose.

- Consideration should be given to whether the letter needs to be provided and explained to the person by a clinician.

The administrator **must** also provide a copy of the letter to the Chief Psychiatrist and the person who made the request.

3.5.2 Direction made on the Chief Psychiatrist's own initiative

The Administrator of the AMHS is responsible for ensuring the person is provided with a copy of the direction and given notice of the requirement to attend the arranged psychiatrist appointment. The appointment must be **within 28 days** of giving the direction to the person.

Key points

- If notice has been provided and the person fails to attend the appointment and the administrator is satisfied that all reasonable efforts have been made to encourage/facilitate attendance, the administrator may require the person to be taken to the AMHS to be examined by the authorised psychiatrist (see *Chief Psychiatrist Policy Managing Involuntary Patient Absences*).
  - **Note:** If the person is taken to the AMHS, there is no authority to detain the person. Detention should only occur on the basis of clinical need.
  - The administrator's authorisation to require the person to be taken to the AMHS does not apply to a person in prison/custody.

3.6 Transfer of responsibility for report

If the Chief Psychiatrist has directed that a specific authorised psychiatrist provide a report, and the AMHS providing treatment and care changes, or the authorised psychiatrist is no longer able to complete the report, the Office of the Chief Psychiatrist should be advised without delay.

In any other circumstance, transfer of responsibility for the preparation of the psychiatrist report is to be by agreement between the relevant AMHS administrators.

- The Office of the Chief Psychiatrist should be advised of the transfer of responsibility.

In the event that responsibility for the preparation of the report cannot be resolved between the relevant administrators, the matter is to be escalated to the Chief Psychiatrist.

4 Actions after psychiatrist report is made to the Chief Psychiatrist

4.1 Chief Psychiatrist direction for a second report

In certain circumstances, if the Chief Psychiatrist believes that the matters in the first psychiatrist report require further examination, the Chief Psychiatrist may:

- Direct the Administrator of the person's treating health service to arrange for an authorised psychiatrist to prepare another psychiatrist report on the matters (the second report), or
- Direct an authorised psychiatrist to prepare the second psychiatrist report on the matters, including someone from outside the treating health service if considered more appropriate.

The direction **must** be given within **seven (7) days** of the Chief Psychiatrist receiving the first report.

The Chief Psychiatrist will consult with the relevant administrator prior to issuing a direction for a second psychiatrist report.

The requirements for the first psychiatrist report apply in the same way for a direction for a second psychiatrist report, including the relevant statutory timeframes, including:

- preparation of the second report is required within **sixty (60) days** from the date that the direction for the second report is made
- a request for extension for the second report is made by a *Request to extend timeframe for psychiatrist report* and must be made no less than **seven (7) days** prior to the expiry of the **sixty (60) day** time frame. Only **one (1)** extension may be given.

4.2 Distribution of psychiatrist report

Key points

- The Chief Psychiatrist will provide a copy of the report(s) to the person subject to the report, unless the Chief Psychiatrist considers this may adversely affect the person's health and wellbeing.
  - If a second report is directed, both reports are to be distributed at the same time.
- In this instance, the report may instead be provided to another person who has sufficient interest in the person's health and wellbeing.
- The psychiatrist's report is to provide advice on these matters to assist the Chief Psychiatrist's decision.
- If the report was prepared due to a request, the Chief Psychiatrist will also provide the report to the person who made the request.
- The administrator will be informed of the individuals who have been provided with a copy of the psychiatrist report.

The psychiatrist report is available to clinicians in CIMHA clinical notes. The report **must** not be given to any person without appropriate authority:

- If the Chief Psychiatrist has already provided a copy of the report to a person (i.e. the subject of the report or another person on their behalf, or the person who requested the report) and the person requests a copy at a later time, the clinician may provide the person with a copy of the report.
- If the person who is the subject of the report has capacity to make the decision and consents to the report being provided to another person, the clinician may provide the report to the other person.
- If a personal guardian or attorney with the required decision-making authority consents to the report being given to another person, the clinician may provide the report to the other person.
- In all other circumstances, the clinician should contact the Office of the Chief Psychiatrist to discuss provision of a report.

The clinician **must** record actions taken in a CIMHA clinical note identifying the authority relied upon.

4.3 Chief Psychiatrist decision about reference to Mental Health Court

The psychiatrist's report may be used by the person or their lawyer to make a reference to the Mental Health Court.

The Chief Psychiatrist will consider whether the matter should be referred, regardless of whether the report was obtained on request or on the Chief Psychiatrist's own initiative.

Key points

- The Chief Psychiatrist can only make a reference to the Mental Health Court if satisfied:
  - the person may have been of unsound mind at the time of the offence or the person may be unfit for trial, and
  - having regard to the report and the protection of the community, there is a compelling reason in the public interest to refer the matter. (see Section 2.1 Chief Psychiatrist's consideration of public interest issues).
- If the report is prepared on request, the Chief Psychiatrist **must** make the reference **within twenty-eight (28) days** of providing a copy of the report to person who made the request.
- The Chief Psychiatrist will not make a decision about the reference **until fourteen (14) days after** giving the report to the person who made the request. This will allow the person or their representative to determine whether they wish to refer the matter.
- If a report is prepared on direction of the Chief Psychiatrist, at their own initiative, and the Chief Psychiatrist is satisfied that a reference to the Mental Health Court should be made, the Chief Psychiatrist **must** refer the matter **within twenty-eight (28) days** of receiving the report.

If the person is unfit for trial but may become fit for trial, the Chief Psychiatrist may defer making a decision for a period of up to **four (4) months**. In this instance a further psychiatrist report to address fitness for trial will be requested within that period.

The administrator will be advised if the Chief Psychiatrist makes a reference to the Mental Health Court or defers the decision.

The administrator **must** ensure the information is provided to relevant clinicians (e.g. treating psychiatrist and case manager) and communicated to the person and their support person/s.

This communication is of particular importance if the Chief Psychiatrist defers the decision.

The clinician providing the information is to record the information provided in a CIMHA clinical note.

4.4 Impact on suspension of proceedings

If the matter is referred to the Mental Health Court (by the Chief Psychiatrist or someone else), the criminal court proceedings will continue to be suspended until the Mental Health Court determines the matter.

If no reference is made to the Mental Health Court, proceedings will usually be recommenced **within twenty-eight (28) days** of the Chief Psychiatrist receiving the psychiatrist report or providing a copy of the report to person and relevant others.

- The Chief Psychiatrist provides notice to the Chief Executive for Justice in this instance.

However, if the person is a classified patient, the proceedings will continue to be suspended while the person is a classified patient (see *Chief Psychiatrist Policy Classified Patients*).

The proceedings will also continue to be suspended in circumstances where the Chief Psychiatrist has deferred a decision regarding reference to the Mental Health Court because the person is unfit for trial or in circumstances where a second psychiatrist report is requested.

5 Chief Psychiatrist may revoke direction

The Chief Psychiatrist may revoke a direction to prepare a psychiatrist report, if satisfied that it is appropriate to do so.

For example:

- if a request for psychiatrist report has been made, the Chief Psychiatrist may revoke the direction for a report, where the person who requested the report withdraws their request
- if the direction for the report was given on the Chief Psychiatrist's own initiative, the Chief Psychiatrist may revoke the direction if for example, the Chief Psychiatrist considers it is no longer in the public interest.

6 Update reports

Update reports are required by the Chief Psychiatrist for the Mental Health Court in relation to consumers with matters before the court. These are typically due **one (1) week** prior to the court hearing and are an update on current circumstances, mental state and treatment as well as fitness for trial and recommendations in relation to future management.

For information on Fitness for Trial and Future Management in psychiatrist reports see sections 5.4 and 5.5 of the *Chief Psychiatist Guidelines for preparing psychiatrist reports* .

Further information

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
Associated Offence	An offence that occurred around the same time as the serious offence.
CIMHA	Consumer Integrated Mental Health and Addiction (CIMHA) application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Clinician	Court Liaison Service clinician, case manager or treating doctor.
HHS	Hospital and Health Service
Nominated support person	A family member, carer or other support person **formally appointed** by a patient to be their nominated support person. NSP rights include: • **must** be given all notices about the patient that are required under the Act • may discuss confidential information about the patient's treatment and care • may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and • may request a psychiatrist report if the person is charged with a serious offence.
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.
Relevant AMHS administrator	The relevant AMHS administrator is: • the administrator of the AMHS currently providing clinical services to the person, or • if the person is not currently receiving mental health services (i.e. no open service episode), the administrator of the AMHS for the location where the person resides.
Serious Offence	An indictable offence other than an indictable offence that **must** be heard by a magistrate.
Support person/s	Includes, an appointed nominated support person or, if the person does not have a nominated support person, a family member, carer or other support person.

Referenced policies and resources

Chief Psychiatrist policies and guidelines

- Chief Psychiatrist Policy – Classified patients
- Chief Psychiatrist Policy – Involuntary patient absence
- Chief Psychiatrist Policy – Independent Patient Rights Advisers
- Chief Psychiatrist Guidelines for preparing psychiatrist reports

Mental Health Act 2016 forms and other resources

- Form – Request for psychiatrist report
- Form – Advice to Chief Psychiatrist - Public interest consideration
- Form – Request to extend timeframe for psychiatrist report
- Form – Notice to administrator - Person not participating in good faith
- Flowchart 1 – Psychiatrist reports: Overview
- Flowchart 2(a) – Psychiatrist reports: Report on request
- Flowchart 2(b) – Psychiatrist reports: Direction for report (Report on request)
- Flowchart 3 – Psychiatrist reports: Direction for report (Chief Psychiatrist Initiative)
- Flowchart 4 – Psychiatrist reports: Determining referral to Mental Health Court
- Guide to patient rights under the Mental Health Act 2016

Legislation

- The Hospital and Health Boards Act 2011
- Public Guardian Act 2014
- Guardian and Administration Act 2000
- Powers of Attorney Act 1998

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Mental Health Act 2016

Chief Psychiatrist Guidelines

Guidelines for preparing psychiatrist reports (Chapter 4 reports)

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1 Purpose

The purpose of these guidelines is to provide authorised psychiatrists with information to assist in the preparation of psychiatrist reports. These reports are required to be prepared about a person in relation to a charge of a serious offence, under a direction of the Chief Psychiatrist as per sections 91 and 93 (Chapter 4) of the *Mental Health Act 2016* (the Act).

These guidelines also apply to a direction by the Chief Psychiatrist, under section 100 of the Act, to prepare a second psychiatrist report about the person.

These guidelines support the *Chief Psychiatrist Policy Psychiatrist reports for persons charged with a serious offence*.

2 Background

2.1 Queensland Criminal Code

The *Criminal Code Act 1899* (Criminal Code) allows for consideration of the criminal responsibility of a defendant with a mental condition through the legal construct of 'insanity'.[1] In relation to the charge of murder, the Criminal Code also provides for the charge to be downgraded to manslaughter through the concept of diminished responsibility[2] (see Appendix 1 – Relevant legislation).

2.2 Mental Health Act 2016

The provisions in Chapter 4 of the *Mental Health Act 2016* allow the Chief Psychiatrist to direct a psychiatrist report about a person charged with a serious offence[3] either:

- on request of the person or other specified persons, or
- on the Chief Psychiatrist's own initiative.

The provisions apply to a person charged with a serious offence who, at the time of the alleged offence or any time after the alleged offence, is subject to a Treatment Authority, Forensic Order or Treatment Support Order. The psychiatrist report should address the serious offence or offences and any associated offences, which will be listed in the *Chief Psychiatrist Direction for Psychiatrist Report*.

Offences against a law of the Commonwealth are excluded from these provisions.

[1] Sections 27 and 28 Queensland Criminal Code.

[2] Section 304A Queensland Criminal Code

[3] As defined in the schedule to the *Mental Health Act 2016*, serious offences are indictable offences other than those that, under the Criminal Code, must generally be heard and decided summarily.

2.2.1 Second psychiatrist reports

Section 100 of the Act also provides that if the Chief Psychiatrist believes that the matters in a psychiatrist report require further examination, the Chief Psychiatrist may:

- direct the Administrator of the person's treating health service to arrange for an authorised psychiatrist to prepare a second psychiatrist report (second report) on the matters, or
- direct an authorised psychiatrist to prepare the second report, including someone from outside the treating health service if considered more appropriate.

2.2.2 Timeframes for preparation of a psychiatrist report

Psychiatrist reports must be prepared within sixty (60) days of the Chief Psychiatrist's direction. The Chief Psychiatrist may extend this by granting an extension of up to thirty (30) days. This extension may be granted upon receipt of a request and explanation from the reporting psychiatrist. The request must be received as close to and no less than seven (7) days prior to the report due date. Only one extension may be given.

3 Purpose of a psychiatrist report

A psychiatrist report provides a medico-legal assessment of a person's mental state at the time of alleged offending, and in relation to fitness for trial. These reports are used to inform a Court's decision regarding the person's criminal responsibility in relation to the crime that they have allegedly committed, or current fitness for trial. The report may have significant implications for how a person's criminal charges are dealt with and the future care and treatment of the person.

Key points

These reports may be used to:

- assist the person or their legal representative to decide how to proceed with their matter and to assist any further proceedings,
- assist the Chief Psychiatrist to determine whether or not the matter of the person's mental state relating to an offence should be referred to the Mental Health Court (MHC) in the public interest, and
- assist the MHC in making a determination about whether or not the person was of unsound mind at the time of the offence (i.e. not criminally responsible) and whether the person is unfit for trial, and if so, whether the unfitness for trial is of a permanent nature.

4 Examination for the purpose of the report

Section 95 of the Act provides that the psychiatrist must prepare a report based on their own examination of the person and must consider the person's health records, the brief of evidence and any other relevant information.

Examinations may occur at any location the doctor considers is clinically appropriate, including in an authorised mental health service, a public sector health service facility, a person's home or by audio-visual link.

The psychiatrist report must contain details of the results of the examination of the person and the psychiatrist's associated medico-legal conclusions.

5 Content of psychiatrist reports

Key points

The key terms to be addressed in the psychiatrist's analysis are:

- **Substantial dispute** about whether the person committed the offence
- **Unsoundness of mind** (deprivation of one or more of the relevant capacities)
- **Diminished responsibility** (only in cases where the person is accused of murder)
- **Fitness for trial**

The standard of proof that the psychiatrist should base their conclusions on is **'the balance of probabilities'**. This means that something is more likely, or more probable, than not.

- The psychiatrist is not required to be satisfied 'beyond a reasonable doubt'.
- The psychiatrist should clearly explain the rationale and facts upon which their opinion is based.

The report must only be in relation to the charges listed in the Chief Psychiatrist's direction. This includes the serious offences and any associated offences[4] that the Chief Psychiatrist requests to be addressed.

[4] An associated offence is an offence that the person is alleged to have committed at or about the same time as the serious offence.

Section 95(5) of the Act outlines what must be included in the report:

(1) The person's mental state and, to the extent practicable, the person's mental state when the serious offence was allegedly committed

(2) Whether the psychiatrist considers the person was of unsound mind when each of the offences listed in the direction was allegedly committed

(3) Whether the psychiatrist considers the person is fit for trial

(4) If the psychiatrist considers the person is unfit for trial – whether the psychiatrist considers the unfitness is permanent.

5.1 Substantial dispute

The Mental Health Court must not make a decision in relation to unsoundness of mind or diminished responsibility if it is satisfied that there is a substantial dispute about whether the person committed the offence as particularised in the brief of evidence, unless the dispute exists only because of the person's mental condition.

Legal test and application

When addressing whether there is a substantial dispute a two-part test **must** be applied:

1. Is there a substantial dispute about whether the person committed the offence?
2. Does this dispute exist only as a result of the person's mental condition?

The person being unable to recall the offence does not constitute a dispute.

The psychiatrist should report the person's account of events. If the person's account is substantially different to the brief of evidence, the psychiatrist must address whether the dispute exists only because of the person's mental condition.

If the dispute does exist only because of the person's mental condition, then the Court may proceed to make a finding in relation to unsoundness of mind or diminished responsibility.

5.2 Unsoundness of mind

Unsoundness of mind is defined at section 109 of the Act by reference to section 27 and 28 of the Criminal Code (see Appendix 1 – Relevant Legislation).

Legal test and application

The legal test that **must** be applied for a finding of unsoundness of mind is:

- Whether **at the time of the alleged offence** the person was in such a **state of mental disease or natural mental infirmity** as to deprive them of:
  - The capacity to understand what they were doing, or
  - The capacity to control their actions, or
  - The capacity to know that they ought not do the act or make the omission.[5]

Unsoundness of mind does not include a state of mind resulting, to any extent, from intentional intoxication or stupefaction alone or in combination with some other agent at or about the time of the alleged offence (see 5.2.3).[6]

Key points

- The psychiatrist **must** express an opinion as to whether the person was of unsound mind according to the legal test stated above.
- The test must be applied as at the time of the offence.
- 'Mental disease' has the same meaning as mental illness.[7] 'Natural mental infirmity' includes an intellectual impairment.[8] (See 5.2.1.)
- 'Deprivation' of capacity refers to a complete or total loss of capacity. 'Impairment' refers to merely a partial loss. There cannot be a partial deprivation.
- The functional link between the person's mental illness or natural infirmity (or a combination of both) and the identified deprivation of capacity must be detailed in the report.
- The issue of intoxication will need to be addressed (see 5.2.3).
- Each capacity should be addressed separately within the report.
- Each of the alleged offences must be considered, and different conclusions may be reached in relation to different offences.

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[5] Section 27 Criminal Code.

[6] Section 109(2) Mental Health Act 2016.

7 *R v Radford* (1985) SASR 266; *R v Falconer* [1990] HCA 49; (1990) 171 CLR 30.

[8] See R v Falconer (1990) 171 CLR 30 and the Queensland Supreme and District Court Bench book No. 82.1 - Insanity, March 2017.

5.2.1 Mental disease or natural mental infirmity

These are legal concepts, not medical concepts, and are not strictly defined.

Generally speaking, a mental disease refers to a mental illness, be it permanent or temporary, that is:

- caused from an internal defect or vulnerability,
- not merely an exaggeration of human emotion,
- not the reaction of a healthy mind to extraordinary external stimulus, and
- prone to recurrence.[9]

A natural mental infirmity refers to a defect in intelligence or of the higher intellectual processes such as abstract thinking or problem solving. It may be caused by an external insult to the brain or an internal defect or vulnerability. It is usually stable and permanent. An intellectual impairment is a natural mental infirmity.[10]

5.2.2 The three capacities

The fact that a person has a mental disease or natural mental infirmity alone does not necessarily result in a finding of unsoundness of mind. The Mental Health Court will only make a finding of unsound mind if it concludes that a person's mental disease or natural mental infirmity deprived them of one or more of the relevant capacities at the time of the alleged offence[11].

The opinions given by psychiatrists on a person's capacities at the time of an alleged offence are critical to the Court's decision-making process.

[9] Ibid

[10] Ibid.

[11] See *Re W* (1997) QMHT 170 per Dowsett J for further explanation of the capacities.

Key points

The three capacities are:

1) the person's capacity to understand what they were doing in relation to the offence, i.e. –

   a) the capacity to appreciate the nature and quality of the act they were doing at the time of committing the offence or to understand the physical nature of the act (not its moral or legal consequences)

2) the person's capacity to control their actions in relation to the offence:

   a) it may be relevant to consider whether or not a person has the capacity to exercise willpower to control their actions.[12]

3) the person's capacity to know that they ought not do the act or make the omission constituting the offence, i.e. –

   a) The capacity to know the difference between right and wrong in relation to the action according to the ordinary standard of reasonable people.

   b) Awareness that the act is wrong according to law is relevant, but it is not decisive.

   c) Consideration must be given to whether the person was able to appreciate the rightness or wrongness of the particular act they were doing at the particular time, and were able to think rationally of the reasons which to ordinary people make that act right or wrong and reason about the matter with a moderate degree of sense and composure.

5.2.3 The role of intoxication

The question of the effect of an intoxicant on the patient's mental state is clinically and legally complex.

The definition of unsound mind in the Act does not include 'a state of mind resulting, to any extent, from intentional intoxication or stupefaction alone or in combination with some other agent at or about the time of the alleged offence'.[13]

[12] See *R v Byrne* [1960] 2 QB 396 at 403.

[13] Section 109(2) Mental Health Act 2016

Legal test and application

The Courts have held that the following test must be applied when addressing the issue of intoxication:

- A person who was deprived of one of the relevant capacities at the time of an alleged offence will not be found to be of unsound mind if intoxication **contributed to any extent** to that deprivation of capacity.

Application of the test:

The psychiatrist should use the following steps to address the test:

- whether the person was **deprived of one of the relevant capacities at the time** of the offending,
- if so, is there **evidence** that the person **used alcohol or any other intoxicating substance around the time of the alleged offence**,
- If there is evidence of use, whether in the psychiatrist's opinion, on the available evidence, the person was **intoxicated at the time of the alleged offence**?
  - When applying s109(2) of the Act, it is essential to distinguish the specific question of whether the person was **intoxicated at the time of the alleged offence, from the question of their more general substance use**.
- if the psychiatrist considers the person was intoxicated, whether the intoxication **contributed to the deprivation of capacity to any extent**.[14]

When assessing intoxication, the psychiatrist should consider what evidence there is of intoxication having regard to the brief of evidence and the patient's account.

- Reference to self-account, witness statements and laboratory investigations all assist with an objective comment in this area.

The psychiatrist should provide reasoned argument to support their opinion. Where intoxication is a relevant consideration in determining whether a person was of unsound mind, it is not relevant whether the person's mental illness was capable of depriving them of a capacity despite the intoxication or in the absence of intoxication. If the intoxication contributed to any extent to the deprivation of a capacity the person cannot be found of unsound mind.

However, it is open to the psychiatrist to conclude that a person who was deprived of a capacity was intoxicated but their intoxication did not contribute to the deprivation. In those circumstances, the person may still be found unsound of mind.

[14] Re Clough [2007] QMHC 002; Re Smith [2015] QMHC 8; SCN v Director of Public Prosecutions (Qld) & Anor [2016] QCA 237

5.3 Diminished responsibility

Diminished responsibility only relates to a charge of murder and is defined at section 108 of the Act in reference to section 304A of the Criminal Code (see Appendix 1 – Relevant Legislation).[15]

Legal test and application

What is required to be considered is whether, at the **relevant time**:

- the person was suffering from an **abnormality of mind**, and
- that such abnormality of mind:
  - arose from something **endogenous or inherent** in the person (whether illness, injury or another inherent cause such as a condition of arrested or retarded development of mind), and
  - was such as to have **substantially impaired** the person's capacity to understand what they were doing, or their capacity to control their actions, or their capacity to know that they ought not do the act or make the omission at the time of the alleged offence of murder.

Key points

The requirements for an **'abnormality of mind'** under section 304A of the Criminal Code are different to what is required for **'mental disease or natural mental infirmity'** under section 27.

- **Abnormality of mind** refers to **state of mind so different from that of ordinary human beings that the reasonable person would term it abnormal**.
- **Substantially impaired** does not mean a complete or total loss of the capacities, but **it must be more than a trivial or minimal impairment.** The abnormality of mind must be a real cause of the person's conduct because it substantially impaired a relevant capacity. It does not have to be the sole cause of the conduct, but it must be more than a merely trivial one which made no real or appreciable difference to the relevant capacity.[16].
- The causal relationship between the underlying pathology said to amount to a **mental abnormality** and the **substantial impairment of capacity** must be clearly identified.

[15] Section 304A Queensland Criminal Code.

[16] See R v Lloyd [1967] 1 QB 175, Regina v Biess [1967] Qd R 470, R v Smith (aka Stella) [2021] QCA 139

In all cases where the person is charged with murder, the psychiatrist must address both the issue of unsoundness of mind and the issue of diminished responsibility, even if the psychiatrist's opinion is that the person was of unsound mind.

5.3.1 Intoxication in relation to diminished responsibility

The courts have determined that when addressing the matter of diminished responsibility in circumstances where the person was intoxicated at the time of the killing, the effect of drugs or alcohol (intoxicants), should be disregarded and the question that should be addressed is:

- Whether, even though the person was intoxicated, the abnormality of mind (mental illness or intellectual impairment) did in fact substantially impair their capacity or capacities.[18]

5.4 Fitness for trial

The definition and test of 'fit for trial' is not defined within the Act and accordingly, common law principles apply.[17] In Australia, this was established in the case *R v Presser* [1958] VR 45.

Legal test and application

The principles established in *R v Presser*, known as the **Presser Criteria**, were later articulated as follows:

- The minimum standards that a person must meet to satisfy the requirements of fitness for trial, require the person's ability to:
  - **understand the nature of the charge**
  - **plead to the charge** and to **exercise the right of challenge**
  - **understand the nature of the proceedings**, namely, that it is an inquiry as to whether the accused committed the offence charged
  - **follow the course of the proceedings**
  - **understand the substantial effect of any evidence that may be given in support of the prosecution**, and
  - **make a defence or answer the charge.**

[18] R v Dietschmann [2003] 1 AC 1209; Re Greenfield [2017] QMHC 4

[17] R v Pritchard (1836) 173 ER 135.

Key points

- The psychiatrist's report should address factors that would affect the question of whether the patient, for any reason whatsoever, is unable to comprehend the course of proceedings of the trial so as to make a proper defence.
- Each of the Presser Criteria must be considered as part of the test of fitness for trial and must be individually addressed.
- The psychiatrist must determine and indicate in their report whether or not in their opinion the person is fit for trial and, if unfit for trial, whether or not it is temporary or permanent in nature.

The application of the Presser Criteria involves a consideration of the person's ability:

- to understand the nature of the charges and to enter, and understand the nature of, a plea,
- to understand the general nature of court proceedings (that it is an inquiry as to whether they did what they are charged with),
- to follow the course of proceedings in a general sense, but they need not understand all the formalities,
- to understand their right to challenge a prospective juror and capacity to do so,
- to understand and make sense of the substantial effect of any evidence given against them and appreciate whether there are any facts which contradict or explain the evidence against them
- ability to decide what defence to offer, and
- ability to explain their version of the facts to counsel and legal representatives and, if necessary, to the court.

Special considerations – The psychiatrist should also address whether any special considerations could be provided by the court, which would assist a person to meet the Presser Criteria and be fit for trial.

This may include, for example:

- The person being granted frequent breaks,
- The presence or assistance of support persons

5.4.1 Temporarily unfit for trial

Key points

- The Chief Psychiatrist may defer the referral of a matter to the MHC for a period of up to **four (4) months**, if the Chief Psychiatrist considers the patient is unfit for trial, but is likely to be fit for trial within the extended **four (4) month** period.
- This may occur, for example, when a period of time to optimise medication would likely result in a person becoming fit for trial.

The Chief Psychiatrist's decision as to whether or not a person is temporarily unfit for trial is informed by the psychiatrist report.

Where a psychiatrist finds a person is temporarily unfit for trial, it is important to clearly state the likely duration of the person's unfitness.

5.4.2 Permanently unfit for trial

When determining whether to refer a matter to the MHC, the Chief Psychiatrist must consider whether a person is permanently unfit for trial. This is informed by the psychiatrist report.

If the psychiatrist making the report considers the patient is unfit for trial, the psychiatrist should then provide an opinion as to whether the unfitness is of a permanent nature. The basis for the permanence of the unfitness for trial should be clearly explained in the report.

5.5 Future management

5.5.1 Future management plan

The psychiatrist should provide an overview of the proposed shorter and longer-term plans for the patient's future management, addressing both psychosocial needs and biological management of the person's illness.

5.6 Recommendations

5.6.1 Should the matter be referred to the Mental Health Court?

On receipt of the report, the Chief Psychiatrist may make a reference to the MHC if:

- satisfied that the person may have been of unsound mind or may be unfit for trial; and
- having regard to the report and the protection of the community, there is compelling reason in the public interest to refer the matter to the MHC.

The psychiatrist is required to provide advice in the report to enable the Chief Psychiatrist to decide whether to make a public interest referral. This must include consideration of both individual and community interests when evaluating and reporting on this.

A psychiatrist's opinion alone that a person was of unsound mind is not a compelling reason in the public interest to refer the matter to the Mental Health Court.

5.6.2 The question of public interest

Chief Psychiatrist decisions take account of the policy intent for individuals to, as far as possible, make their own decisions about how legal matters are dealt with. This includes acknowledging the rights of individuals to decide not to request for their matter to be referred to the Mental Health Court. However, the matter may still be referred by the Chief Psychiatrist if it is in the public interest.

The Chief Psychiatrist will not make a reference to the Mental Health Court solely on the basis that a person may have been of unsound mind at the time of an alleged offence. A reference will only be made if the Chief Psychiatrist is satisfied that the person may have been of unsound mind at the time the offence(s) were committed or may be unfit for trial; and, having regard to the report and the protection of the community, there is a compelling reason in the public interest for the person's mental state in relation to the serious offence(s) to be referred to the Mental Health Court.

Key points

When considering and addressing questions of public interest, the psychiatrist should consider and address both **individual** and **community interests**, including for example, the following:

- **Individual interests:**
  - The person's mental condition and whether this condition significantly impacts their capacity to represent their own interests in relation to the charge(s).
  - Additional supports that may be available, such as guardians, attorneys and legal representatives, who may protect the person's interests.
  - The person's treatment and care requirements.
- **Community Interests:**
  - Reducing the risk of reoffending (where offending behaviour is consequent to the person's mental illness).
  - The seriousness of the offending.
  - All members of the community are entitled to a fair legal process.

Having regard to all relevant factors, the psychiatrist should advise whether they believe it is in the public interest for the matter to proceed through the Mental Health Court.

Psychiatrists should also be aware that there are alternate mechanisms for the charges to be dealt with, including referral to the Mental Health Court by the person's legal representative or dismissal of the charges via the Magistrates Court in certain circumstances.

Further information regarding public interest can be found in the *Chief Psychiatrist Policy Psychiatrist reports for persons charged with a serious offence*.

5.6.3 Should the Mental Health Court make a Forensic Order or Treatment Support Order or no order?

The psychiatrist should give consideration to, and provide an opinion on, whether the MHC should make a forensic order or a treatment support order or no order, if the MHC finds that the person was of unsound mind at the time of the alleged offence or is unfit for trial.

This will ultimately involve a consideration of whether a Forensic Order, or alternatively a Treatment Support Order, is necessary, because of the person's mental condition and to protect the safety of the community, including from the risk of serious harm to other persons or property.[18]

Note, however, that the MHC must make either a Forensic Order or a Treatment Support Order if it finds that a person is temporarily unfit for trial.[19]

Key points

When providing comment on the making of a forensic order or treatment support order, the psychiatrist should consider the key differences in these types of orders (See Appendix 2 – Treatment Support Order vs Forensic Order).

In particular the intention that a forensic order operates in a way that is **more restrictive** of a persons' rights and liberties than a treatment support order.

- Key points to consider and comment on include:
  - The person's **level of insight and engagement** in treatment
  - the **nature of offences**
  - **Adherence** to any current treatment (for example, if currently under a treatment authority, is there a history of absence without approval)
  - **Risk assessment** - Can the risk management needs be met under a treatment support order rather than a forensic order?

[18] Section 134 and 143 Mental Health Act 2016.

[19] Section 132 Mental Health Act 2016.

5.6.4 Provision of the report to the person subject to the report

The Chief Psychiatrist must provide a copy of the report to the person subject to the report, unless satisfied that this may adversely affect the persons health and wellbeing.

The psychiatrist should address this matter, including how and why, providing the person a copy of the report will adversely affect their health and wellbeing. Clear reasons should be provided to assist the Chief Psychiatrist in determining whether the report should or should not be provided to the person.

If the Chief Psychiatrist determines that the report should not be provided to the person, a copy of the report may be provided to another person who has sufficient interest in the person's health and wellbeing.

Further information

Copies of cases cited in this document can be obtained from:

Mental Health Act Liaison Service
Office of the Chief Psychiatrist
Phone: 07 3328 9899
Email: MHA2016@health.qld.gov.au

Referenced policies and resources

Chief Psychiatrist policies and associated resources

- Chief Psychiatrist Policy – Psychiatrist reports for persons charged with a serious offence
- Chief Psychiatrist Policy – Forensic Orders and Treatment Support Orders: Category, Conditions and Limited Community Treatment
- Flowchart 1: Overview
- Flowcharts 2(a)–(b): Report on request and direction for report
- Flowchart 3: Direction for report (Chief Psychiatrist initiative)
- Flowchart 4: Determining referral to Mental Health Court

Legislation

- *Criminal Code Act 1899*
- *Mental Health Act 2016*

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Appendix 1 – Relevant legislation

Section 27 of the Criminal Code provides:

1) A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission the person is in such a state of mental disease or natural mental infirmity as to deprive the person of capacity to understand what the person is doing, or of capacity to control the person's actions, or of capacity to know that the person ought not do the act or make the omission.

2) A person whose mind, at the time of the person's doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of the foregoing provisions of this section, is criminally responsible for the act or omission to the same extent as if the real state of things had been such as the person was induced by the delusions to believe to exist.

Section 28 of the Criminal Code provides:

1) The provisions of section 27 apply to the case of a person whose mind is disordered by intoxication or stupefaction caused without intention on his or her part by drugs or intoxicating liquor or by any other means.

2) They do not apply to the case of a person who has, to any extent intentionally caused himself or herself to become intoxicated or stupefied, whether in order to afford excuse for the commission of an offence or not and whether his or her mind is disordered by the intoxication alone or in combination with some other agent.

3) When an intention to cause a specific result is an element of an offence, intoxication, whether complete or partial, and whether intentional or unintentional, may be regarded for the purpose of ascertaining whether such an intention in fact existed.

Section 304A of the Criminal Code provides:

1) When a person who unlawfully kills another under circumstances which, but for the provisions of this section, would constitute murder, is at the time of doing the act or making the omission which causes death in such a state of abnormality of mind (whether arising from a condition of arrested or retarded development of mind or inherent causes or induced by disease or injury) as substantially to impair the person's capacity to understand what he is doing, or the person's capacity to control the person's actions, or the person's capacity to know that the person ought not do the act or make the omission, the person is guilty of manslaughter only.

2) On a charge of murder, it shall be for the defence to prove that the person charged is by virtue of this section liable to be convicted of manslaughter only.

3) When two or more persons unlawfully kill another, the fact that one of such persons is by virtue of this section guilty of manslaughter only shall not affect the question whether the unlawful killing amounted to murder in the case of any other such person or persons.

Appendix 2 – Treatment Support Order vs Forensic Order

Greater oversight and review is required for people on a Forensic Order than a Treatment Support Order.

Further information can be found in the *Chief Psychiatrist Policy Forensic Orders and Treatment Support Orders: Category, Conditions and Limited Community Treatment*.

Treatment Support Order	Forensic Order

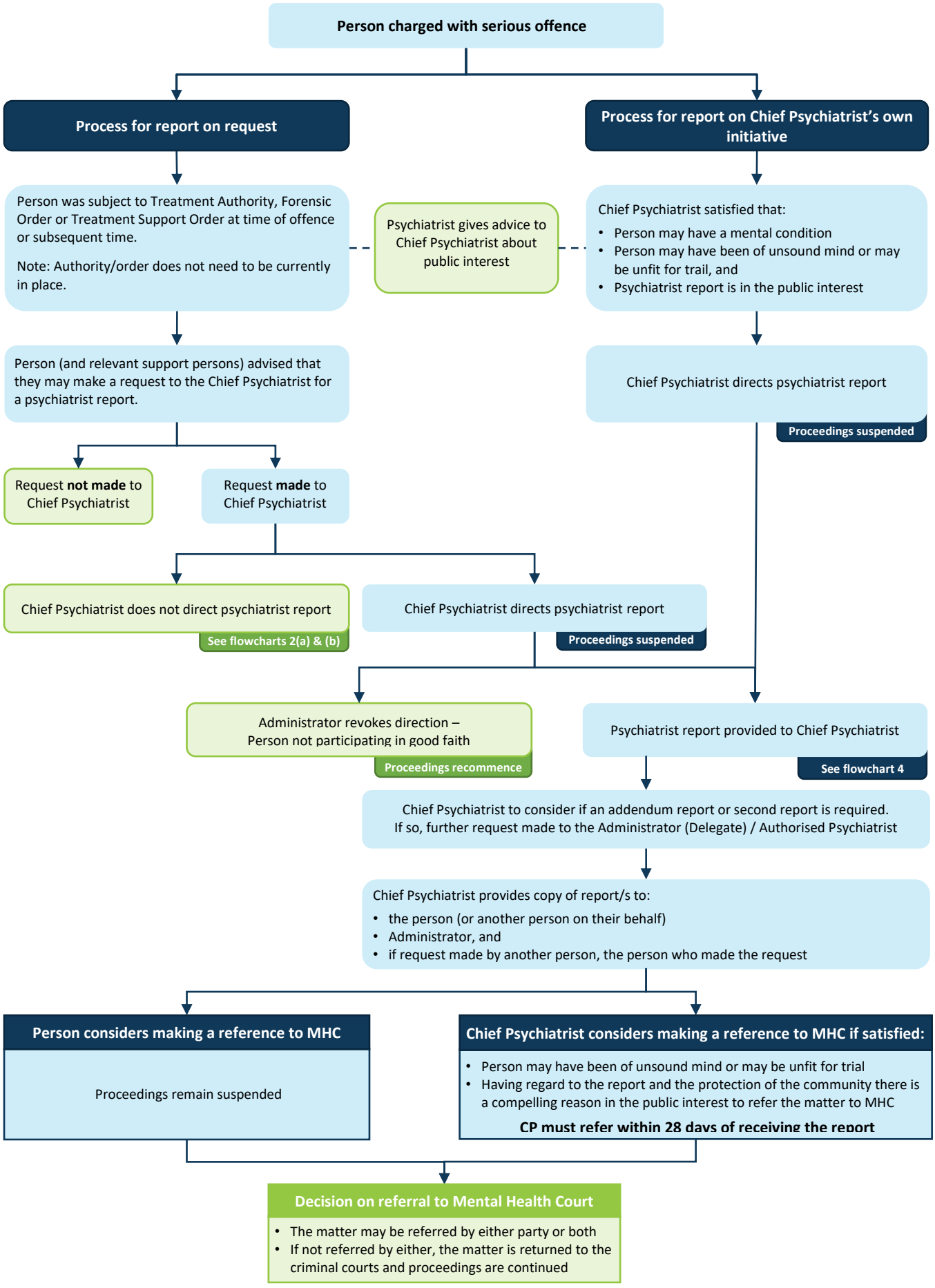
• A Treatment Support Order (TSO) must be made if the MHC/MHRT considers a TSO, but not a FO, is necessary to protect the safety of the community, including a risk of serious harm to others or property.
• Must be 'Community Category' unless the person's treatment and care needs, safety and welfare or the safety of others cannot be met in the community.
• Only available for those with a mental condition other than an intellectual disability or dual disability.
• Cannot be made for a person with an intellectual disability alone.
	• A Forensic Order (FO) must be made if the MHC considers a FO is necessary to protect the safety of the community, including the risk of serious harm to others or property.
	• Can only be 'Community Category' if there is not an unacceptable risk to the safety of the community, including serious risk of harm to other persons or property.
	• FO (mental health) is for treatment of people with:
	  o a mental condition other than intellectual disability, or
	  o a mental condition and intellectual disability.
	• FO (Disability) is for care of persons with intellectual disability only.
	• MHC can recommend intervention programs (e.g. drug and alcohol program or sexual offender program).
	• MHC can impose non-revocation period of up to 10 years for prescribed offences.

Treatment Support Order	Forensic Order
Monitoring and Review	

• No minimum timeframe for a psychiatrist's initial assessment after the TSO is made.
• No mandatory ARMC review within a specified timeframe after the order is made.
• ARMC review is only required:
  o within 90 days when the person's order is changed from FO to TSO,
  o if there is an increase in risk (Tier 2 or 3 of VRAM framework),
  o at the Clinical Director or Chief Psychiatrist's discretion.
• All monitoring and review timeframes are determined by the treating psychiatrist.
	• A Psychiatrist must assess a person within 7 days of the person becoming subject to the FO.
	• ARMC review is required within 30 days of the person becoming subject to the FO.
	• Minimum of 2 ARMC reviews per year (at least every 6 months)
	• CFOS referral for prescribed offences must be made and a review undertaken within 60 days of the FO being made.
	• ARMC determines timeframes for reviews.

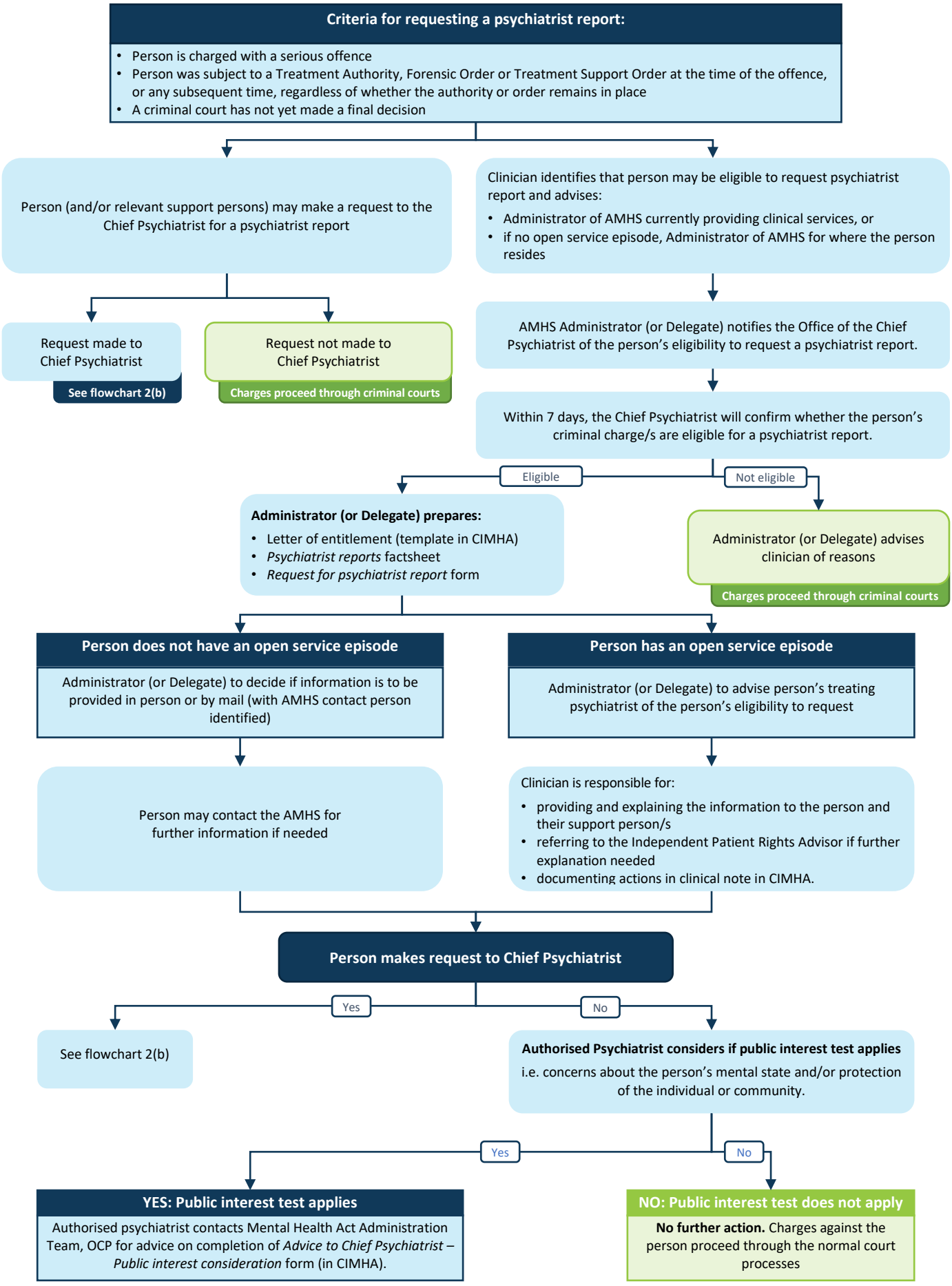
Psychiatrist reports

Flowchart 1: Overview



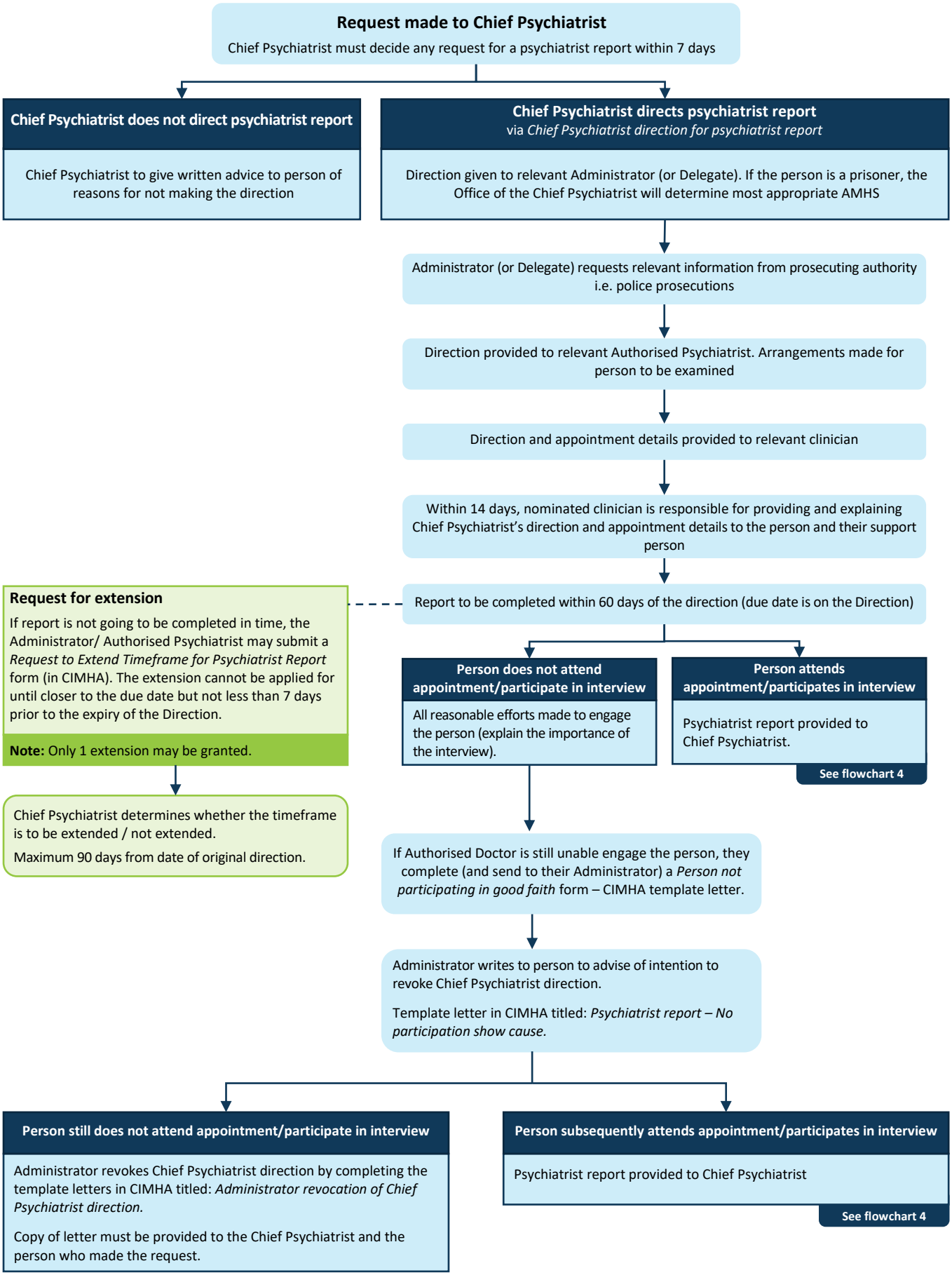
Psychiatrist reports

Flowchart 2(a): Report on request



Psychiatrist reports

Flowchart 2(b): Direction for report (Report on request)



Psychiatrist reports

Flowchart 3: Direction for report (Chief Psychiatrist initiative)

Chief Psychiatrist (CP) satisfied that:

- Person may have a mental condition, and
- Person may have been of unsound mind at time of offence or may be unfit for trial, and
- The preparation of a psychiatrist report is in the public interest.

Note: A decision to direct a report by the CP's own initiative or make reference to the Mental Health Court will only occur in exceptional circumstances for the protection of the individual and/or the community.

Chief Psychiatrist directs psychiatrist report via *Chief Psychiatrist Direction for Psychiatrist Report* form.

Proceedings suspended

Direction given to relevant Administrator (or Delegate). If the person is a prisoner, the Office of the Chief Psychiatrist will determine most appropriate authorised mental health service.

Note: a direction for a psychiatrist report on CP's own initiative may specify the authorised psychiatrist to provide the report and, in some instances, the appointment time.

Administrator (or Delegate) requests relevant information from prosecuting authority i.e. police prosecutions.

Direction provide to relevant Authorised Psychiatrist. For a Direction that does not specify an Authorised Psychiatrist, arrangements must be made for the person to be examined within 28 days of the direction.

Direction and appointment details provided to relevant clinician.

Within 14 days, nominated clinician is responsible for providing and explaining Chief Psychiatrist's direction and appointment details to the person

Report to be completed within 60 days of the direction (due date is on the Direction)

Person does not attend appointment/participate in interview

All reasonable efforts made to engage the person (explain the importance of the interview)

If the person is not an inpatient, failure to attend the appointment may result in the person being transported to an AMHS (by an authorised person) – see Chief Psychiatrist Policy for Managing Involuntary Patient Absences

Person attends appointment/participates in interview

Psychiatrist report provided to Chief Psychiatrist.

See flowchart 4

Request for extension:
If report is not going to be completed in time, the Administrator/ Authorised Psychiatrist may submit a *Request to Extend Timeframe for Psychiatrist Report* form (in CIMHA). The extension cannot be applied for until closer to the due date but not less than 7 days prior to the expiry of the Direction.

Note: Only 1 extension may be granted.

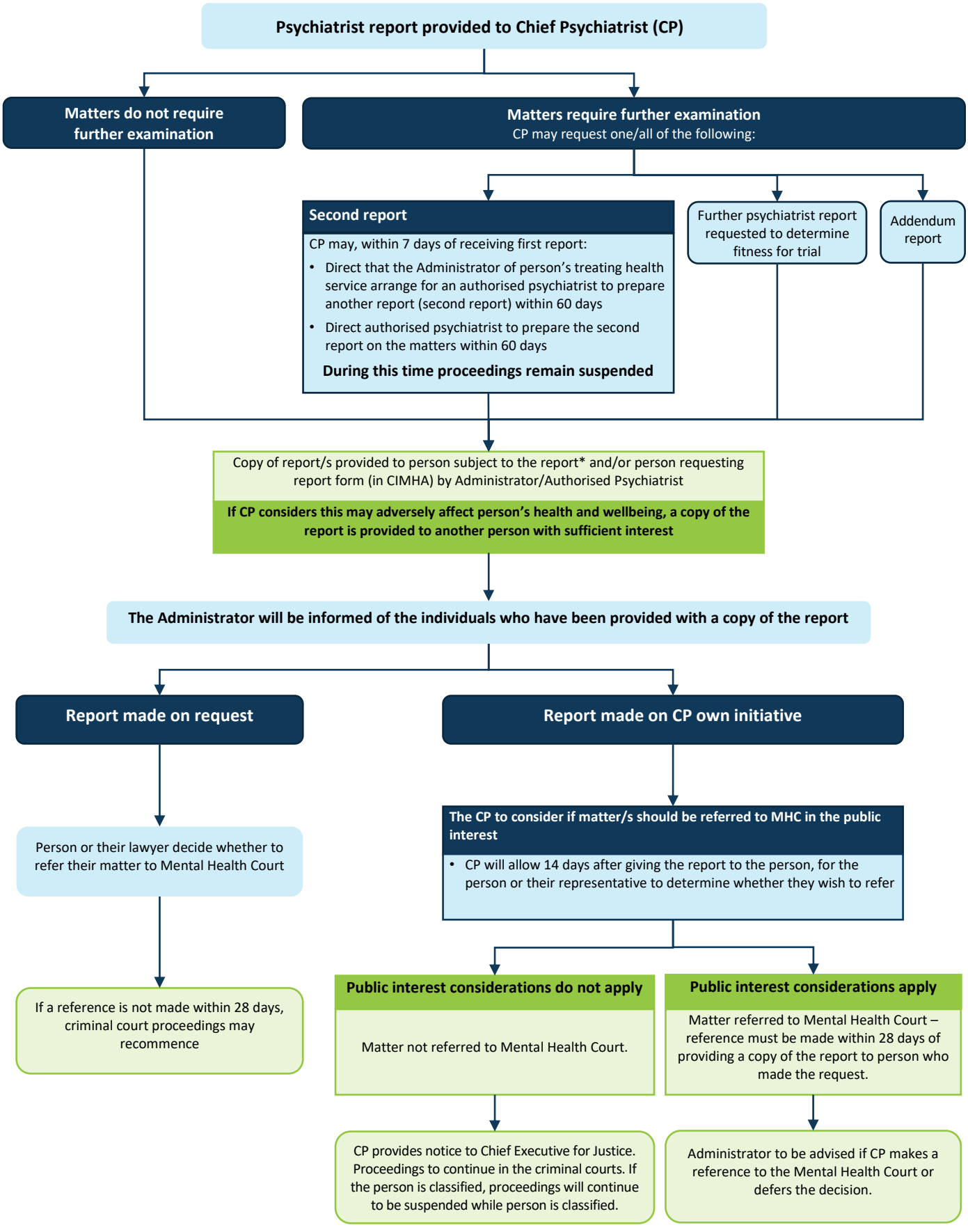
Chief Psychiatrist determines that timeframe is extended/not extended to 90 days from date of the Direction.

Psychiatrist report completed and provided to Chief Psychiatrist

See flowchart 4

Psychiatrist reports

Flowchart 4: Determining referral to Mental Health Court



Note: If the person is unfit for trial but may become fit for trial, the CP may defer the decision for up to 4 months (proceedings remain suspended)

Mental Health Act 2016

Chief Psychiatrist Policy

Searches and security

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General

The Mental Health Act 2016 (the Act) provides a framework for ensuring the safety and security of patients and others within an authorised mental health service (AMHS) or public sector health service facility (PSHSF).

This framework includes the authorisation of searches, mail procedures and processes relating to the exclusion of visitors.

Searches under the Act may be authorised under specific circumstances for patients and their belongings, as well as for visitors and visitors' belongings.

Scope

This Policy is mandatory for all Authorised Mental Health Services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this Policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

This Policy does not preclude other lawful searches and seizures authorised under another law or in accordance with local policy and procedure.

Policy

1 Application of search provisions

Key Points

The Act provides that searches may be authorised for the following:

- particular persons detained in a PSHSF
- particular patients of an AMHS, in any part of the AMHS (e.g. inclusive of emergency departments)
- an involuntary patient on admission or entry to a high security unit or an approved AMHS
- visitors entering a high security unit or an approved AMHS
- posted items received at an AMHS for:
    - an involuntary patient, or
    - a voluntary patient receiving treatment in the AMHS.

1.1 Types of Searches

1.1.1 General Search

A general search means a search of a person:

- to reveal the content of the person's outer clothing or hand luggage without touching the person or the luggage, or
- in which the person may be required to open their hands or mouth for a visual inspection, and also to shake his or her hair vigorously.

1.1.2 Personal search

Key Points

A personal search means a search in which light pressure is momentarily applied to the person over the person's general clothes without direct contact being made with the person's genital or anal areas (including breast for persons identifying as female).

- A personal search may include any or all of the following:
  - removing and inspecting an outer garment or footwear of the person,
  - removing and inspecting all things from the pockets of the person's clothing,
  - touching the clothing worn by the person only to the extent necessary to detect things in the person's possession, and
  - removing and inspecting any item found.

A personal search **must** be carried out in a way that respects the dignity of the person being searched and causes as little inconvenience to that person as possible in the circumstances.

The searcher may conduct a personal search only if:

- the searcher is the same gender as the person, and
- the search is carried out in a part of a building that ensures the person's privacy.

1.1.3 Postal article search

An AMHS administrator, or an appropriately qualified person authorised by the administrator, may open or search anything received at the AMHS for a patient. For example, a letter, parcel package or other item carried by a courier service.

A posted article search may include the use of electronic scanning device or physical examination, including for example opening the article.

1.1.4 Scanning search

A scanning search means a search of the person by electronic or other means that does not require the person to remove their clothes or to be touched by another person.

A scanning search may be achieved by, for example, the use of a hand-held scanning device that passes over the person's body, or by requiring the person to walk through a scanning device.

1.1.5 Search of possessions

A person authorised to carry out a search of a person's possessions (e.g. a health practitioner, doctor or authorised security officer) may:

- open or inspect a thing in the person's possessions, and
- remove or inspect any detected thing.

A search of possessions may only occur if the owner of the possession is present or has been given the opportunity to be present.

1.1.6 Search requiring the removal of clothing

Key Points

A search requiring the removal of clothing means a search in which the person removes all clothing during the course of the search; however no direct physical contact is made with the person.

A search requiring the removal of clothing can only be authorised with the approval of the AMHS administrator (or their delegate).

If the search is occurring outside of a high security unit or an approved AMHS, the person in charge of the PSHSF may also give approval for a search requiring the removal of clothing.

- The administrator or person in charge can only approve this type of search if they believe the removal of clothing is necessary in the circumstances.

A search requiring removal of clothing **must** be carried out by at least two of the following persons who are authorised to conduct this type of search:

- a health practitioner,
- doctor, or
- in high secure or approved units, an authorised security officer.

There **must** be no more people involved in the search than is necessary to carry out the search.

Each person carrying out the search **must** be the same gender as the person being searched.

Before searching, one of the searchers **must** explain to the person:

- that the person will be required to remove the person's clothing during the search, and
- the reasons why it is necessary to remove the clothing.

The searcher **must:**

- ensure the search is carried out in a part of a building that ensures the person's privacy

- ensure the way in which the person is searched causes minimal embarrassment to the person
    - take reasonable care to protect the person's dignity
    - carry out the search as quickly as practical, and
    - allow the person to get dressed as soon as the search is finished.

The searcher **must**, if reasonably practicable, give the person the opportunity to remain partly clothed during the search, including, for example, by allowing the person to keep their clothing on their upper body before being required to remove clothing from the lower part of the body, and vice versa.

If the searcher seizes clothing as a result of the search, the searcher **must** ensure that the person is left with, or given, reasonably appropriate clothing.

Authorisation for a search requiring the removal of clothing is limited to removing clothes for the purpose of searching only; it does not extend to other circumstances where clothing may need to be removed (e.g. emergency clinical situations).

2 Postal articles

Key Points

The postal article search provisions apply to:

- involuntary patients, and
- a person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under an advance health directive or with the consent of a personal guardian or attorney.

Patients in an AMHS have the same rights as any other person in the community to send and receive postal articles.

It is an offence under the Act to prevent or impede the delivery or sending of *postal articles* to and from an AMHS.

These provisions do not apply if the addressee of the *postal article*:

- is the subject of a non-contact order, or
- has given written notice to the relevant AMHS Administrator requesting that postal articles sent by the patient to the addressee be withheld.

The administrator, or an appropriately qualified person authorised by the administrator, may open or conduct a postal article search on anything received at the AMHS, for a patient.

- The administrator may only open or search the article if the patient is present or if the patient has been given an opportunity to be present.
    - This does not apply if the patient obstructs the administrator's ability to search the article.

2.1 Seizure of postal articles

An administrator or appropriately qualified person authorised by the administrator, may seize an item if, on opening or examining the article, they reasonably suspect an item is:

- connected with, or is evidence of, the commission or intended commission of an offence, or
- a harmful thing[1].

Section 8 of this policy outlines processes associated with the seizure of an item.

3 Searches of patients in an AMHS or PSHSF

Key Points

An involuntary patient or a classified patient (voluntary) may be searched in an AMHS or PSHSF (in any part of the AMHS or PSHSF, e.g. including an emergency department) if a doctor or health practitioner believes the patient may have something harmful in their possession.

- The doctor or health practitioner may carry out a general search, scanning search, or personal search of the patient without the patient's consent.
- The doctor or health practitioner may also search the patient's possessions.

If the relevant AMHS administrator or person in charge of a PSHSF gives approval for a search requiring the removal of clothing, the doctor or health practitioner may carry out the search.

Non-consensual searches represent a significant personal intrusion. A search of a patient or their possessions should, as far as possible, occur with the patient's consent.

The authority to search should only be considered if it is not possible to obtain consent and the individual circumstances warrant a non-consensual search.

Before carrying out a search, the doctor or health practitioner **must** tell the patient and their support person/s the reasons for the search and how it is to be carried out. Reasonable steps **must** be taken to ensure the patient understands the information. This may include, use of an interpreter or other methods of communication, such as sign language, written explanations or explanation with assistance from a support person.

[1] Harmful thing means anything that may be used to threaten the security or good order of an AMHS or PSHSF; or threaten a person's health or safety; or that, if used by a patient in an AMHS or PSHSF is likely to adversely affect the patient's treatment or care. (E.g. a dangerous drug, alcohol, medication, provocative or offensive documents).

A search under this authority may be undertaken at any time (e.g. on or during admission to a unit or on return from limited community treatment) provided the doctor or health practitioner has a belief that the patient has a harmful thing.

In considering the need to authorise a search for a harmful thing, the doctor or health practitioner should have regard to the individual circumstances of the case. Relevant factors will vary with individual circumstances but may include:

- if the patient has not consented to a search, the reason for any objection
- the patient's history
- any collateral information, and
- the environment, including items that might constitute a harmful thing in that environment.

The doctor or health practitioner **must** document their decision and the reasons for it, including any relevant factors taken into account, in the patient's records on CIMHA.

A doctor or health practitioner may carry out a search under this section with the help (including the assistance of security officers), and using the force, that is necessary and reasonable in the circumstances.

3.1 Searches of involuntary patients on admission or entry to a high security unit or approved service

Key Points

An involuntary patient of a high security unit, or an approved service, may be searched on admission or entry to the unit or service.

- Entry to a unit may include entry to a particular room (such as a seclusion room) or part of the service.

A search on admission or entry can occur in a routine manner without the searcher requiring a belief that the person has a harmful thing.

An authorised security officer may carry out a general search, scanning search, or personal search of the patient without the patient's consent. The officer may also search the patient's possessions.

If the relevant AMHS administrator gives approval for a search requiring the removal of clothing, the authorised security officer may carry out the search.

Non-consensual searches represent a significant personal intrusion. A search of a patient or their possessions should, as far as possible, occur with the patient's consent.

The authority to search should only be considered if it is not possible to obtain consent and the individual circumstances warrant a non-consensual search.

Before carrying out a search, the authorised security officer **must** tell the patient and their support person/s the reasons for the search and how it is to be carried out. Reasonable steps **must** be taken to ensure the patient understands the information. This may include, use of an interpreter or other methods of communication, such as sign language, written explanations or explanation with assistance from a support person.

A search under this section may be carried out with the help, and using the force, that is necessary and reasonable in the circumstances.

3.2 Seizure of items

An item may be seized by a searcher undertaking a search of a patient if they reasonably suspect an item is:

- connected with, or is evidence of, the commission or intended commission of an offence, or
- a harmful thing.

Section 8 of this policy outlines processes associated with the seizure of an item.

4 Searches of visitors to a high security unit or approved service

Key Points

A visitor to a high security unit, or an approved service, may be asked by an authorised security officer to consent to a:

- general search, scanning search, or personal search, or
- search of the visitor's possessions.

The authorised security officer **must**:

- tell the visitor the officer's powers in relation to the search,
- how the search will be carried out, and
- the visitor's rights in relation to the search.

If the visitor does not provide consent to the search, the authorised security officer may refuse the visitor permission to enter the service.

- If the visitor has already entered the service, the authorised security officer may direct them to leave. A visitor **must** comply with this direction.

A visitor may ask a search to be stopped at any time if the visitor is prepared to leave the service immediately.

- An authorised security officer **must** comply with this request and the visitor will be required to leave the service immediately.

If an authorised security officer believes a possession of the visitor is a harmful thing, they may request that it be left with the officer until the visitor leaves the service.

- If the visitor does not comply with this request, the authorised security officer may refuse the visitor entry to the service.
- If the visitor has already entered the service, the authorised security officer may direct them to leave. A visitor **must** comply with this direction.

A visitor may also leave their possessions with the authorised security officer for the duration that they are visiting the service.

If a visitor's possession was left with an authorised security officer, the officer **must** ensure the item is returned if the visitor requests that it be returned, and the officer is satisfied the visitor is about to leave the service.

An authorised security officer may seize anything found during the search of a visitor if the officer reasonably suspects the item is connected with, or is evidence of, the commission or intended commission of an offence.

5 Records of searches

A record **must** be kept for:

- a search requiring the removal of clothing, and
- any item seized during a search.

As soon as practicable after carrying out the search, the searcher **must** make a written record of the search, including:

- the reasons for the search
- the names of the people present during the search
- how the search was carried out
- details of any items seized during the search and the condition of the item,
- the reasons for seizing these items, and
- what actions were taken in relation to the item (e.g. stored, provided to police, disposed etc.).

A copy of the record **must** also be uploaded to CIMHA.

6 Seizure of items during a search

6.1 Harmful things

Key Points

If a searcher believes that an item seized from a patient is a harmful thing, the searcher **must**:

- keep it for the patient and return it to the patient when they are discharged from the AMHS or PSHSF,
- give it to someone else if the patient is able to, and has provided, their agreement, or
- give or send the item to another person if the *searcher* is satisfied that someone else is entitled to possession of the thing.

If the searcher is satisfied that the item is of negligible value, the searcher may dispose of it in the way in which the administrator or the person in charge deems appropriate.

Value judgements in relation to an item should not be limited to monetary value, and if practicable consultation with the patient on the item's value to them should be undertaken prior to any item being disposed of.

6.2 Items related to committing an offence

If the searcher believes an item that has been seized is connected with, or evidence of, committing an offence against an Act, the searcher **must** give it to an authorised inspector under that Act.

- An authorised inspector is a person authorised under an Act to perform inspection and enforcement functions for that Act (e.g. Police officers).

If the authorised inspector agrees that the item is evidence of an offence or intent to commit an offence, then the authorised inspector **must** deal with it in accordance with the relevant Act under which the inspector is appointed.

If the authorised inspector does not consider the item is evidence of an offence of intent to commit an offence, the inspector **must** return it to the searcher who should deal with it as if it was a harmful thing or a visitor's seized item.

6.3 Forfeiture of visitor's items

An item seized from a visitor is forfeited if the searcher*:*

- cannot find the visitor after making reasonable inquiries, or
- cannot return it to the visitor after making reasonable efforts.

Reasonable attempts to contact a visitor or to return an item to a visitor are not required if it would be unreasonable in particular circumstances to make inquiries or return the item (e.g. there is a safety concern in relation to making contact or returning an item to a visitor).

The nature and extent of inquiries and efforts to return an item should be determined with regard to the nature of the item, its condition and overall value.

6.4 Receipt for seized items

If an item is seized during a search, the searcher **must** give the person from whom the item was seized a receipt for the item. The receipt should briefly describe the item seized and its condition.

A receipt is not required to be given for a seized item that is given to another person (e.g. the patient has agreed that the item can be given to another person or the seized item belongs to another person). However, there should be clear documentation of the patient's decision to have the item go to another person.

6.5 Access to seized thing

If an item has been seized, the searcher **must** allow the owner of the item to inspect it and, if it is a document, to copy it, until the item is forfeited or returned.

This does not apply if it would be impracticable or unreasonable to allow access to the item or for the document to be copied.

7 Compensation for damage to belongings

A patient or visitor may claim compensation for the cost of repairing or replacing their possessions if they are damaged in the processes of a search or seizure.

A court may order an amount be paid only if it is fair to make the order in the circumstances.

8 Authorised security officers – only for high security units

Key Points

When considering authorising a security officer or employee as an authorised security officer, the AMHS administrator should take account of:

- the type of searches that are to be conducted (i.e. different skills may be required depending on whether it is intended the person be permitted to conduct a search of belonging or a search of the person)
- the person's experience and expertise in mental health service provision and the level of supervision required, and
- the type/level of training that the person has undertaken or requires to conduct searches.

An authorised security officer for a high security unit or an approved service **must** carry an identity card approved by the administrator which identifies the person as an authorised security officer.

In authorising the officer or employee, the administrator should limit the person's powers as appropriate in the circumstances (e.g. the instrument of authorisation should specify if the person is authorised to only conduct general searches).

9 Exclusion of visitors

Key Points

An AMHS administrator may refuse entry to a visitor, if there is concern that the visit will adversely affect that patient's treatment and care.

- This concern may include concern that the patient's mental state may deteriorate based on previous deterioration that occurred during or after the last visit from that visitor.

The administrator **must** give the person written notice of the decision. A template letter is available in CIMHA for this purpose. The notice **must** state:

- the reasons for the decision, and
- the process for the person to appeal against that decision to the Mental Health Review Tribunal (MHRT) within twenty-eight (28) days of receiving the notice.

Where appropriate, the written notice should also specify the duration of the exclusion (i.e. a start and end date). The decision to exclude a visitor should be reviewed at regular intervals.

Consultation on the content of the letter with local legal services is strongly encouraged.

The administrator cannot exclude:

- a patient's legal representative
- a health practitioner whose visit has been requested by the patient, or
- a person performing a function under another Act (for example a community visitor under the *Public Guardian Act 2014*, or a police officer).

9.1 Appeals against decision of an AMHS administrator

If the person who is refused entry by an administrator is dissatisfied with this decision, the person may apply against the decision to the MHRT.

The person **must** give notice of appeal to the MHRT within **twenty-eight (28) days** of receiving the decision of the administrator. This notice is available at www.mhrt.qld.gov.au.

The MHRT **must**:

- give notice of the appeal to the relevant administrator within **seven (7) days** after the appeal is started, and
- give **seven (7) days**' notice of the hearing to the parties to the appeal.

In deciding an appeal, the MHRT may confirm or set aside the decision of the administrator to refuse entry to the visitor.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
22 May 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
Authorised security officer	Means a security officer, or an appropriately qualified employee of an AMHS who is authorised by the administrator of the AMHS to provide security services to the AMHS.
Authorised inspector	Means a person who is authorised under an Act to perform inspection and enforcement functions (e.g. a police officer).
Approved service	Means an AMHS, or part of an AMHS, which has been approved by the Chief Psychiatrist for the purpose of searching on entry or admission.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Harmful thing	Means any item that may be used to: • threaten the security or good order of an AMHS or public sector health service facility • threaten a person's health or safety, or • if used by a patient in an AMHS or public sector health service may adversely affect the patient's treatment or care. Examples of harmful things are a dangerous drug, alcohol, medication, weapon or provocative or offensive documents.
Health practitioner	Means a person registered under the Health Practitioner Regulation National Law; or another person who provides health services, including, for example a social worker. For the purpose of clarity, a person registered includes a nurse, psychologist or occupational therapist.

Term	Definition

Involuntary patient	Means:
	• a person subject to any of the following:
	  - an examination authority
	  - a recommendation for assessment
	  - a treatment authority
	  - a forensic order
	  - a treatment support order
	  - a judicial order, or
	• a person detained in an AMHS for up to an hour to enable a recommendation for assessment to be made, or
	• a person absent without permission from another State detained in an AMHS.

Non-contact condition	Is a condition of a forensic order or treatment support order that prevents contact with a stated person.
Postal article	Includes a postal article carried by a courier service.
Searcher	Means a person authorised to conduct a personal search under the Act.
Security officer	Means a person employed or engaged by an AMHS to provide security services.
Support person	For explaining to a patient, the reasons for search, support person means a nominated support person or, if the person does not have a nominated support person, a family member, carer or other support person.
The Act	*Mental Health Act 2016*

Referenced Documents and Policies

Public Guardian Act 2014

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Mental Health Act 2016
Chief Psychiatrist Policy

Seclusion

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General

Seclusion is the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented. Seclusion significantly affects patient rights and liberty and therefore can only be authorised as a last resort to prevent imminent and serious risk of harm to patients and staff, where less restrictive interventions have been unsuccessful or are not feasible.

The *Mental Health Act 2016* (the Act) makes provision for a range of safeguards and restrictions in relation to the use of seclusion in an authorised mental health service (AMHS). In line with national approaches, this policy supports the reduction and elimination of seclusion for patients.

It is an offence to seclude a person in an AMHS other than in accordance with the Act.

AMHSs **must** comply with a written direction given by the Chief Psychiatrist about seclusion.

The following principles **must** be applied in the use of seclusion:

- maintaining the safety, wellbeing and dignity of the patient is essential,
- protecting the safety and wellbeing of staff is essential,
- seclusion should only be used for the minimum period of time necessary, and
- all staff actions should be justifiable and in proportion to the patient's behaviour and broader clinical context.

Scope

This policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

Staff should work collaboratively and in partnership with individuals in their care to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. This should include the timely involvement of appropriate local supports and a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

This policy is issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 October 2021

Policy

1 Application of seclusion provisions

Key points

- The seclusion provisions of the Act may only be applied to a **relevant patient** in an AMHS.
- In relation to the seclusion provisions, a relevant patient is:
  - A patient in an AMHS, subject to a Treatment Authority, Forensic Order (Mental Health or Disability) or Treatment Support Order, or
  - A person who is absent without permission from an interstate mental health service and who has been detained in an AMHS.
- A person detained for examination or assessment, or patients who are accessing mental health services voluntarily or with the consent of a substitute decision-maker **cannot** be placed in seclusion under the Act.
- Seclusion may be authorised in any unit within an AMHS, including an emergency department, provided the room or area complies with this policy and sufficient resources are available to safely meet the needs of the patient.
- Seclusion of a relevant patient under the Act must be recorded on the patient's clinical record in CIMHA (see section 6.2 Recording).

Mechanical restraint **must not** be used on a patient in seclusion.

When using seclusion under the Act, staff **must** do all of the following:

- Use verbal strategies, de-escalation techniques and other evidence-based strategies such as sensory modulation to help the patient safely gain control of their behaviour,
- Be appropriately trained to protect the welfare, dignity and safety of the patient. Training must include de-escalation strategies, trauma-informed care, recovery-oriented practice, de-briefing strategies and the use of seclusion,
- As far as practicable in the circumstances, explain to the patient the reason for seclusion, what will happen during the seclusion (such as clinical observations, access to food and drink, access to the toilet), and the circumstances in which they may be removed from seclusion.

1.1 Seclusion-type management of persons other than a relevant patient

The Act only enables seclusion to be authorised for **'relevant patients'.**

By exception, there may be urgent circumstances where a person other than a relevant patient requires seclusion-type management (e.g. containment in a room from which the person cannot leave). In these circumstances, other legal frameworks and mechanisms authorising the use of seclusion-type management (e.g. the *Guardianship and Administration Act 2000*) should be used in line with local and Hospital and Health Service policies and procedures. Management of individuals in this way should only be considered as a matter of last resort.

A record of such an event **must** be made on the patient's clinical record (clinical note/progress note) if the event occurs:

- in a mental health inpatient or other specialist mental health unit of an AMHS, or
- in another area of an AMHS (for example, an Emergency Department) where mental health service staff are involved in the seclusion-type management.

Escalation within the service as a significant event and/or notification to the Chief Psychiatrist of suspected significant non-compliance with the Act should also be considered (refer to the *Chief Psychiatrist Policy Notification to the Chief Psychiatrist of critical incidents and significant non-compliance with the Mental Health Act 2016*).

Where a person in a mental health inpatient unit, who is not a relevant patient, is subject to seclusion-type management, an assessment by an authorised doctor should also occur as soon as possible, to determine whether the person satisfies the criteria for treatment and care under the *Mental Health Act 2016* and whether to implement appropriate actions e.g. provision of treatment under a Treatment Authority.

2 Emergency authorisation of seclusion

Key points

- A health practitioner in charge of a unit (see definitions) within an AMHS may initiate an emergency authorisation of seclusion of a relevant patient for up to **one (1) hour**, if satisfied that:
  - it is not practicable for an authorised doctor to authorise the seclusion (e.g. the authorised doctor is not immediately available),
  - there is no other reasonably practicable way to protect the patient or others from physical harm, and
  - the seclusion complies with a written direction about seclusion from the Chief Psychiatrist (where a direction has been given).
- Emergency seclusion must not be authorised if the total period of emergency seclusion is, or will reach under the authorisation, more than **three (3) hours within a 24-hour period**.
- A total of **three (3) hours in a 24-hour period** may be reached when a patient is secluded on a number of separate occasions of up to **one (1) hour** each (totalling **three (3) hours**), or when a patient has been secluded three times consecutively for **one (1) hour** each time.
- Consecutive use of emergency authorisations of seclusion should only be used in exceptional circumstances.

During emergency seclusion, the patient **must** be continuously observed.
CCTV is **not** a sufficient way to continuously observe a patient in seclusion.

2.1 Health practitioner in charge of a unit responsibilities

Key points

- To authorise seclusion in an emergency, the health practitioner in charge **must** complete the *Emergency Authorisation of Seclusion form* as soon as practicable after caring for the patient.
  - The *Emergency Authorisation of Seclusion form* **must** be completed electronically on CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA.
- The health practitioner in charge **must** notify the authorised doctor, as soon as practicable after the start of seclusion.
- This notification **must** occur via a phone call or face to face and cannot be done via email or instant messaging notification.

The health practitioner in charge may remove the patient from seclusion prior to the end of the emergency authorisation period if satisfied the seclusion is no longer necessary to protect the relevant patient or others from physical harm.

If the patient is released from seclusion prior to the end of the emergency authorisation period, the authority to seclude the patient ends. If the patient requires emergency seclusion again, a new *Emergency Authorisation of Seclusion form* **must** be completed.

2.2 Authorised doctor responsibilities

Key points

- The authorised doctor that is notified of the emergency seclusion **must**, as soon as practicable:
  - examine the patient, or ensure the patient is examined by another authorised doctor, and
  - determine whether seclusion should be authorised for the patient.
- If seclusion is to be authorised by the authorised doctor, an *Authorisation of Seclusion form* must be completed.

Any period the patient has spent in seclusion under the emergency authorisation **must** be included when determining the total period for which the patient has been secluded within a **24-hour** period.

The patient **must** be examined by an authorised doctor even if the patient is removed from emergency seclusion **before one (1) hour** has elapsed or before the doctor's arrival.

The doctor's examination **must** be recorded in the patient's clinical record. Wherever possible this should be in CIMHA.

3 Process for authorising seclusion

Seclusion may be authorised for up to **three (3) hours** at a time by an authorised doctor by completing the *Authorisation of Seclusion form* on CIMHA.

An authorised doctor's order for seclusion **must** be based on a face-to-face medical review of the patient and cannot be made in advance (i.e. in anticipation that seclusion may be required). This review **must** occur even if consecutive authorisations are made by the same authorised doctor.

Appendix 1 contains an example of the process for authorising seclusion.

3.1 Authorised doctor responsibilities

Key points

- The authorised doctor **must** be satisfied that:
  - there is no other reasonably practicable way to protect the patient or others from physical harm,
  - the seclusion complies with this policy,
  - the seclusion complies with a written direction about seclusion from the Chief Psychiatrist (where a direction has been given), and
  - the seclusion complies with an approved *Reduction and Elimination Plan (R&E Plan)* (where a *R&E Plan* is in place).
- The *Authorisation of Seclusion form* **must** include:
  - the duration of the seclusion, including start and finish times, which must not exceed **three (3) hours**,
  - specific measures to ensure the health, safety and comfort of the patient,
  - observation requirements while the patient is in seclusion (see section 3.2 Observation of patients in seclusion), and
- whether a health practitioner may remove the patient from seclusion before the authorised period ends.

When authorisation for a period of seclusion has expired, further time in seclusion requires a new authorisation.

Each authorisation **must** be completed on the *Authorisation of Seclusion form* on CIMHA and **must** include the information detailed above.

A patient's total hours in seclusion **must not** exceed **nine (9) hours in a 24-hour period**.

A total of **nine (9) hours in a 24-hour period** may be reached when a patient is secluded on a number of separate occasions of up to **three (3) hours** each (totalling nine (9) hours), or when a patient has been secluded three times consecutively for **three (3) hours** each time.

A 24-hour period commences from the first time the patient is placed in seclusion. This includes time spent in seclusion under an *Emergency Authorisation of Seclusion* (see section 2 Emergency authorisation of seclusion).

If necessary, seclusion may be authorised for more than **nine (9) hours in a 24-hour period** only if approved under a *R&E Plan* (see sections 3.5 Extension of period of seclusion and 4 Reduction and Elimination Plans).

3.2 Observation of patients in seclusion

Observation of a patient in seclusion **must** be continuous or at intervals of no more than **fifteen (15) minutes**. This **must** be determined by the authorised doctor based on clinical assessment.

CCTV **is not** a sufficient way to continuously observe a patient in seclusion.

Patient care and observation requirements **must** be documented on the *Authorisation of Seclusion form* on CIMHA.

Where an authorised doctor authorises seclusion and determines that continuous clinical observations for a patient in seclusion is not clinically appropriate, the relevant clinical background and rationale for this decision should be recorded on the patient's clinical record, including on CIMHA.

Clinicians should refer to the *Therapeutic Visual Observation Guidelines for Mental Health Alcohol and Other Drugs Services* for information on relevant clinical considerations when determining the frequency of observations.

3.2.1 Considerations for vulnerable persons

If seclusion is required, consideration should be given to the vulnerabilities of persons at higher risk for trauma, harm/suicide (e.g. minors, persons of Aboriginal and/or Torres Strait Island descent, victims of torture, or refugees) to determine whether continuous observation is clinically appropriate for the person. This should include consultation with appropriate support persons. In this context an appropriate support person is:

- an appropriate family member,
- a cultural support person,
- an Aboriginal or Torres Strait Islander health or peer support worker, or
- for a minor – a parent[1].

Wherever possible, a shared position on observation requirements should be reached between clinical teams and the appropriate support person/s for the patient. However, the treating team is ultimately responsible for making decisions on observation requirements as clinically appropriate.

Any decision that continuous clinical observations are not appropriate should be considered with and approved by the consultant psychiatrist responsible for clinical care and documented on an approved R&E Plan. If there is no R&E Plan, the decision should be made by the consultant psychiatrist on the first occasion on any day on which seclusion occurs.

The rationale for decisions on observation requirements for vulnerable persons should be recorded on the patient's clinical record in CIMHA, including whether support was sought from a support person.

In circumstances where a peer support worker or health worker is involved in the decision making, the worker will record relevant considerations discussed on the patient's clinical record in CIMHA.

3.3 Health practitioner in charge of unit responsibilities

The health practitioner in charge of the unit has responsibilities to ensure the authorisation of seclusion is complied with. This includes meeting observation requirements and ensuring any specific measures required by the authorised doctor for the patient's health and safety are carried out.

[1] Under the Act, a parent includes a guardian of the minor, or a person who exercises parental responsibility for the minor, other than on a temporary basis, or for minors of an Aboriginal background, a person who, under Aboriginal tradition, is regarded as a parent of the minor, and for a minor of Torres Strait Islander background, a person who, under Island custom, is regarded as the parent of the minor.

3.4 Restrictions on authorisations

Authorisation for a relevant patient to be in seclusion **must not** be provided if the patient's total time in seclusion is, or will reach under the authorisation, more than **nine (9) hours** in a **24-hour** period unless:

- an approved R&E Plan for the patient provides for seclusion in excess of **nine (9) hours** in a **24-hour** period (see section 4 Reduction and Elimination Plans), or
- a seclusion extension has been approved by the clinical director of the unit where the seclusion is taking place.

The Administrator of the AMHS **must** ensure that a local process is implemented within the AMHS to ensure that the actual time a patient spends in seclusion is able to be readily calculated.

3.5 Extension of period of seclusion

A single extension to seclusion of up to **twelve (12) additional hours** may be made when:

- seclusion has or is likely to exceed **nine (9) hours** in a **24-hour** period, and
- an approved R&E Plan is not yet in place.

The purpose of the extension is to allow for the development and approval of a R&E Plan

An extension requires:

- the approval of the clinical director (or their delegate), and
- authorisation by an authorised doctor.

An *Authorisation of Seclusion form* **must** be completed for each period of seclusion under an extension in accordance with section 3.1 Authorised doctor responsibilities. See also Attachment 1 – Seclusion scenario examples.

3.5.1 Authorised doctor responsibilities

Key points

- In making an extension of seclusion the authorised doctor **must** be satisfied that:
  - the clinical director (or delegate) of the AMHS has given written approval for the extension,
  - there is no other reasonably practicable way to protect the patient or others from physical harm,
  - the seclusion complies with this policy,
  - the seclusion complies with a written direction about seclusion from the Chief Psychiatrist (where a direction has been given), and
  - it has not been reasonably practicable for a *R&E Plan* to be approved during the **nine (9) hours**.
- The *Extension of Seclusion form* **must** be completed electronically in CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA. The authorised doctor **must** include:
  - the period for which seclusion is to be extended, including start and finish times, which **must not** be more than **twelve (12) hours**,
  - specific measures to ensure the health, safety and comfort of the patient,
  - observation requirements for the extension period, and
  - whether a health practitioner may remove the patient from seclusion before the authorised period ends.
- The clinical director's written approval is to be provided on the *Extension of Seclusion form*.

If it is likely that an *Extension of Seclusion* will be required (e.g. it is late evening, a patient has been in seclusion for **seven (7) hours** within the **24-hour** period and it has not been possible to complete a R&E Plan), the *Extension of Seclusion* can be completed before it is required; provided this occurs within a reasonable timeframe and is for the purposes of providing appropriate treatment and preventing expiration of the seclusion authority.

In urgent circumstances the clinical director may provide initial approval via email following a telephone discussion with the authorised doctor and receipt of an email from the authorised doctor containing:

- relevant clinical details regarding the patient,
- specific measures to ensure the health, safety and comfort of the patient, and
- the reasons for use of seclusion.

An *Extension of Seclusion form* **must** be provided to the clinical director for approval as soon as practicable and within **24-hours** of the email approval being provided.

The approval of an *Extension of Seclusion* **does not** replace the requirement for authorisation of each individual period of seclusion.

While the patient remains secluded, an *Authorisation of Seclusion form* and a medical review by an authorised doctor **must** be undertaken every **three (3) hours**. The medical review should include a physical examination (if clinically appropriate and safe to do so) and **must** consider whether seclusion should be continued or ceased.

3.5.2 Health Practitioner in charge of unit responsibilities

The health practitioner in charge of the unit has responsibilities to ensure the seclusion authorisation is undertaken as directed. This includes meeting observation requirements and ensuring any specific measures required by the authorised doctor for the patient's health and safety are carried out.

4 Reduction and Elimination Plans

A *Reduction and Elimination Plan (RE Plan)* outlines measures to be taken to reduce and eliminate the use of seclusion for a patient and to reduce the potential for trauma and harm.

The R&E Plan reinforces efforts to proactively reduce the use of seclusion for a patient by ensuring clinical leadership, monitoring, accountability and a focus on safe, less restrictive alternatives.

4.1 Requirements for Reduction and Elimination Plans

Key points

- It is recommended practice for a *R&E Plan* to be in place in all instances where a patient is secluded, in particular where multiple instances of seclusion occur.
- An approved *R&E Plan* **must** be in place for any patient who is secluded for more than **nine (9) hours in a 24-hour period**.
  - Development of a *R&E Plan* should be initiated in advance if it is considered likely that the seclusion of a patient could exceed **nine (9) hours in a 24-hour period**.
  - The clinical director (or delegate) may approve the first *R&E Plan* required for a patient in an acute management period (see section 4.1.1 Delegation of authority to approve Reduction and Elimination Plan).
  - An authorised doctor **must** apply to the Chief Psychiatrist for approval of any subsequent *R&E Plan*.
    - The Office of the Chief Psychiatrist will review the proposed plan and make a recommendation to the Chief Psychiatrist about its approval.
    - The Office of the Chief Psychiatrist may contact the authorised doctor making the application for further information.
    - The clinical director and authorised doctor will be advised in writing of the Chief Psychiatrist's decision as soon as possible, but within **two (2) working days** of receiving the plan.
- The Chief Psychiatrist may also direct, on their own initiative, that a *R&E Plan* be prepared for a patient.
  - Where a direction is made, the treating doctor and relevant clinical director will be advised of this requirement via telephone and email.
- The *R&E Plan* form is available within the clinical documents via 'online MHA forms' in CIMHA. If the form is not completed on CIMHA, it **must** be completed manually and uploaded onto the patient's clinical record in CIMHA as soon as possible.

In urgent circumstances the Chief Psychiatrist may provide initial approval of a *R&E Plan* via email following a telephone discussion with the authorised doctor and receipt of an email from the authorised doctor containing:

- relevant clinical details regarding the patient,
- the reasons for use of seclusion, and
- the planned use of seclusion and strategies for the reduction and elimination of use.

A full *R&E Plan* **must** be provided to the Chief Psychiatrist within **24-hours** of the email approval being provided.

A *R&E Plan* **must** not be approved for longer than **seven (7) days**. The timeframe for an approved plan **cannot** be extended.

If a patient requires seclusion for a period longer than **seven (7) days**, a new *R&E Plan* **must** be submitted to the Chief Psychiatrist for approval.

A clinical director **cannot** approve subsequent *R&E Plans* (see section 4.1.1 Delegation of authority to approve Reduction and Elimination Plan).

Key points

- A *R&E Plan* must be recorded on the patient's clinical file and **must** include the following details:
  - the name and date of birth of the patient
  - the name of the AMHS
  - any previous use of seclusion for the patient
  - any strategies previously used to reduce the use of seclusion for the patient and the effectiveness of the strategies
  - a description of the behaviour that has led to the proposed seclusion
  - a description of significant risks to the patient or others
  - the reasons that the authorised doctor believes there is no other reasonably practicable way to protect the patient or others from physical harm
  - the proposed frequency and duration of seclusion for the duration of the *R&E Plan*
  - the strategies proposed to reduce and eliminate the use of seclusion.
- The approval of a *R&E Plan* **does not** replace authorisation of each individual period of seclusion.
- An *Authorisation of Seclusion form* and a medical review **must** be completed by an authorised doctor every **three (3) hours**.

A single *R&E Plan* may apply to **both** mechanical restraint and seclusion.

Only the Chief Psychiatrist may approve a *R&E Plan* that covers both seclusion and mechanical restraint, or mechanical restraint alone.

Seclusion and mechanical restraint **must not** be used simultaneously.

4.1.1 Delegation of authority to approve Reduction and Elimination Plan

The Chief Psychiatrist may delegate the authority to approve a *R&E Plan* for seclusion to the clinical director (or another senior clinician of the AMHS).

- The clinical director (or delegate) may only approve the first *R&E Plan* required for a patient in an acute management period.
- Subsequent plans must be approved by the Chief Psychiatrist.

An acute management period is an acute phase during an admission, in which seclusion for more than **nine (9) hours** in a **24-hour** period may be necessary.

5 Removal from seclusion

Key points

- An authorised doctor **must** remove a patient from seclusion prior to the end of an authorisation period if satisfied the seclusion is no longer necessary to protect the patient or others from physical harm.
- A health practitioner **must** remove a patient from seclusion if:
  - the authorised doctor has stated that a health practitioner may remove the patient from seclusion before the authorised period ends in the *Authorisation of Seclusion form* or *Extension of Seclusion form*, and
  - the health practitioner is satisfied the seclusion is no longer necessary to protect the patient or others from physical harm.

Except for emergency seclusion, if the patient is removed from seclusion prior to the authorisation ending, they may be returned to seclusion under the same authorisation if necessary, to protect the patient or others from physical harm.

This movement in and out of seclusion must be documented on the *Return to and release from seclusion form* which should then be uploaded onto the patient's clinical record on CIMHA.

A break in a patient's seclusion or release from seclusion **does not** include circumstances where another person (such as an authorised doctor) enters, or the patient is removed from, the seclusion room for the purpose of meeting the patient's needs. This includes, for example, assisting the patient to access toilet facilities, for the administration of medication or medical review of the patient.

Movement of individuals in/out of seclusion rooms for these purposes **should not** be recorded on the *Return to and release from seclusion form*.

5.1 Removal from seclusion on Chief Psychiatrist direction

The Chief Psychiatrist may also direct an authorised doctor or health practitioner in charge to remove a patient from seclusion if satisfied the seclusion is no longer necessary to protect the patient or others from physical harm.

The authorised doctor or health practitioner in charge **must** comply with this direction.

5.2 Requirements following seclusion

5.2.1 Medical Review of the patient

A medical review of the patient, including a physical examination if clinically appropriate and safe to do so, **must** be undertaken by an authorised doctor at the end of each authorised period of seclusion (e.g. after **three (3) hours** of seclusion, or earlier).

The medical review should occur as soon as practicable after the seclusion period ends and must consider whether seclusion should be continued or ceased.

Note: A doctor is not required to attend in the middle of the night to conduct a medical review unless a further authorisation of seclusion is likely to be required.

The outcomes of the review **must** be recorded in the patient's clinical record, including on CIMHA.

5.2.2 Post-event debriefing

A review (or debrief) with the patient involved in the seclusion (with the patient's consent), and with other patients involved in any event that led to the seclusion, **must** be undertaken as soon as is clinically appropriate after the seclusion ends, in order to:

- enable open discussion about the seclusion, the events leading to it and the patient's experience of it,
- allow the patient to ask questions, and
- provide an opportunity to identify strategies that may assist in preventing the need for seclusion in the future. This may include a written plan or list of strategies that can be shared with and utilised by the patient, their support person(s) and staff.

The review (or debrief) should include support persons such as a family member or peer worker where possible and appropriate.

A review (or debrief) for all staff involved in the seclusion of the patient **must** also be undertaken as soon as practicable after the seclusion ends, to:

- enable open discussion about the seclusion, the events leading to it and the staffs' experience of it,
- identify the triggers which resulted in the need to use seclusion,
- evaluate the success/efficacy of methods used to respond to the event, and
- identify measures to reduce, and where possible, prevent future use of seclusion.

Reviews for patients and staff may require more than one meeting to address different aspects of the seclusion.

6 Notifications and recording

6.1 Notifications

Key points

- The administrator of the AMHS **must** ensure that processes are in place within the AMHS to ensure compliance with the notifications and recording requirements outlined in this policy.
- The clinical director (or appropriately delegated person) **must** notify the Chief Psychiatrist immediately where seclusion results in, or is associated with:
  - the death of a patient during or within **twenty-four (24) hours** following seclusion of the patient
  - significant harm to a patient or other person during seclusion or within **twenty-four (24) hours** following seclusion of the patient.
  - This notification process is in addition to the requirements contained in the *Chief Psychiatrist Policy Notification of Critical Incidents and Non-compliance under the Mental Health Act 2016*.

Notification to the Chief Psychiatrist **must** be made via phone or email.

6.2 Recording

Key points

- Each time a relevant patient is secluded, the health practitioner in charge of the unit **must** ensure the following information is recorded in the patient's clinical record in CIMHA as soon as practicable:
  - the start and end times of each seclusion event, and
  - any *R&E Plan* approved by the Chief Psychiatrist or where delegated, a clinical director of the AMHS, and
  - the *Authorisation of Seclusion form* or *Authorisation of Emergency Seclusion form*, and
  - the *Return to and Release from Seclusion form*.

In addition, the following information must be recorded in the patient's clinical record in CIMHA:

- the reasons for the seclusion, including the events that led to the seclusion
- why there was no other reasonably practicable way to protect the patient or others from physical harm, including any strategies used to prevent the need for seclusion
- the patient's health at the time of the seclusion, including signs of alcohol or drug use or withdrawal
- the patient's behaviour during the seclusion
- whether physical or mechanical restraint directly preceded a seclusion event
- medications administered up to one hour before, during or immediately after the seclusion (medication name, dose, and route of administration)
- any adverse events related to the seclusion (for example, injury to the patient or staff)
- food and fluid intake during the seclusion
- level of visual observations undertaken
- the examinations that took place during and after the seclusion, and
- post-event debriefing of the patient, staff and any other relevant persons.

Seclusion of persons other than patients receiving treatment and care under the Act must be recorded in the patient's clinical record. The Administrator of the AMHS should ensure that procedures are in place to ensure these records are maintained, consistent with *National Safety and Quality Health Service Standards 2nd Edition* in relation to all seclusion-type events.

Further information

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service – A health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health and Addiction Application – The statewide mental health database which is the designated patient record for the purposes of the Act.
Clinical director	A senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the clinical director functions and responsibilities outlined in this policy.
Health practitioner in charge of a unit	A health practitioner in charge is any health practitioner with oversight, in control of or with responsibility for a given unit in an AMHS.
NSP	Nominated support person – A family member, carer or other support person formally appointed by a patient to be their nominated support person. NSP rights include that they: • must be given all notices about the patient that are required under the Act • may discuss confidential information about the patient's treatment and care • may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and • may request a psychiatrist report if the person is charged with a serious offence.
Relevant patient	A patient in an AMHS, subject to a Treatment Authority, Forensic Order or Treatment Support Order, or A person who is absent without permission from an interstate mental health service and who has been detained in an AMHS.
Seclusion	The confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.
Support person/s	Includes, an appointed nominated support person or, if the person does not have a nominated support person, a family member, carer or other support person.

Referenced policies and resources

Chief Psychiatrist policies

- Notification of Critical Incidents and Non-compliance under the Mental Health Act 2016.

Mental Health Act 2016 forms and other resources

- Authorisation of Emergency Seclusion form
- Authorisation of Seclusion form
- Return to and Release from Seclusion form
- Reduction and Elimination Plan
- Therapeutic Visual Observation Guidelines for Mental Health Alcohol and Other Drugs Services
- National Safety and Quality Health Service Standards 2nd Edition

Legislation

- *Guardianship and Administration Act 2000*

Document status summary	
Date of Chief Psychiatrist approval:	15 October 2021
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Assessment of compatibility with the Human Rights Act 2019 completed on:	25 October 2019

Appendix 1 – Scenarios (Examples only)

SCENARIO One – Seclusion and observations

A patient on a Treatment Authority (community category) becomes acutely unwell and is admitted to an inpatient unit of an AMHS. The patient becomes verbally abusive and threatening towards staff.

The mental health care team attempts to verbally de-escalate and provide the person with time-out in a quiet area to help them de-stimulate. However, the person becomes increasingly agitated and verbally aggressive towards staff. Team members attempt to contact the person's appointed nominated support person who has previously had a calming influence on the person, however, they are unable to be contacted.

The team members attempt to direct the person to the quiet area for a second time-out, when the person begins hitting at and kicking at staff.

The clinical nurse in charge of the inpatient unit requests assistance from health security to help physically restrain the person. The team agree there is no less restrictive way to protect the patient, staff and others from physical harm, and the authorised doctor prepares an Authorisation of Seclusion.

The authorised doctor's clinical assessment of the person determines observations are to occur at fifteen (15) minute intervals and this is included on the form. Clinical background and rationale for this decision is documented on the patient's clinical record (including on CIMHA).

The clinical nurse documents the physical restraint event in CIMHA on the Physical restraint clinical note.

SCENARIO Two – Extension of Seclusion

It is 9:00pm. A patient has been in seclusion for seven (7) hours within a 24-hour period and it has not been possible to complete a *Reduction and Elimination Plan (R&E Plan)*. By 11:00pm, the patient will have been in seclusion for nine (9) hours (the maximum time allowed in a 24-hour period).

An authorised doctor completes an *Extension of Seclusion form* for the 12-hour period from 11:00pm that night to 11:00am the following morning. The extension is approved by the clinical director (or delegate). A *R&E Plan* is developed and approved by the time the extension expires at 11:00am.

SCENARIO Three - Extension of Seclusion (separate acute phase)

A patient admitted to an AMHS on an inpatient order or authority may require seclusion during the first week of the admission while they are acutely unwell. An *Extension of Seclusion* may be authorised once for each phase of the admission in which the patient requires acute management for the purpose of developing a *R&E Plan* for the person.

It is day two of a patient's admission and they have been secluded for eight (8) hours and require further seclusion due to their presentation. An *Extension of Seclusion* is authorised to allow time for the development of a *R&E Plan*. The *R&E Plan* is approved for a three-day period.

The patient's mental state improves, and the patient continues their admission for a further four weeks with no subsequent seclusion events. However, in the fourth week of the admission, the patient's mental state deteriorates, and seclusion is required as part of a planned response to manage behaviours while they are acutely unwell. To allow time for approval of a new *R&E Plan*, an *Extension of Seclusion* is authorised, as it relates to a separate acute 'phase' for the patient.

Note that in this example, two separate acute phases have occurred within a single inpatient admission for the patient, with a clear period of more settled behaviour in between, during which seclusion has not been necessary.

SCENARIO Four – Extension of Seclusion (re-admission)

A patient on an inpatient category order is admitted to an AMHS. During the patient's admission, a period of seclusion is required, an *Extension of Seclusion* is authorised, and a *R&E Plan* is developed. Once stable, the patient is discharged from the inpatient unit.

The patient returns to the emergency department the following day and requires another admission and a further period of seclusion.

In this case and because there are two separate admissions, an *Extension of Seclusion* can be authorised, if required, to enable the development and approval of a new *R&E Plan*.

The timeframes and scenarios outlined above are examples only and other applications of this policy will apply in practice.

The Office of the Chief Psychiatrist should be contacted as early as possible if an authorised doctor or health practitioner in charge of a unit requires advice in relation to the circumstances in which seclusion may be authorised.

Mental Health Act 2016 Seclusion Flowchart 1

Patient is on Treatment Authority, Forensic Order, Treatment Support Order or detained from interstate.

NO

Person cannot be secluded under the *Mental Health Act 2016*

YES

All other reasonably practicable ways to prevent harm have been considered / attempted.

NO

Seclusion cannot be authorised
Contact an Authorised Doctor / Psychiatrist or Psychiatrist On-Call to discuss alternative intervention(s).

YES

Seclusion authorisation required
Is an Authorised Doctor available immediately to complete a review?

NO

'Emergency Authorisation of Seclusion'

Health Practitioner in charge to authorise emergency seclusion.

Valid for up to 1hr. Max total time spent in seclusion in a 24hr period under *Emergency Authorisation(s)* is 3hrs.

YES

'Authorisation of Seclusion'

Authorised Doctor to assess the patient to determine whether seclusion is required.
If seclusion is required, Authorised Doctor to complete *Authorisation of Seclusion* form.

Valid for up to 3hrs

'Authorisation of Seclusion'

Authorised Doctor to re-assess the patient to determine whether ongoing seclusion is required.
If seclusion is required, Authorised Doctor to complete additional *Authorisation of Seclusion* form.

Each authorisation is valid for up to 3hrs. Max total time spent in seclusion in a 24hr period without a *Reduction and Elimination Plan* is 9hrs.

If the patient is likely to be secluded for more than 9hrs in a 24hr period:

If the patient is likely to be secluded for more than 9hrs in a 24hr period:

- Commence *Reduction and Elimination Plan* **(see Flowchart 2)**
- Medically review patient at least every 3hrs
- Ensure nursing observations as required
- Continue Authorisations of Seclusion as required
- Seclusion must be ceased if it is no longer justified.

Post-event debriefing with the patient (with consent), staff and any other relevant persons involved in the seclusion

Key points

- Seclusion is the confinement of a person, at any time of the day or night, alone in an area from which free exit is prevented.
- Seclusion is to be used only as a last resort to prevent imminent and serious harm to patients and staff.
- Seclusion must be ceased when no longer justified.
- A patient may be secluded for no more than 9hrs in a 24hr period, unless approved under a *Reduction and Elimination Plan* or an *Extension of Seclusion form* (see Flowchart 2).
- 9hrs in a 24hr period is total actual time in seclusion. This time may or may not be continuous and includes time under both *Emergency Authorisation(s)* AND *Authorisation of Seclusion(s)*.
- An *Authorisation of Seclusion* made by an Authorised Doctor should not include/ cover time person was secluded under an *Emergency Authorisation of Seclusion*.
- Upon the expiry of a seclusion authorisation, further seclusion is authorised using a new *Authorisation of Seclusion* form (NOT an *Extension of Seclusion*).
- While a patient is in seclusion, a medical review and a new seclusion authorisation are required every 3hrs minimum, including when an *Extension of Seclusion* or *Reduction and Elimination Plan* is in place.
- A patient in seclusion must be continuously observed, or observed at intervals of no more than 15 minutes.
- A medical review must be conducted as soon as practicable after seclusion ends.
- Ensure seclusion plans, forms and events are recorded in CIMHA as per the Chief Psychiatrist's Policy on *Seclusion*.

If at any time seclusion is no longer justified the patient is to be removed from seclusion and process is to be concluded.

To contact Chief Psychiatrist:

In hours:
Phone 3328 9899
Email mha2016@health.qld.gov.au

After hours:
Phone 0408 750 369
Email cp.afterhours@health.qld.gov.au

This flowchart is a guide only, for use by authorised mental health service staff in relation to the use of seclusion under the *Mental Health Act 2016*. This flowchart should be read in conjunction with the Chief Psychiatrist's Policy and Practice Guidelines on *Seclusion* and with the *Mental Health Act 2016*.

Effective date: June 2020

www.health.qld.gov.au/mental-health-act

Queensland Government

Mental Health Act 2016 Seclusion
Flowchart 2: Reduction and Elimination Plan

Patient likely to require more than 9hrs seclusion in 24hrs.

Will a *Reduction and Elimination Plan* be approved prior to 9hrs (total) in seclusion?

NO

'Extension of seclusion'

Authorised Doctor to complete an *Extension of Seclusion* form.
*only 1 extension is permitted

In hours

Send *Extension of Seclusion* form to relevant Clinical Director for approval.

After hours

Send *Extension of Seclusion* form to Psychiatrist On-Call for approval.

Where necessary, Clinical Director or Psychiatrist On-Call can email approval to Authorised Doctor, and sign the form within 24hrs. Copy of email should be uploaded to CIMHA.

Seclusion extended to allow for the REP to be approved.

Valid for up to 12hrs
Commence REP

YES

'Reduction and Elimination Plan'

Authorised Doctor to complete a *Reduction and Elimination Plan* (REP).

In hours

Send REP to relevant Clinical Director for approval.

After hours

Send REP to Psychiatrist On-Call for approval.

Does this REP supersede or directly follow on from a previous REP OR involve mechanical restraint?

NO

No further approval required.

YES

Send REP to Chief Psychiatrist (in hours) or Chief Psychiatrist On-Call (after hours) for approval.

*Amendments may be requested by the Chief Psychiatrist before approval can be provided.

REP is approved.

Valid for up to 7 days

- Medically review patient at least every 3hrs
- Ensure nursing observations as required
- Continue *Authorisations of Seclusion* as required
- Seclusion must be ceased if it is no longer justified
- Consider whether a further REP will be required.

Chief Psychiatrist approval for a *Reduction and Elimination Plan (REP)* is required when:

- a REP supersedes or follows on from a previous REP, OR
- the Chief Psychiatrist has directed that a REP must be in place for a particular patient or class of patient, OR
- a REP involves mechanical restraint, with or without seclusion.

Initial Plans: Clinical Directors and On-Call Psychiatrists have delegation to approve initial REP (seclusion only).

While a patient is in seclusion: a medical review and a new seclusion authorisation are required every 3hrs minimum, including when an *Extension of Seclusion* or *Reduction and Elimination Plan* is in place.

CIMHA: Ensure seclusion plans, forms and events are recorded in CIMHA as per the Chief Psychiatrist's Policy and Guideline on *Seclusion*.

Add Clinical Director / On-Call Psychiatrist contact details here:

To contact Chief Psychiatrist:

In hours:
Phone 3328 9899
Email mha2016@health.qld.gov.au

After hours:
Phone 0408 750 369
Email cp.afterhours@health.qld.gov.au

This flowchart is a guide only, for use by authorised mental health service staff in relation to the use of seclusion under the *Mental Health Act 2016*. This flowchart should be read in conjunction with the Chief Psychiatrist's Policy and Practice Guidelines on *Seclusion* and with the *Mental Health Act 2016*.

Effective date: May 2019

www.health.qld.gov.au/mental-health-act

Queensland Government

Policy and practice guideline for Hospital and Health Service Chief Executives – Securing adult acute mental health inpatient units

Overview

This policy and practice guideline is issued under sections 309A and 493A of the *Mental Health Act 2000* ('the MH Act'). It relates to the securing of adult acute mental health inpatient units as required by the Director of Mental Health pursuant to an order made under section 493AE(2)(e) of the MH Act (*Action director may take for a significant matter and related risk*).

This policy and practice guideline sets out requirements in relation to securing adult acute mental health inpatient units effective on and from 15 December 2013.

Purpose

The purpose of making this policy and practice guideline is to prevent involuntary patients from absenting themselves from adult acute mental health inpatient units without permission and causing a serious risk to their own life, health or safety or a serious risk to public safety.

This policy and practice guideline should be applied with that purpose in mind.

Policy and practice guideline

Further to the memorandum issued by the Deputy Director-General, Health Service and Clinical Innovation, on 6 December 2013, and to the order made on 13 December 2013, this policy and practice guideline requires that, subject to the matters set out below, the main entry and exit doors to all acute mental health inpatient units be locked on and from 15 December 2013.

However, voluntary patients, visitors, persons who are not involuntary patients or involuntary patients who have a valid basis for departing from the unit (including a leave entitlement) should be allowed to move freely in and out of the units (and through any exit or entry doors which are otherwise locked), subject to all appropriate steps being taken to ensure that persons who do not fall into one of these categories do not depart from the unit.

The appropriate steps that need to be taken to enable such movement in and out of the units will depend on each facility.

For example, a staff member might need to be located at or near the door at all times between 7am and 11pm to check each person's identification (preferably photographic identification) against a list of involuntary patients to ensure that the person is not an involuntary patient. Consideration should be given to compliance

with the requirements of Part 7 (Confidentiality) of the *Hospital and Health Boards Act 2011* (Qld) in selecting the appropriate person to perform such a role.

Consideration should also be given to ensuring that persons who have a valid basis for departing from the unit if the door is unattended at any time are able to make arrangements to depart when they wish to do so or are otherwise made aware of the circumstances in which they will be able to depart the unit.

The safety of patients, staff and visitors to the unit is also of critical importance. To that end, this policy and practice guideline should not be carried out if this has the consequence that any legislative requirement is not complied with by the facility.

For example, each facility must ensure that it complies with the *Fire and Rescue Service Act 1990* (Qld) and the *Building Fire Safety Regulation 2008* (Qld). All mental health services should consult with their local Occupational Health and Safety Units to ensure that appropriate fire safety arrangements and evacuation procedures are in place.

The facility should take all necessary steps to carry out any required works or arrange for the attendance of additional staff to enable the facility to comply with all legislative requirements (to be identified by each facility) and this policy and practice guideline, by no later than March 2014 if possible.

For example and depending on the facility, a staff member may need to be located at or near the door at all times during the day and night to ensure compliance with legislative requirements relating to evacuation for fire.

Further, appropriate steps will need to be identified and taken to ensure that an involuntary patient is not left alone in an area within the facility with the effect that they are kept in seclusion within the meaning of section 162J of the MH Act applies unless allowed under Chapter 4A Part 2 of the Act.

Key contacts

Director of Mental Health

- During business hours (Monday to Friday - 8am to 4.00pm)

  Phone: 3328 9540

  Email: MHA2000@health.qld.gov.au

  Fax: 3328 9619

Key resources

Mental Health Act 2000

https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealthA00.pdf

Hospital and Health Boards Act 2011 (Qld) Confidentiality guidelines (update pending)

http://www.health.qld.gov.au/foi/docs/conf_guidelines.pdf

Mental Health Act 2016

Chief Psychiatrist Policy

Support to the Mental Health Review Tribunal

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Queensland Government

General

The Mental Health Review Tribunal (Tribunal) reviews and hears applications on the following matters:

- review of treatment authorities
- making/review of forensic orders
- making/review of treatment support orders
- review of fitness for trial of particular persons
- detention of minors in high security units
- application for examination authorities
- application for approval of regulated treatments (electroconvulsive therapy and non-ablative neurosurgery)
- application to transfer particular patients into and out of Queensland.

The Tribunal also hears appeals against particular decisions made by the Chief Psychiatrist and administrators of authorised mental health services (AMHSs).

Scope

This policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this Policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Facilities

AMHSs are to be respectful of the nature of the Tribunal proceedings, the rights and needs of the patients and others attending the hearings, and the requirements of Tribunal members conducting hearings.

Key Points

AMHSs **must** provide the Tribunal with appropriate rooms that:

- can comfortably accommodate up to **twelve (12) people**,
- have appropriate air conditioning, power and lighting,
- cater for special needs if required, such as being wheelchair accessible, and
- have available waiting space for patients to meet with their legal representative, nominated support person or other support persons.

Rooms must be accessible for the Tribunal before and after hearings, preferably an hour either side of the proceeding.

Given the sensitivities of the Tribunal hearings, the rooms provided **must** enable privacy for the proceeding. If the rooms are accessible with a key or swipe card these must be provided to the Tribunal members in advance.

The rooms **must** provide a safe and secure environment. There **must** be a duress alarm for the Tribunal, either fixed in the room or available to use while in the facility. Appropriate AMHS staff are to be available to assist if the need arises.

AMHSs **must**:

- provide a contact staff member who can assist with administrative tasks,
- orient Tribunal members to the premises by providing a map or directions and taking members through evacuation procedures,
- provide technology to enable proceedings to be conducted by teleconferencing or videoconferencing, and
- provide administrative facilities, including computers, telephones, photocopy machines, printers and stationery for the purposes of proceedings.

In addition:

- toilets should be easily accessible, and
- consideration should be given to making refreshments available in near proximity.

All staff at the AMHS should assist patients to attend hearings, particularly if they are inpatients.

The *Audit tool: Facilities and support provided to the Mental Health Review Tribunal* is provided at **Attachment 1**.

2 Reports and other matters

Key Points

The relevant treating psychiatrist **must** provide accurate and up-to-date clinical reports and other relevant documents, such as risk management plans, at least **seven (7) clear** days prior to the hearing (See MHRT Practice Direction 1 of 2017).

- The report needs to be legible, preferably typed, and signed (either manually or digitally) by the treating psychiatrist.
- The report is given to the Tribunal and the person who is the subject of the review (unless the treating practitioner intends to apply for a confidentially order). The report needs to be discussed with the person who is subject to the review.

At least one member of the treating team for the relevant patient is required to attend the proceeding. However, it is preferable that both the treating psychiatrist and the principal service provider, such as the community case manager or primary inpatient nurse attend.

Communication may be required between the treating team and the Tribunal prior to the hearing if the proceeding is expected to be sensitive, complex, where a confidentiality order will apply, or where the patient has legal representation. This will help to ensure the efficient running of the hearing and avoid adjournments.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service - a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
Seven (7) Clear Days	For further information on how to calculate seven (7) clear days in QLD legislation, see s38 of the *Acts Interpretation Act 1954* or MHRT Practice Direction 1 of 2017.
The Tribunal	Mental Health Review Tribunal

Referenced documents and policies

- *Acts Interpretation Act 1954*
- Mental Health Review Tribunal website

Document status summary

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Attachment 1: Audit tool: Facilities and support provided to the Mental Health Review Tribunal

Authorised Mental Health Service:	
Audit undertaken by: (Name/s and designation/s)	
Audit date:	

AMHS procedures	Yes	No	Comments
Patients receive appropriate information about the Tribunal and its processes and functions and, where necessary, patients (e.g. inpatients) are assisted to attend and participate in the hearing.			
Patients are provided with information relating to entitlement to, and process for, access to legal representation in relevant circumstances.			
Mental Health Review Tribunal Clinical Reports are provided to the Tribunal and the patient **at least 7 clear days** prior to the hearing.			
Timely access to additional clinical material by the patient or their legal representative.			
Attendance of the authorised psychiatrist and case manager at the hearing.			
Consideration to the most appropriate hearing venue i.e. requesting the MHRT schedule the hearing for a community patient at a hospital where there are additional security measures may be appropriate in some circumstances.			

Hearing room - general requirements	Yes	No	Comments
Privacy of proceedings protected Conversations not audible in adjacent rooms/areas with hearing room door/s closed.			
Room booking The room must be booked in a way that ensures the Tribunal panel have access to the room one hour prior and one hour after the scheduled hearing times.			
Two entry/exit points One that accesses a secure area and another that accesses a public area.			
Patient and support person access Located within close proximity to waiting area/space used for patients to meet with legal representative and support persons.			
The room should be: • airconditioned, • located within easy access to toilets, and • close to refreshment facilities.			
The hearing room requires: • adequate lighting, • adequate access to power (e.g. for member equipment), and • should be wheelchair accessible.			
Furniture and Equipment	**Yes**	**No**	**Comments**
Table area Required to be at least 1 metre wide and 2 metres in length to enable sufficient work area and personal space for participants.			
Seating Sufficient seating to accommodate up to 12 persons in the hearing room.			
Furniture arrangement/room layout Required to be arranged in a way that minimises risk of Tribunal members access to doors or duress alarms being obstructed. E.g. If members are required to leave the room due to aggressive behaviour.			

Teleconference/videoconference facilities Should be available in the room or readily able to be arranged on request.			
Administrative facilities Including computers, telephones, photocopy machines, printers and stationary is available to Tribunal members for the proceedings.			
Water containers and drinking cups should be supplied.			
Safety Considerations	**Yes**	**No**	**Comments**
Patients at risk of agitated or aggressive behaviour in the context of a Tribunal hearing are to be assessed, and where appropriate, strategies to minimise and manage risk are implemented. E.g. checks for concealed weapons or other potentially harmful objects.			
Duress alarm/s Suitably located in the hearing room or made available to Tribunal members for use while in the facility.			
Duress alarm/s Procedures in place to ensure duress alarms are checked prior to the commencement of hearings and that appropriate staff are available to respond.			
Consideration should be given to the items within the hearing room, for example water jugs, glassware etc. to ensure they are safe for Tribunal members and consumers.			
All hearing rooms should have two entry/exit points that are easily accessible.			
General	**Yes**	**No**	**Comments**
Orientation and Swipe card access Tribunal members should be oriented to the facility and emergency evacuation procedures and, if relevant, provided with swipe cards to access room/areas as required.			
A staff member should be available to assist the Tribunal with administrative tasks where required.			

Mental Health Act 2016

Chief Psychiatrist Policy

Temporary absence

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General

The Chief Psychiatrist may approve particular patients who are detained in an inpatient unit of an authorised mental health service (AMHS) to be temporarily absent under prescribed circumstances.

A temporary absence may be approved to enable access to health care, to attend a court or judicial hearing, to seek accommodation as part of discharge planning or for compassionate grounds.

Scope

This Policy is mandatory for all Authorised Mental Health Services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the *Mental Health Act 2016* (the Act) must comply with this Policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

This policy must be read in conjunction with the relevant provisions of the Act.

Policy

1 Authorisation of temporary absences

1.1 Patients who may require a temporary absence approval

Particular patients who are detained in an inpatient unit of an AMHS may require approval to be temporarily absent for a specific purpose. Particular patients are:

- patients subject to a Forensic Order (inpatient category) (FO) who do not have the required limited community treatment authorised or ordered, or
- classified patients, or

- patients subject to a Judicial Order[1].

1.2 Reasons a temporary absence may be required

The Chief Psychiatrist may approve a temporary absence for the following reasons:

- for the patient to see a doctor, dentist, or other health care provider, or
- for the patient to be able to go to court, tribunal or other judicial body if needed, or
- for the patient to look for accommodation as part of discharge planning, or
- on compassionate grounds, for example if the client has a funeral to attend, and
- for any other purpose the Chief Psychiatrist is satisfied justifies the need for the temporary absence.

A temporary absence is **not** required for a FO or classified patient, when being transported on grounds within an AMHS to attend an appointment (e.g. between two units in the AMHS to attend a medical appointment, such as a medical imaging scan or blood test).

1.3 Approval of temporary absence

Only the Chief Psychiatrist can approve a particular patient's temporary absence from an AMHS.

An authorised doctor **must** request written approval from the Chief Psychiatrist by completing the Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients form.

This form is to be completed electronically in CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA.

The request must include:

- the reasons the temporary absence is being sought, and
- the proposed start and end dates and times, and
- details of the proposed absence (e.g. the nature and location of health care to be provided), and

[1] A judicial order is a court examination order; or an examination order; or another order requiring or permitting the detention of a person in an AMHS, made by a court under any of the following section: 124(1)(b), 183(c)(ii), 193(2), 544(4), 551(4)(b).

- any conditions for the proposed absence (e.g. that the person is to be escorted or accompanied throughout the absence), and
- a current risk assessment of the patient.

The Chief Psychiatrist will determine the request as soon as practicable and provide the outcome to the relevant AMHS administrator and the authorised doctor on the Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients form.

The temporary absence **must** be recorded as a clinical note on the patient's file in CIMHA.

2 Return after temporary absence

A temporary absence ends at the end of the approved period stated in the Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients form or when the patient returns to the AMHS.

If the patient does not return within the approved period, an authorised person can transport the patient back to the service. The Chief Psychiatrist Policy – Transfers and Transport and Chief Psychiatrist Policy – Managing Involuntary Patient Absences outlines the powers of an authorised person for transporting a patient who has not returned as required from a temporary absence.

Issued under section 305 of the Mental Health Act 2016

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Judicial Order	• A court examination order or, • An examination order, or • Another order requiring or permitting the detention of a person in an AMHS, made by a court under any of the following: o S 124(1)(b) o S 183(c)(ii) o S 193(2) o S 544(4) o S 551(4)(b)
The Act	*Mental Health Act 2016*
Authorised person	Includes a health practitioner, an ambulance officer, a police officer, the Administrator of an AMHS, and a health service employee appointed by the Administrator. • The Administrator may appoint a specific health service employee, or a class of health service employees (for example all consumer consultants employed in the AMHS) as authorised persons.
Temporary absence	Means a brief period during which a patient is authorised to be absence from an AMHS for a specific purpose.

Referenced documents and sources

Chief Psychiatrist Approval – Temporary Absences and Limited Community Treatment for Particular Patients form
Chief Psychiatrist Guidelines – Involuntary Patient Absences
Chief Psychiatrist Practice Guidelines – Transfers and Transport

Referenced documents and sources

Mental Health Act 2016

Document Status Summary

Date of Chief Psychiatrist approval:	15 April 2020
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Supersedes version that took effect on:	05 March 2017
To be reviewed by:	15 April 2020

Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
AMHS Administrator	Phone: Email:
Clinical Director	Phone: Email:
Queensland Ambulance Service	Phone: Email:
Queensland Police Service	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Mental Health Act 2016

Chief Psychiatrist Policy

Transfers and transport

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General

The *Mental Health Act 2016* (the Act) makes provision to transfer an involuntary patient and a classified patient (voluntary) from one authorised mental health service (AMHS) to another AMHS. Requirements for approving and ordering the transfer differ depending on the patient's status.

Patient transfers should be determined on a case by case basis, taking account of the transfer considerations, legislative authority, individual clinical needs, the wishes of the patient, and local arrangements and supports available for the patient.

An authorised person can act under an agreement or approval for a patient transfer to transport the patient to, and from, an AMHS.

Additional requirements regarding the transportation of patients who are required to return following an absent without approval event are outlined in the Chief Psychiatrist Policy – Managing Involuntary Patient Absences.

Scope

This Policy is mandatory for all Authorised Mental Health Services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this Policy.

This policy **must** be read in conjunction with the relevant provisions of the Act.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Patient transfers between AMHSs

1.1 Authority to transfer between AMHSs

1.1.1 Administrator approval

Key points

The following patients may be transferred to another AMHS by agreement between the AMHS administrators of the referring AMHS and the receiving AMHS:

- a person detained in an AMHS under an Examination Authority
- a person detained in an AMHS for the purposes of an involuntary assessment
- a patient on a Treatment Authority
- a patient on a Treatment Support Order, or
- a classified patient (voluntary).

In agreeing to the transfer, the Administrators **must** have regard to the transfer considerations (see section 1.2) and **must** complete the Patient Transfer form. The administrator may delegate this function to an appropriately qualified employee within the AMHS. The administrator is responsible for ensuring that an appointed delegate for this function is appropriately qualified.

- Any supporting, collateral material **must** be provided to the receiving AMHS, or be clearly available on CIMHA.

A copy of the Patient Transfer form **must** be kept on the patient's clinical file in CIMHA.

Until the Patient Transfer is given effect, the referring AMHS remains responsible for the patient's treatment and care, including taking required actions if the patient is non-compliant with their authority or order.

1.1.2 Chief Psychiatrist approval

The transfer between services, of forensic patients and patients subject to a judicial order, can only occur:

- With the Chief Psychiatrist's written approval, provided on the Patient Transfer form, and
- With agreement between the referring and receiving AMHS's.

Agreement between the AMHSs **must** be reached before seeking the Chief Psychiatrists approval.

The Chief Psychiatrist's approval is sought by sending a copy of the Patient Transfer form to the Office of the Chief Psychiatrist.

- Any supporting, collateral material **must** be provided, or be clearly available on CIMHA.

The Chief Psychiatrist's approval is also required for transfers to a High Security Unit for the following patients:

- a patient subject to a Treatment Authority who is not a classified patient, and
- a patient who is a minor[1].

The Chief Psychiatrist may also require the transfer of any other involuntary patient or classified patient (voluntary) from one AMHS to another under a Patient Transfer form.

- All avenues of local agreement **must** be considered before the Chief Psychiatrist is contacted in relation to patients where Chief Psychiatrist approval is not mandatory.
- Until the Patient Transfer is given effect, the referring AMHS remains responsible for the patient's treatment and care (see section 1.1.1).

1.2 Considerations for transfers

Key Points

Agreement for patient transfers should be determined on a case by case basis and **must** take account of:

- the transfer considerations,
- the patient's wishes,
- legislative authority,
- individual clinical needs, and
- local arrangements and supports available for the patient.

The transfer considerations are:

- the person's mental state and psychiatric history
- the person's treatment and care needs
- whether the transfer is in the best interests of the person, and
- if relevant, security requirements for the person.

[1]A judicial order is a court examination order; or an examination order; or another order requiring or permitting the detention of a person in an AMHS, made by a court under any of the following section: 124(1)(b), 183(c)(ii), 193(2), 544(4), 551(4)(b)

Consideration of victim issues should be included when planning transfers for Forensic Order and Treatment Support Order patients. Changing the place at which a patient resides may bring them into contact with the victim.

The Act supports victims through Information Notice provisions which enable eligible victims to receive specific information about the patient that is relevant to their safety and wellbeing. Information Notices are recorded in CIMHA. In most cases, the existence of an Information Notice and/or the identity of the relevant victim **must** remain confidential from the patient.

The Queensland Health Victim Support Service can provide information and advice about management of known victim issues.
Queensland Health Victim Support Service
Phone: 1800 208 005
Email: victim.support@health.qld.gov.au

A discussion between members of the patient's current and receiving treating team (e.g. authorised doctor to authorised doctor) **must** occur as soon as possible prior to a proposed transfer to ensure these transfer considerations can be considered.

Additionally, the treating team in the referring AMHS **must** initiate consultation with relevant parties as early as possible once a potential transfer has been identified.

Relevant parties include, but are not limited to:

- the patient,
- the patient's family, carer, guardian, and nominated support person,
- the administrator and/or Clinical Director of the receiving service (forensic, classified or judicial order patients),
- the Forensic Liaison Officer (forensic patients),
- the Chief Psychiatrist, where the Chief Psychiatrist's approval is required.

A transfer is considered appropriate if the patient is relocating to a place within the catchment area of another AMHS, or if the patient's treatment and care needs would best be met by another AMHS.

Where a person is itinerant or residing in temporary accommodation, it may be more appropriate to defer transfer arrangements until the patient relocates to more stable accommodation.

- The AMHS holding responsibility for the patient's authority or order, and the service covering the area in which the patient is residing, should negotiate the most appropriate means of meeting the patient's treatment and care needs in the interim period.

In addition to collateral material, consultation between AMHSs should include, but is not limited to, the following:

- the anticipated benefits of the proposed transfer for the patient,
- the receiving AMHS's capacity to provide the treatment and care required by the patient, including bed availability and clinical arrangements,
- If relevant; the need for shared case management arrangements for a period to facilitate a smooth transfer of patient care,
- the mutually agreed date that the receiving AMHS will accept the transfer,
- discussion of clinically relevant documents, including the patient's Care Plan, Risk Screen, Recovery Plan, and Transfer of Care document,
- the status and ongoing responsibility for the Act requirements (e.g. outstanding psychiatrist reports), and
- the most recent decision of the Mental Health Review Tribunal (MHRT) or Mental Health Court (the court) and the timing of the next MHRT review.

Outcomes from the above considerations should be readily available to assist with consultation between AMHSs.

1.2.1 Timing for patient transfers

Key Points

Some flexibility may be required for the completion of a Patient Transfer form in certain circumstances (e.g. where urgent admission to an inpatient unit in a receiving AMHS is required).

- In these circumstances, a Patient Transfer form should be completed as soon as practicable, but within **one (1) month** of the patient's relocation to the catchment area of the receiving AMHS.

This flexibility **does not** apply if the MHRT or court has ordered the transfer of responsibility for the patient.

For patients in the community who may transfer between AMHSs over an extended period; ongoing consultation and liaison **must** occur between the referring and receiving treating teams in relation to the patient's treatment and care, including any issues relating to non-compliance with their authority or order.

- Where action is required in response to non-compliance (e.g. in relation to an absence without approval event), responsibility for commencing the required action should be determined by the clinical and risk circumstances at the time of the event and through consultation across the two AMHSs involved in the patient's treatment.

1.3 Transfers for patients in custody

Consistent with the Chief Psychiatrist Policy - Classified Patients, decisions to transfer a patient's involuntary status on reception to, and discharge from, custody should be determined on a case by case basis.

The responsibilities of the AMHS which held the patient's order or authority immediately prior to imprisonment (i.e. the AMHS of origin) **do not** cease upon the patient's imprisonment.

The AMHS of origin should, as far as possible, remain engaged with the patient and maintain contact with the Prison Mental Health Service (PMHS) during the period of imprisonment.

- This includes, but is not limited to, jointly preparing clinical reports for the MHRT.

1.3.1 Sentenced prisoners

Patient Transfers for sentenced prisoners should be negotiated by the PMHS with the patient's AMHS of origin as soon as practicable after the patient's initial contact with PMHS.

- The exception to this is when it is clear that contact with PMHS will only be for a short period of time (e.g. a sentenced prisoner is to be released within the next three months).

1.3.2 Prisoners on remand

A Patient Transfer should be negotiated by the PMHS with the patient's AMHS of origin within **two to three (2-3) months** of initial contact with PMHS, if there is an expectation that the patient will remain in custody for further three or more months.

- It is important that to note that remand status can change quickly and a review of pending court dates should occur when transfer of a patient's order is being considered.

1.3.3 Release from custody

The AMHS of origin should be entered in CIMHA under the 'Cases and Referrals tab' under the 'Current Status menu' by selecting the drop-down option "awaiting return/ release from custody".

Key Points

- Statutory responsibility for the patient should be transferred back to the AMHS of origin immediately at the time of the patient's release from prison.
- Where a patient's mental health treatment and care is to be transferred to another AMHS, the AMHS of origin **must**, with the assistance of the PMHS, provide a Patient Transfer form to the alternative AMHS immediately on the patient's release from custody.
- In all circumstances, PMHS **must** provide the alternative AMHS with collateral material or ensure that it is clearly available on CIMHA.

The requirement for immediate transfer of care to take place when a patient is released from custody is necessary due to the increased risks associated with post-prison release (i.e.

recidivism, relapse and mortality). PMHS **must** ensure that the receiving AMHS (including the AMHS of origin) be provided as much notice as possible prior to the patient's release from custody.

Clear arrangements for contact with the patient by the receiving AMHS should be established prior to, or at the time of, the patient's release from custody.

- The administrator of the receiving AMHS should ensure face-to-face review by a mental health practitioner during the first week following prison release. (Note: a delay in this review **must** not result in a delay in the patient's transfer to the relevant AMHS).

In certain exceptional circumstances, such as where a face-to-face review is not possible it may be necessary to make alternative arrangements.

- For example, due to residence in a remote location, follow up through a remote area nurse or telephone contact during the first week following prison release may be appropriate.
- Where alternative arrangements are necessary, these arrangements **must** be approved by the Clinical Director or, in the absence of the Clinical Director, another senior doctor nominated by the administrator.

If there are concerns regarding the transfer of a patient's involuntary status on reception to, or at discharge from, custody the relevant Clinical Directors of the AMHS and PMHS should be notified. Clinical Directors may escalate concerns to the Chief Psychiatrist if it is deemed necessary, for example if the Clinical Director considers additional oversight is warranted.

1.4 Transfers following an order of the MHRT or Mental Health Court

Key Points

The MHRT or the court may order the transfer of any of the following patients between AMHSs:

- a patient subject to a Treatment Authority
- a patient subject to a Treatment Support Order, or
- a patient subject to a Forensic Order.

The transfer takes effect as soon as the order is made by the MHRT or the court. The receiving AMHS **must** take responsibility for the patient from this time.

The patient's former AMHS **must** ensure that the information outlined in section 1 is available as soon as practicable to support the patient's transfer.

2 Transfers to and from the Forensic Disability Service (FDS)

Key Points

The Chief Psychiatrist and the Director of Forensic Disability may agree to transfer the responsibility for a person subject to a Forensic Order (disability) between an AMHS and the FDS.

Agreement for transfers between an AMHS and the FDS should be determined on a case by case basis, taking account of:

- the transfer considerations,
- the person's intellectual disability,
- legislative authority,
- individual clinical needs,
- the wishes of the person, and
- local arrangements and supports available for the person.

If it appears that a patient needs to be transferred between and AMHS and the FDS, the administrator or Clinical Director should contact the Chief Psychiatrist as soon as practicable to discuss the potential transfer.

3 Transportation

3.1 Patient transport within AMHS

Key Points

An involuntary patient or a classified patient (voluntary) may be transported within an AMHS with the approval of the AMHS administrator or a health practitioner.

- The administrator or health practitioner may also approve another person (e.g. a consumer support worker) to transport the person from one place to another place in the AMHS.
- Transport within services may occur, for example:
  - from one inpatient facility in the AMHS to another inpatient facility in the AMHS
- from a community facility in the AMHS to an inpatient facility in the AMHS, or
- from an inpatient facility in the AMHS to another place for an examination or diagnostic test.

3.2 Patient transport to, or from, an AMHS, PSHSF or another place

Key Points

Transport by an authorised person under the Act may include transportation to, or from:

- an AMHS
- the FDS
- a PSHSF
- a place of custody or a court, or
- a place in the community (e.g. a person's home, supported accommodation, a private health service, etc.).

If a person is being transported to or from a correctional services facility or court, a corrective services officer may transport the patient.

If a young person is being transported to or from a youth detention centre or court, a youth detention employee may transport the patient.

The use of an authorised person to facilitate the transfer should be determined on a case by case basis, having regard to the patient's clinical and risk presentation. It may, for example, be appropriate for a patient to transport themselves or for family or a support person to facilitate the transport.

While an authorised person is acting to transport a patient, they may act with the help, and using the force, that is necessary and reasonable in the circumstances. This includes the ability to detain the person if required.

The authority for authorised persons to transport a patient also apply if the patient is transferring interstate (see section 5).

- Note: the authority to detain or involuntarily medicate or restrain a patient does not apply outside of Queensland. If these measures are required, the AMHS or FDS proposing the transfer interstate **must** consult with the interstate jurisdiction to ensure that the patient can be safely transported and to determine what legislative framework may apply.

3.3 Patient transport after an involuntary examination or assessment

Key Points

The AMHS administrator or person in charge of a PSHSF **must** take reasonable steps to ensure a person is returned to a reasonable place requested by the person if the person was transported to an AMHS or PSHSF under:

- an Examination Authority
- a Recommendation for Assessment, or
- an Emergency Examination Authority that resulted in a Recommendation for Assessment.

Reasonable steps for returning the person include, but are not limited to, providing the person with means to utilise public transport such as taxi, bus, train or ferry.

A person who attends an AMHS or PSHSF under an Examination Order made by a Magistrate should also be reasonably assisted to return to a reasonable place once they are no longer required to be at the AMHS or PSHSF.

3.4 Mode of transport

The Interagency agreement between Queensland Health, Queensland Ambulance Service and Queensland Police, Safe transport of people with mental illness (Interagency agreement) outlines factors that should be taken into account when considering the mode of transport required for a patient transfer.

3.4.1 Air transport

The interagency agreement outlines considerations and requirements for the use of air transport which also apply for transportation that may occur under this guideline. These requirements include:

- Decisions to use air transport will depend on clinical considerations, distance to be travelled, accessibility of the receiving facility by road, and transport availability.
    - As a general rule, air transport is used for journeys that would take more than two (2) hours (one way) by road, however local protocols may vary.
- When arranging air transport, the *Civil Aviation Act 1988* and the relevant air transport provider's policies regarding risk assessment and risk management should be taken into account.
    - This may include physical restraint and/or sedation being required during air transportation.
    - Additional factors should also be considered, such as the potential distress for the patient, requirements of the Act, and the need for safe extubation of an anaesthetised patient at the receiving hospital.

- Should transport via a commercial flight be deemed appropriate, this will be subject to the flight provider's policies, including fitness to fly requirements.

The Clinical Director or administrator of the treating and receiving AMHSs should be involved in the planning of transport where aeromedical transport will be required.

If a Clinical Director or administrator has concerns regarding the use of air transport for transporting a patient under the Act, they should contact the Chief Psychiatrist.

3.5 Request for police assistance

Key Points

If police are being requested to transport a patient, a Request for Police Assistance form **must** be completed by an authorised doctor, AMHP or the AMHS Administrator.

The Request for Police Assistance form **must** include a statement outlining why it is necessary for police to assist with the transport.

- Generally, police should be involved in transport only where their assistance is required for the management of serious risk to the individual or others, or where the person is detained by police (e.g. criminal charges may be, or have been laid)

The local police **must** be contacted by phone if being requested to assist transporting a patient to establish collaborative transport arrangements.

- A QCAD number **must** be obtained by the AMHS through this phone contact and recorded on the Request for Police Assistance form before it is sent to the local police. This number is obtained by contacting the relevant regional police communications centre.

Where practicable, a health practitioner **must** accompany the police when the patient is being transported.

A copy of the form **must** be sent to the AMHS administrator and placed on the patient's clinical record on CIMHA.

3.6 Administration of medication

Key Points

If required, medication may be provided to transport an involuntary patient [but not a classified patient (voluntary)]. This includes patients who are detained in an AMHS for the purposes of an involuntary assessment.

Medication may only be administered:

- by a doctor or registered nurse acting under a doctor's instruction, and
- if there is no other reasonably practicable way to protect the patient or others from harm.

If medication is required, it should only be administered immediately prior to, or during, the transportation.

All instances of medication for transportation **must** also comply with the Chief Psychiatrist Policy – Clinical Need for Medication.

Administration of medication may, for example, be required when the patient is being moved from a rural or remote area to a regional PSHSF to access inpatient treatment in an AMHS.

3.7 Use of mechanical restraint

Subject to the Chief Psychiatrist's approval, mechanical restraint may be used by an authorised person to transport an involuntary patient, if there is no other reasonably practicable way to protect the person or others from physical harm.

- This provision does not apply to classified patients (voluntary)

Key Points

The Chief Psychiatrist's approval to use mechanical restraint **must** be sought prior to the transportation occurring and should only be utilised for the planned transportation of an involuntary patient.

The Chief Psychiatrist **must** be contacted by the treating psychiatrist or psychiatrist on call immediately if mechanical restraint is proposed to be used.

An Application for Approval to Use Mechanical Restraint **must** be sent to the Chief Psychiatrist.

- A verbal application may be made to the Chief Psychiatrist if required under the circumstances. Verbal approval may also be provided if required in urgent circumstances.
- An Application **must** be sent to the Chief Psychiatrist as soon as practicable after the verbal approval was granted. Verbal approval **must** be recorded on the Application.

The Application **must** be completed by an authorised doctor and include:

- the name of the patient
- details of the person's mental condition, including diagnosis and current treatment
- the purpose of mechanical restraint
- the reasons that the authorised doctor believes there is no other reasonably practicable way to protect the patient or others from physical harm
- the way in which the patient will be continuously observed

- any proposed limitations on the use of mechanical restraint (for example, maximum time periods proposed by the doctor)
- the name of the device proposed to be utilised, and
- the proposed period for which the approval is sought.

The Chief Psychiatrist's approval is provided on the Application for Approval to Use Mechanical Restraint form.

Following the Chief Psychiatrist's approval, an authorised doctor may then authorise the use of the mechanical restraint on the patient for transport purposes.

- Authorisation for mechanical restraint is given by completing the Authorisation of Mechanical Restraint form. This form **must** be recorded on CIMHA.

An authorised doctor's authorisation for mechanical restraint **must** be based on a face to face medical review of the patient.

Applications for, and use of, mechanical restraint **must** comply with the Chief Psychiatrist Policy – Mechanical Restraint.

This application process **does not** apply to the restraint of a person that is authorised or permitted under another law. For example, the use of mechanical restraint by a police officer may be authorised under the Police Powers and Responsibilities Act 2000.

3.8 Warrants

Entry to premises for the purposes of transporting a patient will usually occur with the consent of the occupier of the premise.

When consent to enter cannot be obtained, and entry is considered necessary to enable the transport to occur, a warrant may be required.

A warrant is not required to enter a place without consent in the following circumstances:

- the premise is a public place and the entry is made when the place is open to the public, or
- an Examination Authority has been issued by the MHRT.

In addition, police are authorised under the *Police Powers and Responsibilities Act 2000* to enter a place without consent under prescribed circumstances.

3.8.1 Application for warrant

Key Points

An authorised person, including a police officer, may apply to a Magistrate for a Warrant for Apprehension of Person if it is considered necessary to enable the authorised person to transport a person who is absent without approval for examination, assessment, or treatment and care.

- The application is made via the Application for Warrant for Apprehension of a Person form.

The Application **must** be sworn before a justice of the peace or commissioner for declarations.

If the authorised person is a health practitioner, the forms should be uploaded to the patient's clinical record in CIMHA once sworn.

3.8.2 Issue of warrant

Key Points

A Magistrate may issue a Warrant for Apprehension of Person if satisfied it is necessary to enable the authorised person or police officer to transport a person for examination, assessment, or treatment and care to an AMHS or PSHSF.

The Warrant for Apprehension of Person authorises an authorised person, including a police officer to:

- enter the place where the person is reasonably believed to be
- search the place to find the person
- remain in the place as long as reasonably necessary to find the person, and
- transport the person to a stated AMHS or PSHSF.

The Warrant for Apprehension of Person **must** include the date it is issued and an expiry date. The expiry date **must** be within **seven (7) days** from the date of issue.

3.8.3 Form of warrant

Key Points

A Warrant for Apprehension of Person may be made by phone, fax, email, radio, videoconferencing or another form of communication if it is reasonably considered necessary because of:

- urgent circumstances, or
- other special circumstances, including, for example, the authorised person's remote location.

A facsimile or electronic copy of the Warrant, or the Form of Warrant form, properly completed by an authorised person or police officer, authorises the exercise of powers under the Warrant made by the Magistrate.

The authorised person or police officer **must** complete an Application for Warrant for Apprehension of a Person and, at the first reasonable opportunity, send to the Magistrate:

- the sworn Application, and
- if the authorised person compiled a Form of Warrant, the completed Form of Warrant.

3.8.4 Procedure before entry

Key Points

If an authorised person or police officer intends to enter a place under a Warrant for Apprehension of Person, the authorised person or police officer **must**:

- identify him/herself to a person present at the place who is an occupier of the place, and
- give the person a copy of the Warrant for Apprehension of Person, and
- tell the person the authorised person or police officer is permitted to enter and search the place to find the person, and
- give the person an opportunity to allow an authorised person immediate entry to the place without using force.

However, these requirements do not need to be complied with if the authorised person or police officer reasonably believes immediate entry is necessary to ensure the effective execution of the warrant.

4 Notifications

Key Points

Patient Transfer forms **must** be kept on the patient's clinical record in CIMHA.

The referring AMHS administrator (or delegate) **must** provide the MHRT a copy of the Patient Transfer form, within **seven (7) days** after the involuntary patient's transfer between AMHSs.

- If the Chief Psychiatrist directs the transfer of an involuntary patient, the Chief Psychiatrist **must** make this notification.

Notification to the MHRT is not required for:

- a person detained in an AMHS for the purposes of an Examination Authority
- a person detained in an AMHS for involuntary assessment, and

- classified patients (voluntary).

The referring AMHS administrator (or delegate) **must** also provide a copy of Patient Transfer form to the Chief Psychiatrist for:

- classified patients, where separate approval is not also required, and
- patients who are also subject to Chapter 4, Part 2 (Psychiatrist Reports).

If a reference has been made to the court for the patient being transferred, the referring AMHS administrator **must** send a copy of the Patient Transfer form to the court registry via: registrarmhc@health.qld.gov.au.

5 Interstate transfers

Mental health legislation in a number of jurisdictions requires an interstate agreement to be in place prior to a transfer occurring across jurisdictions. These interstate agreements govern the movement of particular involuntary patients across interstate borders.

Although Queensland does not require an interstate agreement to be in place, these **must** be followed if the receiving jurisdiction's legislation includes this requirement.

Civil interstate agreements may be in place for orders made by psychiatrists or tribunals such as Treatment Authorities.

Forensic interstate agreements apply to orders made by a court or tribunal such as Queensland Forensic Orders and Treatment Support Orders.

If it appears that a patient needs to be transferred into, or out of, Queensland, the Administrator or Clinical Director should contact the Office of the Chief Psychiatrist as soon as practicable to discuss the potential transfer.

5.1 Authority to transfer patients subject to a Treatment Authority out of Queensland

Key Points

Subject to any requirements of the interstate jurisdiction, an AMHS Administrator may agree with the responsible officer of an interstate mental health service to the transfer of a patient subject to a Treatment Authority out of Queensland and to an interstate AMHS.

An interstate transfer should be determined on a case by case basis, and the AMHS Administrator **must** be satisfied:

- the transfer is in the best interests of the person, including, for example, enabling the person to be closer to the person's family, carers or other support persons, and

- appropriate treatment and care is available for the person at the interstate mental health service.

If a patient on a Treatment Authority is transferred out of Queensland, their Treatment Authority ends when the person leaves Queensland.

An AMHS Administrator **cannot** agree to the interstate transfer of a patient on a treatment authority if the patient is a classified patient or also subject to a forensic order (disability).

However, it may be preferable to arrange a formal transfer of responsibility for the patient rather than revoking their authority. The treating AMHS in Queensland should have regard to the Chief Psychiatrist Policy - Treatment Authorities when determining if a Treatment Authority should be transferred or revoked prior to an interstate move.

5.2 Authority to transfer patients subject to an interstate equivalent of a Treatment Authority into Queensland

Key Points

Subject to any requirements of the interstate jurisdiction, an AMHS Administrator may agree with the responsible officer of an interstate mental health service to the transfer of a patient subject to an order equivalent to a Treatment Authority, into an AMHS in Queensland.

An interstate transfer into Queensland should be determined on a case by case basis, and the AMHS Administrator **must** be satisfied:

- the transfer is in the best interests of the person, including, for example, enabling the person to be closer to the person's family, carers or other support persons,
- appropriate treatment and care is available for the person at the AMHS, and
- an authorised doctor is likely to consider, on the person's admission to the Queensland AMHS, that:
    - the treatment criteria apply to the person, and
    - there is no less restrictive way for the person to receive treatment and care for the person's mental illness.

When the person is first transported (or arrives) and is received at the AMHS, an authorised doctor **must** make an assessment of the person to decide:

- whether the treatment criteria apply to the person, and
- whether there is a less restrictive way for the person to receive treatment and care for the person's mental illness.

The person may be detained for the purpose of the assessment, for up to **six (6) hours** from the time the person is admitted to the AMHS.

If the authorised doctor determines that person requires a Treatment Authority, they **must** determine whether the authority is inpatient or community category.

If the authorised doctor determines that the person does not require a Treatment Authority, the person can continue to receive treatment as a voluntary patient in Queensland.

5.3 Authority to transfer patients subject to a Forensic Order or Treatment Support Order (or interstate equivalent) into, and out of, Queensland

Key Points

The MHRT is responsible for determining applications for interstate transfers into and out of Queensland for patients' subject to Forensic Orders (or their interstate equivalent) or Treatment Support Orders. This responsibility applies to:

- Forensic Orders (mental health)
- Forensic Orders (disability), and
- Treatment Support Orders.
- The MHRT's decision **must** take account of any legislative requirements of the interstate jurisdiction (for example, whether an interstate agreement is required). The MHA 2016 refers to these requirements as 'interstate transfer requirements'.

The interstate transfer provisions **do not** apply to classified patients or patients on forensic orders or treatment support orders, who have been found to be temporarily unfit in relation to an alleged offence by the court, unless the patient's charges have been discontinued or the prescribed period for the charges has ceased[2].

The Administrator or Clinical Director should contact the Office of the Chief Psychiatrist as soon as practicable to discuss any potential transfer into, or out of, Queensland. Contact

[2] The prescribed period is 7 years from the date of the Mental Health Court decision for an offence for which the person is liable to life imprisonment; or otherwise, 3 years from the date of the Mental Health Court decision. Discontinuation of charges must be confirmed by the DPP.

should be maintained throughout the transfer process to ensure all legislative requirements are met.

5.3.1 Applications to transfer out of Queensland

Key Points

Subject to any interstate transfer requirements, the MHRT may approve the transfer of a patient subject to a Forensic Order or Treatment Support Order to an interstate mental health service.

An application to transfer out of Queensland may be made by a patient subject to a Forensic Order or Treatment Support Order, or an interested person on their behalf.

An Application to Transfer Interstate form **must** be completed and state:

- the reasons why the transfer would be in the best interests of the person, and
- include a written statement from the relevant person stating whether the interstate transfer requirements may be satisfied.

A relevant person is:

- if an AMHS is responsible for the person – the Chief Psychiatrist; or
- if the FDS is responsible for the person – the Director of Forensic Disability.

If the application requirements are met, the MHRT will conduct a hearing and **must** approve or refuse the transfer.

A decision of the MHRT to approve a transfer interstate will only be made if:

- the transfer is in the best interests of the person, for example, to enable the person to be closer to support persons
- appropriate treatment and care is available at the interstate mental health service, and
- adequate arrangements are in place to protect the safety of the community.

The tribunal may give approval subject to conditions it considers appropriate.

MHRT approval for a transfer out of Queensland only takes effect once the interstate transfer requirements are satisfied.

Throughout the application process, the treating team in Queensland should regularly consult with the treatment team in the receiving jurisdiction. This consultation should consider both clinical and legislative requirements in relation to the transfer.

Once patient is transferred to an interstate mental health service, the patient's Forensic Order or Treatment Support Order is **suspended** and regular reviews by the MHRT are not required.

- If the patient returns to Queensland, their order is immediately reinstated and remains in effect while they are in Queensland.

If the patient does not return to Queensland, their Forensic Order or Treatment Support Order ends **three (3) years** after the transfer takes place, if during the **three (3) year** period they have been continuously absent from Queensland.

If the order has a non-revocation period, the order ends after the non-revocation period if it is longer than **three (3) years** from when the person is transferred.

5.3.2 Applications to transfer into Queensland

Subject to any requirements of the interstate jurisdiction, the MHRT may approve the transfer of a patient subject to an order that is the interstate Forensic Order into an AMHS in Queensland.

Key Points

An application to transfer into Queensland may be made by a patient on an interstate Forensic Order, or an interested person on their behalf.

An interstate forensic order is an order made under a corresponding law of another state that provides for similar matters to a Queensland Forensic Order.

The Application to Transfer Interstate form **must** state:

- the reasons why the transfer would be in the best interests of the person
- the AMHS (or FDS) proposed to be responsible for the person, and
- a written statement from the relevant person stating whether the interstate transfer requirements may be satisfied.

A relevant person is:

- if an AMHS will be responsible for the person – the Chief Psychiatrist; or
- if the FDS will be responsible for the person – the Director of Forensic Disability.

If the application requirements are met, the MHRT will conduct a hearing and **must** approve or refuse the transfer. The Queensland AMHS is a party to these proceedings and will need to provide information to the MHRT about how the patient's treatment and care needs will be met in Queensland.

A decision of the MHRT to approve a transfer into Queensland will only be made if:

- the transfer is in the best interests of the person, for example, to enable the person to be closer to support persons
- appropriate treatment and care is available at the proposed AMHS (or appropriate care if the FDS), and
- a forensic order is necessary because of the person's mental condition to protect the safety of the community, including from the risk of serious harm to other persons of property.

The tribunal may give approval subject to conditions it considers appropriate.

If the MHRT approves the transfer into Queensland, the MHRT **must** make:

- a Forensic Order (mental health) or a Forensic Order (disability).

The Queensland Forensic Order takes effect when the interstate transfer requirements for the person have been satisfied and the person arrives in Queensland.

Throughout the application process, consultation **must** occur between the treating team in Queensland and the referring jurisdiction. This consultation should consider both clinical and legislative requirements in relation to the transfer.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
22 May 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
FDS	Forensic Disability Service
Employee	of an authorised mental health service that is a public sector mental health service, means a health service employee in the service.
HHS	Hospital and Health Service
QCAD	Queensland Computer-Aided Dispatch.
QCAD ID	This is the case identification number provided by Police Communications
The Act	Mental Health Act 2016

Referenced documents and sources

- Application for Approval to use Mechanical Restraint Form
- Application for Warrant for Apprehension of a Person form
- Application to Transfer interstate form
- Authorisation of Mechanical Restraint form
- Form of Warrant form
- Patient Transfer form
- Request for Police Assistance form
- Warrant for Apprehension of Person form

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To be reviewed by:	1 June 2023

Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
AMHS Administrator	Phone: Email:
Clinical Director	Phone: Email:
Queensland Ambulance Service	Phone: Email:
Queensland Police Service	Phone: Email:
Retrieval Services Queensland	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Mental Health Act 2016
Chief Psychiatrist Policy

Treatment and care of patients subject to a Forensic Order, Treatment Support Order or other identified higher risk patients

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General

This policy establishes a clinical governance framework for the management of patients subject to a Forensic Order (FO) or, Treatment Support Order (TSO), and a systematic approach for the identification, assessment and management of other patients identified as a higher risk toward others or to property (higher risk patients). This includes those patients whose FO was made on a reference in relation to a 'prescribed offence' allegedly committed by the person (see section 3.2).

Various domains of risk require assessment and management. All identified risks must have documented interventions to manage them however this policy is focused on risk of harm to others and property.

The monitoring and review of FO, TSO and identified higher risk patients is the responsibility of the authorised mental health service (AMHS).

- This policy sets out the responsibility of the administrator and clinical directors (as nominated by the administrator) at each AMHS.
- Clinical directors are to ensure they have appropriate knowledge of all FO, TSO and identified higher risk patients in the service and make appropriate recommendations or decisions for the person's treatment and care.
- Clinical directors should establish local processes for the identification of higher risk patients.

While it is not possible to identify and eliminate risk entirely, the objective of good clinical risk management is to minimise the likelihood of an adverse outcome. To this end, various mechanisms for assessment and review within the service outside of the consumers treating team are outlined within this policy in section 2.

Scope

This policy should be read in conjunction with the Chief Psychiatrist Policy – Forensic Orders and Treatment Support Orders: Amending category, conditions and Limited Community Treatment.

This policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner (AMHP), AMHS administrator, or other person performing a function or exercising a power under the *Mental Health Act 2016* (the Act) **must** comply with this Policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

The Act promotes the recovery of a person who has a mental illness and the person's ability to live in the community without the need for involuntary treatment and care. Where any rights and liberties of a patient are restricted, these restrictions should only be to the extent required to protect the patient's safety and welfare or the safety of others.

1 Decisions of the Court

Under the Act, the Mental Health Court (the Court) may make a:

- Forensic Order (mental health)
- Forensic Order (disability), or
- Treatment Support Order.

In making a decision in relation to an order, the Court **must** have regard to:

- the relevant circumstances of the person,
- the nature of the offence to which the reference relates and the period of time that has passed since the offence was allegedly committed,
- any victim impact statement, and
- this Chief Psychiatrist policy.

The consideration of this policy is important in the Court deciding whether to make a Forensic Order or Treatment Support Order for a person.

Examples of the types of decisions to be made include:

- whether a Forensic Order or Treatment Support Order is necessary,
- the category of the order,
- whether the person is to receive any treatment in the community, and
- deciding the conditions, if any, to impose on the order.

When a Treatment Support Order is made, the Court may only decide the category of the order is inpatient if the person's treatment and care needs or the safety or welfare of the person or others cannot reasonably be met in the community. The general expectation is that when a person is made subject to a Treatment Support Order the category of the order is community.

2 Framework and mechanisms for risk management and review

2.1 Risk mitigation and clinical governance

2.1.1 Assessment and Risk Management Committee

AMHS administrators **must** establish an ARMC at the AMHS in accordance with the

Attachment 2 - Terms of Reference for Assessment and Risk Management Committee (Attachment 2).

The ARMC framework established **must** be consistent with the three-tier risk assessment approach in the Violence and Risk Management Framework (VRAM Framework) (Section 2.1.3) and local patient risk assessment protocols for the service.

The clinical director is responsible for facilitating the operation and function of the ARMC.

The ARMC's role is of a clinical nature and functions as a peer review of the treatment and care of patient's subject to a Forensic Order, Treatment Support Order and other identified patients. To the greatest extent possible ARMC membership should comprise persons from multi-disciplinary backgrounds across medical, nursing and allied health.

The National Safety and Quality Health Service Standards and the National Standards for Mental Health Services articulate the need for an integrated risk management approach which is inclusive of assessment and review of the person's treatment, care and recovery plan. ARMC review processes do not replace the need for these additional strategies. A review of a patient's treatment, care and recovery plan **must** occur at least every **three (3) months**, consistent with the National Standards for Mental Health Services.

Whilst the ARMC does not replace existing processes for patient risk assessment and review, it may be facilitated in and as part of one of these reviews.

In accordance with the ARMC Terms of Reference, ARMC minutes for each individual patient **must** be uploaded onto the Consumer Integrated Mental Health Application (CIMHA) as an ARMC attachment summary.

A patient subject to a Forensic Order or Treatment Support Order **must** have their treatment and care reviewed by the ARMC when:

- a patient who was subject to a Forensic Order has their order 'stepped down' to a Treatment Support Order by the MHRT or Court (on appeal), within **ninety (90) days** of the Treatment Support Order being made, or
- there is an increase to the patient's risk requiring further assessment (Tier 2 or Tier 3 of VRAM Framework) that resulted in a change to their Care Plan, or
- at any other time the clinical director, administrator or Chief Psychiatrist determines that a review should occur.

There may be circumstances that exist outside the above requirements where an ARMC review may be appropriate such as where an individual has historically been on either a Forensic Order or Treatment Support Order and a significant change in circumstances or increase in risk is identified.

Examples of when the clinical director, administrator or Chief Psychiatrist determines a review should occur may include:

- if a patient's personal circumstances have changed significantly
- if a patient is being placed on a community category order after an extended inpatient admission, or
- a patient is being considered for revocation of a Treatment Support Order.

2.1.1.1 Monitoring compliance with ARMC recommendations

AMHS administrators **must** have a process for reviewing compliance with ARMC recommendations and a process by which decisions not to implement the recommendations from ARMC are escalated within the AMHS.

2.1.1.2 Information sharing

AMHS administrators and clinical directors may share or authorise sharing of information about their established ARMC framework and processes with other AMHS.

- This seeks to reduce inconsistencies across different ARMC frameworks in each AMHS and assist services in meeting the minimum requirements of the ARMC Terms of Reference.

The Mental Health Review Tribunal (MHRT) may request documentation, including ARMC minutes, under the request for documentation provisions of the Act. Services **must** comply with these requests.

However, the service may apply to the MHRT for consideration of a confidentiality order to prevent the disclosure of information to the patient, if the information is likely to cause serious harm to the health of the patient or put the safety of someone else at serious risk.

2.1.2 Community Forensic Outreach Service (CFOS) and Child and Youth Forensic Outreach Service (CYFOS)

Note: If the patient is not an adult, then a reference to CFOS should be taken to refer to CYFOS.

2.1.2.1 Referral to CFOS/CYFOS

Liaison with or referral to specialist forensic services such as CFOS or CYFOS **must** occur when:

- a Forensic Order or Treatment Support Order is made for a person charged with a prescribed offence (see 3.2),
- a patient is identified through the VRAM Framework Tier 2 risk assessment and response process as having a significantly elevated risk profile that is unable to be appropriately managed without specialist forensic input,
- a patient is an inpatient at The Park Centre for Mental Health – High Security Program or the Extended Forensic Treatment and Rehabilitation Unit, within a reasonable time to support community transition in collaboration with the receiving AMHS, or
- revocation of a Forensic Order is being considered to determine whether there is a need for CFOS opinion.

At all other times, referrals are to be made using CFOS referral criteria.

2.1.2.2 Reviews and assessments by CFOS/CYFOS

After the review and assessment of the patient's treatment and care, CFOS will issue a written document (i.e. a report, letter or case note) and discuss the assessment with the treating team.

Any recommendations about a patient's treatment and care **must** be provided to the AMHS in writing.

The MHRT may request documentation, including CFOS assessments and reports, under the request for documentation provisions of the Act. Services **must** comply with these requests.

However, the service may apply to the MHRT for consideration of a confidentiality order to prevent the disclosure of information to the patient, if the information is likely to cause serious harm to the health of the patient or put the safety of someone else at serious risk.

2.1.2.3 Recommendations about a patient's care plan

Prior to releasing any recommendations to the AMHS, the CFOS psychiatrist or clinician who undertook the assessment of the patient **must** discuss the recommendations with the patient's treating psychiatrist.

This discussion **must** occur as soon as practicable after recommendations are determined.

Key points

Within **fourteen (14) days** of receipt of the recommendations from CFOS, the treating psychiatrist must either:

- implement the recommendations within the patient's Care Plan, and
    - document in the patient's Care Plan when and how the recommendations will be implemented; or
- when the treating psychiatrist does not intend to implement the recommendations into the patient's Care Plan:
    - the treating psychiatrist is to discuss the recommendations and the rationale for not implementing with the clinical director,
    - at the clinical director's discretion, an ARMC (which may invite the CFOS report writer/s) may be called to discuss and consider the recommendations and rationale,
    - if after the discussion with the treating psychiatrist and/or the ARMC, the clinical director is satisfied the recommendations should not be implemented, the clinical director must outline this rationale to the clinical director of CFOS.
        - This discussion must occur as soon as practicable, and
        - a written rationale is to be provided to the Chief Psychiatrist and Statewide Director, Queensland Forensic Mental Health Service outlining the agreed clinical plan which should explicitly address risk mitigation strategies.

CFOS may recommend when a patient should be reviewed and assessed by CFOS again or be reviewed by the ARMC.

- The recommendation for next review by CFOS **must** be implemented into the patient's Care Plan.
- The recommendation of a review occurring by the ARMC **must** occur within the time recommended by CFOS.

2.1.3 Violence Risk Assessment and Management Framework

The VRAM Framework provides Queensland Health mental health services with a systematic approach for the identification, assessment and management of consumers who may pose a risk of violence1 towards others that supports clinical practice and governance.

The VRAM Framework aims to support a structured and standardised approach to risk assessment and management through the provision of a three-tiered approach, principles of good practice, clinical tools to underpin clinical expertise, training, and a quality assurance cycle for continuous improvement.

[1] Violence is defined as the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (World Health Organisation 1996).

The focus for risk assessment as outlined in the VRAM Framework is not to categorise the person into a risk group (e.g. lower or higher) but rather to identify how best to manage potential harm. A VRAM assessment for a patient subject to a Forensic Order or Treatment Support Order or patients who may pose a risk of violence towards others, should inform care planning, risk management planning and local procedures.

2.1.4 Other mechanisms for assessment of risk and review

The National Standards for Mental Health Services set out additional requirements for review of a consumer's assessment, treatment and care and recovery planning. However, in response to clinical situations, additional ad-hoc reviews to support decision making may be undertaken such as:

- ARMC
- complex case reviews, or
- other locally developed processes.

3 Monitoring and review

3.1 Person subject to a Forensic Order

A psychiatrist **must** assess and determine the treatment and care needs of a person subject to a Forensic Order as soon as practicable, but within **seven (7) days** of the patient becoming subject to the Forensic Order.

Key points

The ARMC **must** review the treatment and care of a patient within **thirty (30) days** of a patient being made subject to a Forensic Order.

- At the first ARMC, consideration **must** be given to whether a referral to CFOS is appropriate.
  - Note: CFOS **must** review all person's subject to a Forensic Order charged with a prescribed offence (see 2.1.2).
- If the person subject to a Forensic Order is not an adult, consideration should be given to the appropriateness of a referral to CYFOS.

The ARMC **must** review the treatment and care of a person subject to a Forensic Order a **minimum of twice per year**, at intervals of no more than **six (6) months**.

Note: The frequency of ARMC reviews should be determined according to a patient's risk profile.

Reviews may be scheduled earlier or more frequently than mandated timeframes. The ARMC, informed by advice from the treating team, **must** determine the monitoring and review frequency of the patient by the:

- principal service provider (case manager or equivalent),
- forensic liaison officer, and
- an authorised psychiatrist.

Outside the above monitoring and review timeframes, the clinical director is to be notified and briefed with any information required in the following circumstances:

- a patient's matter has been escalated to the Chief Psychiatrist (see section 7.3),
- the patient has required further violence risk assessment at Tier 2 or 3 of the VRAM Framework which has resulted in a change to their Care Plan,
- there is a material change to the patient's circumstance,
- limited community treatment (LCT) is breached, suspended or cancelled, or
- at any other time the clinical director, administrator or Chief Psychiatrist determines that a review should occur.

On notification of the relevant circumstance, the clinical director may, at their own discretion, determine that an ARMC should be held to review the person's treatment and care. The Chief Psychiatrist may determine and advise the administrator or clinical director that an ARMC **must** be held to discuss the circumstance and review a person's treatment and care.

3.2 Persons charged with a prescribed offence

Key points

Patients charged with a prescribed offence **must** be reviewed and assessed by CFOS/CYFOS within **sixty (60) days** of the FO being made by the Court.

- The treating team is responsible for submitting a timely referral to CFOS/CYFOS, noting the timeframe allowed for completion of the assessment.
- The exceptions are persons detained as an inpatient to The Park Centre for Mental Health – High Security Program.
- If the patient is under 18, review and assessment should be undertaken by CYFOS.

The CFOS/CYFOS assessment is to assist in the determination of:

- the patient's current risk profile,
- formulation of risk mitigation and management strategies, and
- making recommendations to a patient's Care Plan.

3.3 Person subject to a Treatment Support Order

Key points

A patient subject to a Treatment Support Order **must** have their treatment and care reviewed by the ARMC when:

- a patient who was subject to a Forensic Order has their order 'stepped down' to a Treatment Support Order by the MHRT or Court (on appeal), within **ninety (90) days** of the Treatment Support Order being made, or
- there is an increase to the patient's risk requiring further assessment at Tier 2 or Tier 3 of VRAM Framework that resulted in a change to their Care Plan, or
- at any other time the clinical director, administrator or Chief Psychiatrist determines that a review should occur.

At all other times the monitoring and review timeframes are to be determined by the patient's treating psychiatrist.

3.4 Person identified on the basis of risk of harm to others or property

Key points

A patient who has been identified on the basis of risk of harm to others must have their treatment and care reviewed by the ARMC when:

- there is an increase to their risk requiring further assessment at Tier 2 or Tier 3 of the VRAM Framework that resulted in a change to their Care Plan,
- there is a material change to the patient's circumstance, or
- at any other time the clinical director, administrator or Chief Psychiatrist determines that a review should occur.

4 Clinical director responsibilities

Key points

The clinical director must ensure:

- they are clinically satisfied with the person's treatment and care (e.g. current access to LCT or future LCT arrangements are considered clinically appropriate at any given time),
- that the ARMC is well informed of the current treatment and care plans it reviews,
- that any recommendations or changes made by the ARMC to the person's treatment and care are documented in the person's Care Plan, and
- that any identified issues requiring escalation are escalated in accordance with the escalation pathway in section 7.3.

The clinical director **must** consider the information that is provided to them from the treating team, forensic liaison officer, CFOS representative or other clinicians in making recommendations or decisions about a person's treatment and care.

If they are not satisfied with the information provided or require further information, the clinical director may seek any information or conduct investigations in order to fulfil their role.

5 Patient Summary

The administrator must ensure patients subject to a Forensic Order or Treatment Support Order and other patients identified as requiring higher level of clinical monitoring on the basis of risk of harm to others, have an Involuntary Patient and Voluntary High-Risk Patient Summary with current information and circumstances completed and recorded on CIMHA at all times.

6 Photographs

A patient subject to Treatment Support Order may be photographed if determined by the treating team, clinical director or administrator as appropriate to do so.

All Forensic Order patients **must** be photographed.

Photographs **must** be uploaded to CIMHA **annually** or as changes to appearance are noted.

7 Reporting to the Chief Psychiatrist

7.1 Immediate reporting

Patient matters **must** be reported to the Chief Psychiatrist immediately when the patient is subject to a Forensic Order or their risk profile is assessed as higher by the treating team and the matter has resulted in:

- media attention,
- controversial events or situations,
- serious and/or continued breaches of LCT, or
- any matter the administrator or clinical director considers is of such importance that it should be reported to the Chief Psychiatrist.

7.2 Reporting

Administrators are required to report matters regarding the treatment and care of patients subject to this policy to the Chief Psychiatrist as part of ongoing monitoring and compliance reports, or at other times as directed by the Chief Psychiatrist.

The Chief Psychiatrist may request an administrator to provide a report regarding any ARMC meeting or any aspect of the ARMC framework established.

7.3 Escalation Pathways

Key points

When concerns or disputes within the treating team arise in relation to a patient's treatment and care subject to this policy, the following escalation pathway **must** be followed:

- a member of the treating team, other than the psychiatrist, is to raise their concerns with the psychiatrist,
- if, after speaking with the psychiatrist, the member of the treating team still has concerns they are to escalate the matter to the clinical director,
- if after speaking with the clinical director, the member of the treating team still has concerns, they are to escalate the matter to the administrator of the AMHS,
- if after speaking with the administrator, the member still has concerns or if the administrator is the clinical director for that particular patient, the member of the treating team is to escalate the matter to the Chief Psychiatrist.

When concern or dispute arises between services:

- the matter is to be escalated to the administrators of each service, or
- if the concern or dispute still cannot be resolved, the matter is to be escalated to the executive director of the service and the Chief Psychiatrist.

Issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly
Chief Psychiatrist, Queensland Health
22 May 2020

Definitions and abbreviations

Term	Definition
AMHP	Authorised mental health practitioner
AMHS	Authorised Mental Health Service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
EPOA	Enduring Power of Attorney
Clinical Director	A senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the clinical director functions and responsibilities.
Identified Higher Risk Patients	Patients identified as a higher risk toward others, or to property.
Patient	An involuntary patient, or A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.
Prescribed Offence	An offence against the Criminal Code of: murder, punishment of murder, manslaughter, punishment of manslaughter, attempt to murder, acts intended to cause grievous bodily harm and other malicious acts, grievous bodily harm, rape, attempt to commit rape, and assault with intent to commit rape.
Support person	An appointed Nominated Support Person or, if the person does not have a Nominated Support Person, a family member, carer or other support person
Violence	The intentional use of physical force or power, threatened or actual, against oneself, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.
Violence Risk Assessment Management Framework (VRAM Framework)	Refers to the Violence Risk Assessment and Management Framework – Mental health services 2019. This Framework provides Queensland Health mental health services with a systematic approach for the identification, assessment and management of consumers who may pose a risk of violence towards others.
VRAM	Violence Risk Assessment and Management tool utilised to inform care planning, risk management planning and local procedures in the management of patient's subject to a forensic order, treatment support order or patients who may pose a risk of violence towards others or property.

Referenced documents and sources

The National Safety and Quality Health Service Standards
National Standards for Mental Health Services
VRAM Framework

Document status summary

Date of Chief Psychiatrist approval:	22 May 2020
Date of effect:	1 June 2020
Supersedes version that took effect on:	5 September 2018
To be reviewed by:	1 June 2023

Attachment 1 – Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Local Administrator	Phone: Email:
Local Independent Patient Rights Adviser	Phone: Email:
Mental Health Review Tribunal	Phone: Email:
Community Forensic Outreach Service	Phone: Email:
Community Youth Forensic Outreach Service	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Attachment 2 - Terms of Reference for Assessment and Risk Management Committee

Purpose

The Assessment and Risk Management Committee (ARMC) provides a forum for clinical discussion and case review. The ARMC's role is of a clinical nature and functions as a peer review of the treatment and care of patient's subject to a forensic order, or treatment support order, and other patients identified as a higher risk toward others, or to property (higher risk patients).

Function

The ARMC will:

- review the treatment and care of required patients under the Chief Psychiatrist Policy – Treatment and care of patients subject to a treatment support or forensic order or other identified higher risk patients,
- make recommendations or decisions about a patient's treatment and care,
- identify systemic issues in relation to the management of the forensic and other higher risk patients, and
- determine the frequency of monitoring and assessment of forensic and other higher risk patients by the case manager (or equivalent), forensic liaison officer and an authorised psychiatrist.

Membership

The ARMC **must** include at least:

- the clinical director (**must** be a psychiatrist nominated by the administrator),
- the treating psychiatrist and other members of the persons treating team,
- the forensic liaison officer, and
- a representative from the Community Forensic Outreach Service (CFOS).
    - If the patient is not an adult, then a representative from the Child and Youth Forensic Outreach Service (CYFOS) should be present instead.

The Chief Psychiatrist (or proxy) may attend any ARMC meeting.

The ARMC may invite others to be part of the meeting. Others may include, but are not limited to:

- the patient
- a representative from a relevant non-government organisation or disability services, or
- the person's attorney or nominated support person.

Member responsibilities

It is expected that all members will:

- attend and contribute to meetings, or nominate a proxy,
- ensure any nominated proxy is briefed about the content of the ARMC, and
- ensure that all members have an opportunity to contribute to the discussion.

Proxy

Members may nominate a proxy to attend the meeting on their behalf. The proxy for the clinical director **must** be a psychiatrist who is not the current treating psychiatrist for the patient.

A proxy for the treating psychiatrist **must** be a psychiatrist.

Governance

The ARMC will be chaired by the clinical director or nominated proxy.

A Secretariat should be nominated by the AMHS. The Secretariat will be responsible for:

- compiling and sending an agenda and minutes,
- coordinating and preparing background information, and
- coordinating and facilitating meeting requirements.

Minutes

Minutes of each ARMC **must** be documented and at minimum note:

- who attended the ARMC,
- what information and evidence was before the ARMC,
- any of the concerns raised by members of the ARMC,
- any recommendation or changes made by the ARMC to the person's treatment and care after review and any rationale for the recommendation or changes, and
- the actions to be taken, and by whom, to ensure the recommendations or changes are actioned.

Frequency of meetings

Meetings are to be held in accordance with the Chief Psychiatrist Policy – Treatment and care of patients subject to a treatment support or forensic order or other identified higher risk patients.

Quorum

Meetings will proceed on the basis that the clinical director, treating psychiatrist, forensic liaison officer and a representative from CFOS (or CYFOS where relevant) are represented.

Review of Terms of Reference

The Terms of Reference may be amended at any time by the Chief Psychiatrist.

Mental Health Act 2016

Chief Psychiatrist Policy

Treatment and care of minors

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Queensland Government

General

The *Mental Health Act 2016* (the Act) recognises and promotes the best interests of minors receiving mental health treatment and care. Under the Act, a minor is an individual who is under 18 years of age.

Minors should have their specific needs, wellbeing and safety recognised and protected, including by receiving treatment and care separately from adults if possible.

Scope

This Policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this Policy.

This policy **must** be read in conjunction with the relevant provisions of the Act and the *Queensland Health Guide to Informed Decision-making in Health Care* in relation to informed decision-making and consent for children and young people.

The policy **must** be read in conjunction with the Chief Psychiatrist Policy - Treatment and care of patients.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Treatment criteria and 'Less Restrictive Way'

The application of the treatment criteria and the assessment of capacity of minors to consent to being treated is guided by the Chief Psychiatrist Policy - Treatment Criteria, Assessment of Capacity, 'Less Restrictive Way' and Advance Health Directives, and the Queensland Health Guide to Informed Decision-making in Health Care.

For a minor, treatment under a less restrictive way includes circumstances where a parent provides consent for the treatment.

Under the Act, a parent includes:

- a guardian of the minor, or
- a person who exercises parental responsibility for the minor, other than on a temporary basis, or
- for minors of an Aboriginal background, a person who, under Aboriginal tradition, is regarded as a parent of the minor, and
- for a minor of Torres Strait Islander background, a person who, under Island custom, is regarded as the parent of the minor.

Key Points

- A Recommendation for Assessment may only be made, after an examination of a minor, if it is likely that the minor would not be able to receive treatment or care with the consent of a parent.
- Providing treatment with the consent of a parent should apply as far as possible.
    - The authorised doctor must make reasonable efforts to discuss the minor's treatment and care needs and, where clinically appropriate, seek consent from the parent.
        - However, the authorised doctor's primary consideration is to ensure the minor receives appropriate clinical care. There may be circumstances where the treatment and care needs cannot be appropriately met by seeking the parent's consent.
    - 'Reasonable efforts' will take account of the clinical circumstances including, for example, urgency and any risks associated with delaying treatment.
        - If timely contact with a parent is not possible, the contact should be made at the earliest possible time.
    - In seeking consent, the authorised doctor should be satisfied that the person providing consent is a parent as defined in the Act.

The authorised doctor **must** provide all of the information required to enable the parent to make an informed decision.

If consent is given, the consent authorises the actions necessary to provide treatment and care including the use of force that is necessary and reasonable in the circumstances.

- If the person needs to be detained as an inpatient for treatment, explicit consent for the detention is required.

A parent cannot consent to the minor being secluded, mechanically restrained or to the administration of electroconvulsive therapy (ECT).

If consent has been sought from a parent and the parent decides not to give consent, the reasons for the decision **must** be taken into account.

However, the authorised doctor may make a Treatment Authority if the treatment criteria are met and:

- the doctor considers treatment is necessary, and
- the decision is in the child's best interests.

1.1 Capacity

In relation to capacity to consent to be treated for a mental illness, the Act does not affect common law provisions relating to:

- the capacity of a minor to consent to treatment, or
- a parent consenting to treatment of a minor.

Key Points

A minor is presumed not to have capacity to give their own consent, unless there is sufficient evidence (e.g. an assessment of capacity by a clinician) they have such capacity to consent.

This is referred to as 'Gillick competence'. Part 3 of the Queensland Health Guide to Informed Decision-making in Healthcare provides information about decision-making and consent for minors.

The following considerations are relevant for determining whether a minor has capacity to consent to treatment for a mental illness:

- the age, attitude and maturity of the child or young person, including their physical and emotional development,
- the child or young person's level of intelligence and education,
- the child or young person's social circumstances and social history,
- the nature of the child or young person's condition,
- the complexity of the proposed health care, including the need for follow-up or supervision after the healthcare,
- the seriousness of the risks associated with the healthcare, and
- the consequences if the child or young person does not have the health care.

The more complex the treatment or serious the consequences, the stronger the evidence of the minor's capacity to consent to the specific treatment will need to be.

A minor is not able to make an Enduring Power of Attorney or an Advanced Health Directive.

2 Notifications

The Act makes specific requirements regarding notifications when a patient is a minor.

2.1 General

Any written notice that may be provided to a minor may also be provided to one or more of the patient's parents in addition to, or instead of, the information being provided to the minor if:

- the minor may not understand or benefit from receiving the notice, and
- giving the notice to the parent appears to be in the minor's best interest.

When determining whether giving notice to a parent is in the minor's best interest, the views and wishes of the minor should be taken into account.

Additionally, where an oral explanation or discussion with the minor is required (for example prior to accessing community leave), the explanation may also be provided to the minor's parent/s.

However, this requirement does not apply if:

- the minor requests, at a time when they have capacity, that the communication not take place, or
- the parent is not willing or readily available for this to occur, or
- the communication with the person is likely to be detrimental to the minor's health and wellbeing.

2.2 Notifications to the Public Guardian

The Act requires the Public Guardian to be notified about:

- the admission of a minor to a high security unit or an inpatient mental health unit of an AMHS other than a child and adolescent inpatient unit, and
- the use of mechanical restraint, seclusion or physical restraint in an AMHS on a patient who is a minor.

2.2.1 Admission of minor to high security unit or inpatient mental health unit other than child and adolescent inpatient unit

The administrator of an AMHS is responsible for ensuring the Office of the Public Guardian receives timely notification of a minor's admission to a high security unit or an inpatient unit of an AMHS other than a child and adolescent inpatient unit.

The purpose of the notification is to enable the Office of the Public Guardian to consider the need for the involvement of a Community Visitor.

Notice is to be given as soon as practicable but **must** be provided within **seventy-two (72 hours)** after the minor's admission.

Notice is provided via email to OPGvisitingpractice@publicguardian.qld.gov.au and is to include:

- the name of the facility to which the minor has been admitted (AMHS and treating unit),
- the minor's age,
- CIMHA identification number, and
- the name, designation, phone number and email address for an appropriate contact person at the AMHS (e.g. Nurse Unit Manager, Shift Coordinator).

Further information about the minor's admission is to be provided on request from the Office of the Public Guardian or the Community Visitor.

2.2.2 Use of mechanical restraint, seclusion and physical restraint

The Office of the Chief Psychiatrist provides monthly reports to the Office of the Public Guardian about the use of mechanical restraint, seclusion or physical restraint of a minor.

The reports, drawn from data entered in CIMHA, are also provided to AMHS administrators.

The use of mechanical restraint, seclusion or physical restraint **must** be recorded against the consumer's CIMHA profile as soon practicable to enable the reporting requirements to be met.

Administrators **must** ensure that there are processes and resources in place to enable the timely entry of data relating to mechanical restraint, seclusion and physical restraint in CIMHA.

2.3 Notifications to the Mental Health Review Tribunal (MHRT)

The MHRT **must** be notified of the admission, or discharge, of a minor to a high security unit (see section 5.1).

3 High Security Unit admissions

Key Points

Prior approval **must** be provided by the Chief Psychiatrist before a minor can be admitted to a high security unit. This applies for any minor admitted as:

- a classified patient
- by way of a transfer from another AMHS, or
- under a judicial order made by a Supreme or District Court.

When determining whether the minor should be admitted to a high security unit, the Chief Psychiatrist **must** have regard to:

- the minor's mental state and psychiatric history
- the minor's treatment and care needs, and
- the security requirements for the minor.

Once the Chief Psychiatrist has provided approval, the administrator of the AMHS may consent to the minor being admitted to the high security unit only if satisfied the unit has the capacity to assess the minor or provide the minor with the required treatment and care.

If the minor is being admitted as a classified patient, the *Chief Psychiatrist Policy - Classified Patients* **must** be complied with.

3.1 MHRT review

The MHRT **must** review the detention of a minor in a high security unit within **seven (7) days** of their admission. This does not apply to admissions under a Judicial Order made by the Supreme or District Court.

Key Points

The administrator of the AMHS must give the MHRT written notice of the admission as soon as practicable. This notice is provided by forwarding a copy of one of the following to the MHRT (whichever applies):

- Custodian Consent (Classified Patient) form – with section 4 completed, or
- Patient Transfer form.

The MHRT will determine whether the minor should continue to be detained in the high security unit or if they should be transferred to another AMHS.

The MHRT **must** also regularly review the minor at intervals of not more than **three (3) months.**

An application for review may also be made for the minor by an interested person (e.g. their parent, carer or legal representative) at any time.

If the minor stops being detained in the high security unit, the administrator **must**, as soon as practicable, give the MHRT written notice of the discharge by providing a copy of either the:

- Notice Event (Classified Patient) form, or
- Patient Transfer form.

4 Seclusion and restraint

The provisions of the Act in relation to seclusion, mechanical restraint and physical restraint apply to a minor who is a relevant patient in the same way as for an adult who is a relevant patient.

A parent **cannot** consent to a minor being secluded or mechanically restrained.

A relevant patient is a person, including a minor, subject to:

- a Treatment Authority,
- a Forensic Order,
- a Treatment Support Order, or
- a person who is absent without permission from an interstate mental health service and who has been detained in an AMHS.

If seclusion or restraint is used for a minor, staff involved **must** be aware of the vulnerability to significant psychological trauma from these practices for minors.

See Chief Psychiatrist Policy – Mechanical Restraint, Chief Psychiatrist Policy – Seclusion and Chief Psychiatrist Policy – Physical Restraint for further detail.

5 Electroconvulsive Therapy

The Chief Psychiatrist Policy - Electroconvulsive Therapy outlines the requirements for authorising the use of ECT in an emergency and with the approval of the MHRT.

A minor, or their parent, **cannot** provide consent for ECT.

Key Points

When determining an application for ECT in relation to a minor, the MHRT must have regard to:

- The views, wishes and preferences of the minor, and
- The views of parents.

The MHRT may only approve ECT for a minor if satisfied:

- The therapy is in the minor's best interest,
- Evidence supports the effectiveness of the therapy for the person's particular mental illness,
- Evidence supports the effectiveness of the therapy for a person of the minor's age, and
- As to the effectiveness of any past attempts, where applicable.

At the hearing for the application, the MHRT **must** appoint a lawyer at no cost to the minor.
The MHRT website provides further information regarding the process of appointing legal representation: www.mhrt.qld.gov.au.

6 Searches

The provisions of the Act in relation to searches apply to a minor in the same way as for an adult.

See Chief Psychiatrist Policy – Searches and Security for further detail.

7 Mental Health Court and MHRT Proceedings

7.1 Confidentiality

It is an offence for a person to publish information that identifies, or is likely to lead to the identification of, a minor who has been a party to Mental Health Court or MHRT proceedings.

Any hearing of the Mental Health Court where the proceedings relate to a minor is not open to the public. The Court may however grant leave for a person to be present during the hearing if satisfied it is in the interests of justice.

7.2 MHRT Proceedings

The Act establishes requirements for the composition of the MHRT when the proceedings involve a minor. If a psychiatrist member is required on the MHRT panel for an application or hearing involving a minor, the psychiatrist member **must** have relevant knowledge in child and adolescent psychiatry.

For any MHRT proceeding where the patient is a minor, the Act provides that the MHRT must appoint a lawyer to represent the minor at no cost to the minor.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
Child and adolescent Unit	An inpatient mental health unit of an AMHS that provides treatment and care only to minors or young adults.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Inpatient mental health unit	The part of an AMHS to which patients are admitted for treatment and care and discharged on a day other than the day of admission.
Minor	An individual who is under 18 years of age.
Parent	Includes: A guardian of the minor A person who exercises parental responsibility for the minor, other than on a temporary basis for minors of an Aboriginal background, a person who, under Aboriginal tradition, is regarded as a parent of the minor, and for a minor of Torres Strait Islander background, a person who, under Island custom, is regarded as the parent of the minor.

Referenced documents and policies

- Queensland Health Guide to Informed Decision-making in Health Care
- Chief Psychiatrist Policy – Treatment and Care of Patients
- Chief Psychiatrist Policy – Classified Patients
- Chief Psychiatrist Policy – Mechanical Restraint
- Chief Psychiatrist Policy – Seclusion
- Chief Psychiatrist Policy – Physical Restraint
- Chief Psychiatrist Policy – Electroconvulsive Therapy
- Chief Psychiatrist Policy – Searches and Security

Referenced documents and policies

Form – Patient Transfer
Form – Notice Event (Classified Patient)
Form – Custodian Consent (Classified Patient)

Document status summary

Date of Chief Psychiatrist approval:	15 April 2020
Date of effect:	22 April 2020
Supersedes version that took effect on:	5 March 2017
To be reviewed by:	15 April 2023

Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Local Independent Patient Rights Adviser	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:
	Phone: Email:

Mental Health Act 2016

Chief Psychiatrist Policy

Treatment and care of patients

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Queensland Government

General

The objects of the *Mental Health Act 2016* (the Act), including the way that treatment and care is provided to persons under the Act, **must** be achieved in a way that:

- safeguard the rights of persons
- is least restrictive of the rights and liberties of a person who has a mental illness, and
- promotes the recovery of a person, and the person's ability to live in the community, without the need for involuntary treatment and care.

> The principles of the Act require that treatment and care must be provided to a person who has a mental illness only if it is appropriate for promoting and maintaining the person's health and wellbeing.

The Act outlines specific responsibilities for the provision of treatment and care to 'Patients.' Patient is defined under the Act as:

- involuntary patients under the Act, and
- persons receiving treatment and care for a mental illness in an Authorised Mental Health Service (AMHS) other than as an involuntary patient (e.g. under an Advance Health Directive (AHD) or with consent of a personal guardian or attorney).

An authorised doctor has a statutory duty to ensure the treatment and care provided to patients is appropriate for the patient's treatment and care needs and is compliant with the requirements of the Act.

An authorised doctor providing treatment and care to patients **must**, to the extent practicable, provide timely, accurate and appropriate information to the patient about their treatment and care.

This policy draws on national guidelines and frameworks for the delivery of treatment and care in a way that optimises patient outcomes.

Additional information relevant to the treatment and care of individuals under 18 years of age is set out in the Chief Psychiatrist Policy Treatment and care of minors.

Scope

This policy is mandatory for all Authorised Mental Health Services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

Key Points

The provision of treatment and care to patients **must**:

- be delivered in accordance with contemporary clinical practice
- incorporate sound quality principles and practices
- be delivered under clinically appropriate governance arrangements, and
- be least restrictive of a person's rights and liberties, having regard to the person's safety and welfare, and the safety of others.

1 National standards

The National Standards for Mental Health Services 2010 and the National Practice Standards for the Mental Health Workforce 2013 are intended to work together to support the ongoing development and implementation of good practices and to guide continuous quality improvement in mental health services.

In addition, the National Safety and Quality Health Service Standards further articulates the need for an integrated risk management approach which is inclusive of assessment and review of a person's treatment, care and recovery plan.

These service standards ensure systems and processes are in place at an organisational level to provide optimum support for people using the service and their families. The practice standards ensure mental health professionals' work practices demonstrate person-centred approaches and reflect nationally agreed protocols and requirements.

Treatment and care must be contemporary evidence-informed practice. The National Practice Standards for the Mental Health Workforce 2013 refer to treatment and support (standard 7). The standard states that, to meet the needs, goals and aspirations of people and their families and carers, mental health practitioners must deliver quality, evidence-informed health and social interventions.

2 Recovery oriented-services

Key Points

Recovery-oriented treatment and care:

- supports people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations,
- involves the patient's family, carers or other support persons,
- recognises that patients have a right to have support persons involved in all aspects of their care, and
- is to the patient's individual needs.

Health practitioners should have regard to the 'Principles of recovery oriented mental health practice' and the 'Supporting recovery' standard (10.1) of the National Standards for Mental Health Services 2010.

Health practitioners should also have regard to the National Framework for Recovery-Oriented Mental Health Services: A Guide for Practitioners and Providers (2013). The framework aims to assist mental health professionals to align their practice with recovery principles and ultimately improve outcomes and quality of life for people experiencing mental health issues.

3 Patient rights

The treatment and care of patients **must** have regard to the Mental Health Statement on Rights and Responsibilities which seeks to ensure that consumers, carers, support persons, service providers and the community are aware of relevant rights and responsibilities and can be confident in exercising them.

This statement is consistent with Australia's international obligations, particularly the United Nations Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child.

4 Least restrictive treatment and care

Key Points

For treatment and care to be provided in the least restrictive way, the treatment and care:

- **must** place the least personal restriction on the rights and choices of the patients, taking into account their living situation, their level of support and the needs of their carer(s) and/or family members, and
- **must** be provided in the community where possible.

Further information is available in the *Less Restrictive Way Guidelines*.

If treatment and care is to be provided in an inpatient setting this is because the person's treatment and care needs require this, or the safety and welfare of the patient or others require this.

- This also supports the recovery-oriented framework which recognises people best recover in their own homes.

This is subject to the requirements of the Act in relation to managing community risks for patients on forensic orders.

5 Continuity of care

Where AMHS Administrators agree to transfer the responsibility for a patient between services, there needs to be communication and planning prior to the transfer taking place.

- Relevant clinical documentation **must** be transferred in a timely way to ensure the continuity of appropriate treatment and care for the patient.

When patients are to receive limited community treatment in the catchment area of another AMHS, clear communication between AMHSs, and the identification of roles and responsibilities of treating teams, are required to ensure the continuity of appropriate treatment and care for the patient.

When a patient is to be discharged, a discharge plan must be developed and communicated with the patient's primary health practitioner in the community to ensure ongoing treatment and care needs are well understood.

6 Parental responsibilities

Where relevant, the treatment and care of patients in parenting or caring roles should support patients to continue conducting effective caring relationships with their dependents.

In cases where child abuse and/or neglect is suspected, practitioners should refer to the Department of Health's Guideline: Reporting a Reasonable/Reportable suspicion of Child Abuse and Neglect (2015) for guidance.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
HHS	Hospital and Health Service
Minor	Individual who is under 18 years of age
Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.
Support person/s	Includes, a Nominated Support Person or, if the person does not have a Nominated Support Person, a family member, carer or other support person.

Referenced documents and policies
National Standards for Mental Health Services 2010
National Practice Standards for the Mental Health Workforce 2013
National Framework for Recovery-Oriented Mental health Services: A Guide for Practitioners and Providers (2013)
Guide to Patient Rights under the Mental Health Act 2016
Less Restrictive Way Guidelines
Mental Health Statement on Rights and Responsibilities (2012)
United Nations Convention of the Rights on Persons with Disabilities
United Nations Convention on the Rights of the Child
Department of Health's Guideline: Reporting a Reasonable/Reportable Suspicion of Child Abuse and Neglect (2015)

Referenced documents and policies

Chief Psychiatrist Policy: Treatment and Care of Minors

Document status summary

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Attachment 1: Key contacts

Key contacts	
Office of the Chief Psychiatrist	Phone: 07 3328 9899 / 1800 989 451 Email: MHA2016@health.qld.gov.au
Local Independent Patient Rights Adviser	Ph: Email:
Multicultural Mental Health	Ph: Email:
Local Cultural Supports	Ph: Email:
Child Safety Services Regional Intake Service	Ph: Email:
Child Safety After Hours Service	Ph: Email:
	Ph: Email:
	Ph: Email:
	Ph: Email:

Mental Health Act 2016
Chief Psychiatrist Policy

Treatment Authorities

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General

If a person is not able to consent to treatment of their mental illness, an authorised doctor may make a Treatment Authority to authorise involuntary treatment for the person.

The doctor must be satisfied that the treatment criteria apply and that there is no less restrictive way of providing treatment and care for the person. The person's views, wishes and preferences are considered.

A Treatment Authority is made by the authorised doctor who has assessed the person under a Recommendation for Assessment (see Chief Psychiatrist Policy - Examinations and Assessments)

An authorised doctor may also examine a person to make a Treatment Authority if:

- the person is subject to an Examination Order made by a Magistrate, or
- the person is subject to an interstate order (i.e. an order made under a corresponding law that provides for similar matters to a Treatment Authority) if an authorised mental health service (AMHS) Administrator has agreed to transfer responsibility for the patient to the AMHS (see Chief Psychiatrist Policy - Transfers and transport).

A Treatment Authority can also be made by the Mental Health Review Tribunal (Tribunal) in circumstances where the Tribunal decides to revoke a Forensic Order or Treatment Support Order and an authorised psychiatrist recommends the making of a Treatment Authority. Refer to the Chief Psychiatrist Policy – Forensic Orders and Treatment Support Orders: Amending category, conditions and limited community treatment.

Scope

This policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner (AMHP), AMHS administrator, or other person performing a function or exercising a power under the *Mental Health Act 2016* (the Act) **must** comply with this policy.

This policy **must** be read in conjunction with the relevant provisions of the Act (Chapters 2 and 7), and the Chief Psychiatrist Policy - Treatment criteria, assessment of capacity, 'less restrictive way' and advance health directives.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Making a Treatment Authority

An authorised doctor can only make a Treatment Authority if satisfied that:

- the treatment criteria apply to the person, and
- there is no less restrictive way for the person to receive treatment and care for the mental illness.

1.1 Treatment criteria and less restrictive way

1.1.1 Treatment criteria

Key points

The treatment criteria include **all** of the following:

- the person has a mental illness,
- the person does not have capacity to consent to be treated for the illness, and
- because of the person's illness, the absence of involuntary treatment, is likely to result in:
  - imminent serious harm to the person or others, or
  - the person suffering serious mental or physical deterioration.

Mental illness

A mental health assessment will involve a clinical assessment and information gathering across a number of areas, including presenting problems, current functioning, medical, family, psychiatric and developmental history, forensic and legal history and substance use.

The unique cultural, communication and other needs of Aboriginal and/or Torres Strait Islander peoples and those from culturally diverse backgrounds **must** always be recognised and taken into account.

A mental state examination **must** also be conducted. The Act provides a clear definition of mental illness, including examples of matters that do not indicate the presence of a mental illness.

Capacity to consent

The Act requires that clinicians presume that a patient has capacity to give or withhold consent to treatment.

The principles of supported decision-making apply to assessing capacity, i.e. the person is taken to have capacity to make decisions if the person has capacity with the assistance of someone else.

The Act provides a clear test, outlining all the relevant elements that **must** be addressed in a capacity assessment.

Risk assessment

In determining risk of the person suffering serious mental or physical deterioration, consideration is to be given to the nature and course of the illness and the patient's clinical history.

Risk of harm is not limited to risk of physical injury or deterioration in physical health. Clinicians should consider the risk of psychological and emotional harm, as well as adverse financial or social impacts, particularly where these are of a significant nature.

Refer to the Chief Psychiatrist Policy - Treatment Criteria, Assessment of Capacity, 'Less Restrictive Way' and Advance Health Directives, for further detail on the application of the treatment criteria.

1.1.2 Less restrictive way

Key points

The 'less restrictive way' of receiving treatment and care requires consideration to be given to alternative consent mechanisms before a Treatment Authority is made.

The authorised doctor must decide whether the person's treatment and care needs can be met in one of the following ways:

- if the person is a minor – with the consent of a parent,
- under an Advance Health Directive (AHD)— with the consent provided in the directions or with the consent of an attorney appointed under the AHD,
- with the consent of a guardian appointed for the person,
- with the consent of an attorney appointed under an Enduring Power of Attorney (EPOA), or
- with the consent of a statutory health attorney[1].

The authorised doctor **must** consider the options in the order listed above.

If the person is an adult, the authorised doctor **must** make reasonable efforts to determine if the person has an AHD or an appointed attorney or guardian. This includes:

- checking the 'External Contacts' and 'AHD/Sub Dec Maker' tabs in the Consumer Integrated Mental Health Application (CIMHA), and
- asking the person, and any other person accompanying the person
  - whether an AHD has been made, or
  - whether an attorney or guardian has been appointed to make health care decisions for the person.

[1] A statutory health attorney is not appointed by the person. Therefore, consideration should be given to treating the person under a Treatment Authority and the extensive oversight and protections afforded by the Act, rather than providing inpatient treatment and care with consent of a statutory health attorney. See also, Chief Psychiatrist Policy Treatment Criteria, Assessment of Capacity, Less Restrictive Way and Advance Health Directives.

'Reasonable efforts' will take account of the clinical circumstances; in particular, urgency and any risks associated with delaying treatment.

In all circumstances, the authorised doctor's decision about whether to make a Treatment Authority or rely on an alternative consent mechanism **must** be consistent with appropriate and safe clinical practice and with consideration of the person views, wishes and preferences.

Refer to the Chief Psychiatrist Policy - Treatment criteria, assessment of capacity, 'less restrictive way' and advance health directives, for further detail on less restrictive ways of treatment.

1.2 Requirements on making a Treatment Authority

Key points

On making a Treatment Authority, the authorised doctor must state:

- the grounds for making the Treatment Authority including the reasons the authorised doctor believes the treatment criteria apply and that there is no less restrictive way to provide treatment for the mental illness, and
- the AMHS responsible for providing treatment and care, and
- the category of the Treatment Authority, and
- if the category is inpatient, whether limited community treatment (LCT) is authorised for the patient, and
- any conditions necessary for the patient's treatment and care.

In addition, the authorised doctor **must** decide the nature and extent of treatment and care to be provided to the patient. In deciding the treatment and care, the doctor **must** have regard to the person's views, wishes and preferences including, for example, those expressed in an AHD.

1.3 Category of Treatment Authority

Key points

The authorised doctor **must** decide if the category of the Treatment Authority is community or inpatient.

The Treatment Authority category **must** be community unless, having regard to the relevant circumstances of the patient, the authorised doctor considers that one or more of the following cannot reasonably be met under a community category:

- the patient's treatment and care needs
- the safety and welfare of the patient
- the safety of others.

If the patient is a classified patient, the category of the Treatment Authority **must** be inpatient.

Relevant circumstances of the person mean the following:

- The person's mental state and psychiatric history,
- any intellectual disability,
- the person's social circumstances, including for example, family and social support,
- the persons response to treatment and care and the persons willingness to receive appropriate treatment and care, and
- if relevant, the persons response to previous treatment in the community.

The authorised doctor cannot determine that the patient receive treatment at a High Security Unit under an inpatient category without the prior written approval of the Chief Psychiatrist.

1.3.1 Limited community treatment

Key points

If the category of the Treatment Authority is inpatient, the authorised doctor must decide whether to authorise LCT.

LCT can only be authorised if the authorised doctor is satisfied it is appropriate having regard to:

- the relevant circumstances of the patient, and
- the purpose of the LCT.

If LCT is authorised, the authorised doctor **must** state:

- the type of LCT i.e. on grounds, off grounds or overnight,
- whether the patient is to be escorted (i.e. with a health service employee) or supervised (i.e. in the company of a person nominated by the authorised doctor),
- the conditions of LCT,
- the actions to be taken if the patient does not comply with conditions,
- the duration of the LCT (NB: leave cannot be more than **seven (7)** consecutive days), and
- the duration of the authorisation.

If the patient accesses LCT under the authorisation, the details **must** be recorded on a Limited community treatment access and return form.

1.3.2 Conditions of Treatment Authority

The authorised doctor may, if necessary, for the patient's treatment and care, specify conditions on the Treatment Authority.

Conditions are most likely to be applied to patients receiving treatment and care on a community category. For example, the authorised doctor may specify that the patient is to attend regular appointments and take prescribed medication.

1.4 Authorised psychiatrist review of Treatment Authority

If the Treatment Authority was made by an authorised doctor who is not a psychiatrist, an authorised psychiatrist **must** undertake a review to decide whether to confirm or revoke the Treatment Authority.

The authorised psychiatrist **must** undertake the review within **three (3) days** after the Treatment Authority is made. If the service is declared an AMHS (rural and remote) the review **must** be conducted within **seven (7) days.**

An authorised doctor who is not a psychiatrist **cannot** revoke the Treatment Authority during this period. Only the authorised psychiatrist may revoke the Treatment Authority after reviewing the patient within this **three-(3) day** period, including by audio-visual technology if the authorised psychiatrist considers it clinically appropriate in the circumstances. This ensures an authorised psychiatrist has considered the appropriateness of continuation of the treatment authority at the time of initiation.

1.4.1 Notice to attend for psychiatrist review

The authorised doctor who made the Treatment Authority may give the patient written notice to attend for the authorised psychiatrist's review e.g. if the Treatment Authority is made for a patient residing in the community.

Key points

The notice to attend must set out the AMHS or public sector health service facility (PSHSF) and the date and time the patient is required to attend. A template letter is available in CIMHA for this purpose.

Giving the patient notice to attend:

- protects against the Treatment Authority ending at **three (3) days** if the patient does not attend as required,
- enables the person to be taken to the AMHS or PSHSF if the person does not attend as required (see Chief Psychiatrist Policy – Managing involuntary patient absences), and
- enables the patient's detention for up to **six (6) hours** from when the patient first attends the AMHS or PSHSF for assessment.

If the patient has an appointed nominated support person, guardian or attorney, they must also be provided with a copy of the notice.

If the patient may not understand the notice and does not have an appointed nominated support person, guardian or attorney, the treating doctor should consider the likely views, wishes and preferences of the patient, and safe clinical practice to determine whether the notice should be provided to another support person e.g. a family member.

- However, the notice cannot be provided to another person if the patient has asked that the communication with the person not occur.
- If the patient is a minor, a copy of the notice can be given to a parent if the patient may not understand the information and providing the notice appears to be in the patient's best interests.

1.4.2 Authorised psychiatrist decisions on review

Key points

The authorised psychiatrist **must** decide whether to confirm or revoke the Treatment Authority. The Treatment Authority can only be confirmed if the authorised psychiatrist is satisfied:

- the treatment criteria apply to the person and,
- there is no less restrictive way for the person to receive treatment and care for the mental illness.

If the Treatment Authority is confirmed, the authorised psychiatrist must decide whether to:

- change the category of the Treatment Authority, and
- grant LCT under the Treatment Authority, and/or
- impose conditions on the Treatment Authority, and
- the nature and extent of treatment and care to be provided to the patient.

The requirements set out in section 1.2 apply equally to the authorised psychiatrist's decision/s.

The authorised psychiatrist's decision to confirm or revoke the Treatment Authority **must** be recorded on the Treatment Authority form in CIMHA, or if completed in hard-copy, uploaded to CIMHA. If the Treatment Authority is revoked, the reasons for the revocation **must** also be recorded on the form.

In addition, if the authorised psychiatrist decides to amend the Treatment Authority (i.e. a change to category, LCT, or conditions of the Authority), an Order / Authority amendment form **must** be completed to reflect the change.

1.4.3 Treatment Authority not confirmed or revoked by authorised psychiatrist

It is the expectation of the Chief Psychiatrist that an authorised psychiatrist review will occur to ensure appropriate access to treatment and care for the person.

If the authorised psychiatrist does not confirm or revoke the Treatment Authority within the **three (3) day** period (or **seven (7) days** if the AMHS (rural and remote)), the Treatment Authority ceases at the end of the period. Reasons why the review did not occur must be recorded on the patient's clinical record.

The Treatment Authority does not cease if the patient was given a notice to attend (see 1.4.1) and does not attend for the psychiatrist's review. In this instance:

- efforts **must** be made to ensure the patient's attendance for the authorised psychiatrist's review at the earliest possible time, and
- an authorised psychiatrist may revoke the Treatment Authority if the AMHS is not able to locate the patient for a period of at least **six (6) months.**

1.5 Providing information to patient and others

1.5.1 Providing information about Treatment Authority

Authorised Doctor responsibilities

Key points

The authorised doctor who makes the Treatment Authority or the authorised psychiatrist who reviews the Treatment Authority **must**, as soon as practicable:

- tell the patient about the decision and explain the effect of the decision, and
- discuss the treatment and care to be provided.

If a Treatment Authority was made for a patient with an AHD, the authorised doctor/psychiatrist **must** explain why the Authority was made and record the reasons in the patient's clinical records.

If the decision to treat the person is contrary to the views, wishes and preferences stated in an AHD, the doctor **must** explain to the person why this decision was made and record the reasons in the patient's clinical records (i.e. CIMHA).

The explanation about making a Treatment Authority and/or not following an AHD may be given at a later time if the authorised doctor/psychiatrist considers the patient would better understand the explanation at a later time.

If, having given the explanation, the authorised doctor/psychiatrist considers the patient requires further assistance to understand the information, the authorised doctor/psychiatrist may seek the assistance of an Independent Patient Rights Adviser to assist the patient's understanding of the Treatment Authority and its effect.

The authorised doctor/psychiatrist **must** also tell and explain their decision to the patient's support person unless the authorised doctor/psychiatrist considers that an exception to informing the support person applies.

Administrator responsibilities

Key points

If a Treatment Authority is made by an authorised doctor who is not a psychiatrist, the administrator **must** provide a copy of the Treatment Authority on request. The request may be made by:

- the patient, or
- the patient's appointed nominated support person/s, or
- a guardian appointed for personal matters or an attorney appointed under an AHD or EPOA**.**

The administrator **must** ensure that appropriate arrangements are in place at the AMHS to ensure the timely provision of the Treatment Authority when a request is made. For example, the administrator may delegate the responsibility to provide the Treatment Authority to authorised doctors.

If a Treatment Authority is made or confirmed by an authorised psychiatrist, the administrator **must**, within **seven (7) days** of the making or confirmation of the authority, provide a copy to:

- the patient,
- the patient's appointed nominated support person/s, and
- a guardian appointed for personal matters or an attorney appointed under an AHD or EPOA.

The Treatment Authority is to be given with a covering letter that provides contact details for a relevant clinician and, for public sector AMHS, an Independent Patient Rights Adviser. A template letter is available in CIMHA for this purpose.

The administrator **must** also send a copy of the Treatment Authority to the Tribunal within **seven (7) days** of it being made.

1.5.2 Providing information about treatment in the community

Treatment in the community includes circumstances where the patient is receiving treatment under a community category or the patient is authorised to have LCT under an inpatient category.

Key points

The authorised doctor **must** provide the patient with an explanation and written information about the patient's treatment in the community, in particular:

- any treatment and care to be provided to the patient e.g. fortnightly home visit, monthly appointment with authorised doctor, and
- the patient's obligations while receiving LCT e.g. to take prescribed medication.

The requirement to provide information does not apply if the patient is only authorised to have escorted LCT.

For LCT, the information only needs to be provided once for each type of LCT. For example:

- if the patient is authorised to have day leave for **three (3) days** in the week, the information is to be given prior to the first day of leave and not on each subsequent day.

The information **must** also be provided to the patient's support person/s, unless the authorised doctor considers that an exception to informing the support person/s applies.

The AMHS administrator must ensure appropriate arrangements are in place to provide patients and their support person/s with information about treatment in the community. Written information may be provided in a range of ways. For example:

- for a patient undertaking LCT, providing the patient with a copy of the Order / Authority amendment form setting out conditions and consequences for not complying with LCT, or
- for a patient whose Treatment Authority category is changed to community, providing the patient with a copy of the Care Plan clinical note which makes provision for recording treatment and care to be provided as well as the patient's obligations in receiving treatment and care in the community.

1.6 Documentation requirements

Key points

The Treatment Authority **must** be completed electronically in CIMHA or, if this is not possible, completed in hard copy and uploaded to CIMHA.

The AMHS administrator **must** ensure that appropriate processes are in place for ready access to the form, including timely upload to CIMHA and retaining a copy on any hard copy clinical records.

In addition, a record of the assessment/s made by the authorised doctor and/or authorised psychiatrist **must** be documented in, or uploaded to, CIMHA clinical notes. The documentation is to include:

- a record of the information obtained and considered in determining whether the treatment criteria applied,
- if the patient had an AHD, whether the AHD was relied upon to provide consent or the reasons the AHD was not followed,
- if the patient had an alternate decision maker, the actions taken to contact and/or obtain consent and the outcome of those actions (including consent to treatment and/or detention if provided), or the reasons why action was not taken,
- the treatment and care to be provided to the patient,
- if a Treatment Authority was made, the date of the first regular assessment of the patient (see 2.1 Regular assessment by authorised doctor), and
- the information provided to the patient, and where relevant, their support person/s, or the reasons for not providing the information.

An Involuntary Patient and Voluntary High-Risk Patient Summary clinical note **must** be completed in CIMHA as soon as practicable.

If, in the course of the assessment, the authorised doctor/psychiatrist identifies an AHD, EPOA or Queensland Civil and Administrative Tribunal (QCAT) decision that is not already recorded in CIMHA, the document **must** be uploaded to CIMHA as soon as practicable. (Refer to CIMHA Clinician Handbook Vol 6: MHA 2016.)

2 Treatment and care under a Treatment Authority

A multidisciplinary team approach is essential to ensuring the best possible outcomes for patients. Treatment and care are also subject to clinical governance arrangements that ensure the quality and safety of services provided. Within this context, the Act establishes specific requirements for treatment and care under a Treatment Authority.

2.1 Regular assessment by authorised doctor

Key points

The following requirements relate to regular assessment of a Treatment Authority once confirmed by an authorised psychiatrist.

A patient subject to a Treatment Authority must be regularly assessed by an authorised doctor at intervals of not more than **three (3) months**.

The initial assessment must be made on or before the date the Treatment Authority was made (see 1.6 Documentation requirements).

An assessment must also be undertaken if, at any time, the authorised doctor considers that the treatment criteria may no longer apply, or there may be a less restrictive way for the patient to receive treatment and care. See section 3.2 Revocation by authorised doctor.

In making an assessment (i.e. on a scheduled assessment or an assessment made at an earlier time), the authorised doctor must decide:

- whether the treatment criteria continue to apply,
- whether there is a less restrictive way for the patient to receive treatment and care, and
- if the Treatment Authority continues, whether any changes are required to the category of the Authority, LCT arrangements (If inpatient category) or the conditions of the Authority (see 1.3).

In addition, the authorised doctor **must** ensure the treatment and care provided continues to be appropriate for the patient's treatment and care needs.

The authorised doctor **must** discuss the assessment and the patient's treatment and care with the patient. The information **must** also be discussed with the patient's support person/s unless the doctor considers that an exception to providing the information applies.

The authorised doctor's assessment and decisions regarding the person's treatment and care **must** be recorded in the patient's clinical record on CIMHA. The doctor's communication with the patient and support person **must** also be documented.

In addition, the doctor **must** determine and record the date of the patient's next assessment by an authorised doctor.

2.2 Mental Health Review Tribunal reviews

Key points

The Tribunal **must** conduct regular reviews of the patient's Treatment Authority as follows:

- an initial review within **twenty-eight (28 days)** of the Treatment Authority being made,
- a second review within **six (6) months** of the initial review,
- a third review within **six (6) months** of the second review, and
- thereafter at intervals of not more than **twelve (12) months**.

In addition, a review may be made on the Tribunal's own initiative or on an application made by the patient, their appointed nominated support person/s or another person with sufficient interest, or the Chief Psychiatrist.

The Tribunal **must** decide whether to confirm or revoke the Treatment Authority and may change the category, conditions or LCT arrangements of the Authority.

Subsequent decisions by an authorised doctor **must not** be contrary to the Tribunal's decision (see 1.3).

In addition, the Tribunal may order the patient's transfer to another AMHS. The patient's current AMHS administrator is responsible for ensuring that a Tribunal's order for the transfer of a patient to the receiving AMHS is given effect.

The authorised psychiatrist is responsible for ensuring that a clinical report is prepared for the purposes of the Tribunal review.

- A Tribunal Clinical Report - Treatment Authority Review clinical note **must** be completed in CIMHA and provided to the patient and the Tribunal at least **seven (7) days** prior to the Tribunal hearing.
- The authorised psychiatrist must provide an explanation and discuss the contents of the report with the patient in a way the patient can best understand it.
    - However, the report is not required to be given to the patient if the authorised psychiatrist intends to request a confidentiality order for the report.

Additional reporting requirements apply to the second **six (6) monthly** Tribunal review:

- If the patient does not have an appointed guardian for health care, the administrator **must** provide a report to the Tribunal about whether the appointment of such a guardian may result in there being a less restrictive way for the person to receive treatment and care.
    - The administrator's report may be annexed to the clinical report or provided separately to the Tribunal.

The Tribunal **must** be notified where the patient is absent without approval within **seven (7) days** of their Tribunal hearing. See Chief Psychiatrist Policy – Managing involuntary patient absences.

2.3 Amending category, conditions or limited community treatment

Key points

An authorised doctor can amend the Treatment Authority following an assessment, or at any time they determine that a change to category, conditions or LCT is required.

The amendment is to be recorded on an Order / Authority amendment form.

- The form **must** be completed electronically in CIMHA or, if this is not possible, completed in hard copy and uploaded to CIMHA.

The authorised doctor **must** discuss the amendment with the patient.

- If the amendment results in the patient receiving treatment in the community (e.g. change of category to community or increase in LCT) the authorised doctor **must** provide the patient with an explanation and written information about treatment in the community (see section 1.5.2).
- Reasonable steps must be taken to ensure the patient understands the information. This may include, use of an interpreter or other methods of communication, such as sign language, written explanations or explanation with assistance from a support person.

The amendment and information about treatment in the community **must** also be discussed with the patient's support person unless the doctor considers that an exception to providing the information applies.

2.3.1 Amending category of Treatment Authority

Key points

The authorised doctor can only change the category of the Treatment Authority from community to inpatient if, having regard to the relevant circumstances of the patient, the authorised doctor considers that one or more of the following cannot reasonably be met under a community category:

- the patient's treatment and care needs,
- the safety and welfare of the patient,
- the safety of others.

If the category of the Treatment Authority is community, the Tribunal **must**, on review of the Authority, decide whether an authorised doctor may reduce the extent of the person's treatment in the community.

If the Tribunal has determined that the extent of treatment in the community can be reduced, the authorised doctor may amend the category from community to inpatient having regard to the above criteria.

If the Tribunal has determined that the extent of treatment in the community cannot be reduced, additional considerations and requirements apply. Specifically:

- the category can only be amended if the authorised doctor reasonably believes there has been a material change in the person's mental state and the patient requires urgent treatment and care as an inpatient,
- if the category is amended to inpatient, the AMHS Administrator **must**, as soon as practicable, give written notice to the Tribunal by providing a copy of the Order / Authority amendment form,
- the Tribunal **must** conduct a review of the Treatment Authority with **fourteen (14) days** of receiving the notice,
- if the category is amended to community before the Tribunal review, the AMHS Administrator **must**, as soon as practicable, provide a copy of the Order / Authority amendment to the Tribunal. In these circumstances, a Tribunal review is not required.

2.3.2 Amending limited community treatment

Key points

An amendment to LCT can only be made if the authorised doctor is satisfied it is appropriate having regard to:

- the relevant circumstances of the patient, and
- the purpose of the LCT.

If LCT is amended, the authorised doctor **must** state:

- the type of LCT (i.e. on grounds, off grounds or overnight) and whether the patient is to be escorted (i.e. with a health service employee) or supervised (i.e. in the company of a person nominated by the authorised doctor),
- the conditions of LCT,
- the actions to be taken if the patient does not comply with conditions,
- the duration of the LCT (NB: overnight leave cannot be more than **seven (7)** consecutive nights), and
- the duration of the authorisation.

If the category of the Treatment Authority is inpatient, the Tribunal may, on review of the Treatment Authority, approve or extend LCT for the person.

- If the Tribunal approves or extends LCT, the Tribunal **must** decide whether an authorised doctor may reduce the extent of the person's treatment in the community.
- If the Tribunal has determined that the extent of treatment in the community cannot be reduced, an authorised doctor's amendment to LCT arrangements cannot be contrary to the Tribunal's decision.

If the patient accesses LCT under the authorisation, the details **must** be recorded on a Limited community treatment access and return form.

3 Revocation of Treatment Authority

If the treatment criteria no longer apply to a person subject to a Treatment Authority, or there is a less restrictive way for the patient to receive treatment and care, the Treatment Authority **must** be revoked.

A Treatment Authority may be revoked by:

- an authorised doctor,
- an authorised psychiatrist,
- the Chief Psychiatrist,
- the Tribunal on a review of the Treatment Authority, or
- the Mental Health Court on an appeal against a Tribunal decision.

3.1 Revocation by authorised psychiatrist

An authorised doctor who is not a psychiatrist cannot revoke the Treatment Authority during the initial three (3) day period after the Treatment Authority is made.

Only an authorised psychiatrist may revoke the Treatment Authority after reviewing the patient within this three (3) day period. This ensures an authorised psychiatrist has considered the appropriateness of continuation of the Treatment Authority at the time of initiation.

The review may be by audio-visual technology if the authorised psychiatrist considers it clinically appropriate in the circumstances.

3.2 Revocation by authorised doctor

Once the Treatment Authority is confirmed by an authorised psychiatrist, an authorised doctor **must** conduct regular reviews of the patient to confirm that treatment under the Act continues to be appropriate for the person and is the least restrictive option for the person to receive treatment and care for their mental illness.

If the authorised doctor considers that the treatment criteria no longer apply or there is a less restrictive way for the patient to receive treatment and care, the Treatment Authority **must** be revoked.

The doctor is not required to revoke the Treatment Authority if the person's capacity to consent to treatment is not stable.

In determining whether capacity is stable, the authorised doctor **must** consider the nature of the mental illness and the functional approach to the capacity assessment. See the Chief Psychiatrist - Treatment criteria, assessment of capacity, 'less restrictive way' and advance health directives.

An authorised doctor who is not a psychiatrist **must** consult with an authorised psychiatrist before revoking the Treatment Authority. Confirmation that the consultation has occurred is provided on the Revocation of Treatment Authority form.

As soon as practicable after revoking the Treatment Authority, the authorised doctor **must** tell the patient and the patient's support person that the Authority has been revoked.

- Information does not need to be communicated to a support person if the authorised doctor considers that an exception to informing the support person applies.
- A Revocation of Treatment Authority form is to be completed electronically in CIMHA or, if this is not possible, completed in hard copy and uploaded to CIMHA.
- A record of the revocation and the basis for the revocation **must** be documented in, or uploaded to, CIMHA clinical notes.

A Treatment Authority can also be revoked in certain circumstances where the patient is absent from treatment. The Revocation of Treatment Authority can only be made by an authorised psychiatrist who is satisfied that the AMHS has not been able to locate the person for at least **six (6) months**.

3.3 Revocation by Chief Psychiatrist

Key points

The Chief Psychiatrist may revoke a Treatment Authority if the Chief Psychiatrist considers that the treatment criteria no longer apply or there is a less restrictive way for the patient to receive treatment and care.

The Chief Psychiatrist **must**, as soon as practicable, provide the Revocation of Treatment Authority to the AMHS Administrator.

An authorised doctor **must**, as soon as practicable, tell the patient and the patient's support person that the Treatment Authority has been revoked.

- Information is not required to be given to the support person if the authorised doctor considers that an exception to informing the support person applies.

3.4 Administrator responsibilities

Within **seven (7) days** of revocation by an authorised doctor or the Chief Psychiatrist, the Administrator **must** give written notice to:

- the patient,
- the patient's appointed nominated support person/s, and
- a guardian appointed for personal matters or an attorney appointed under an AHD or EPOA.

A template letter is available in CIMHA for this purpose.

In addition, the Administrator **must** send a copy of the Revocation of Treatment Authority to the Tribunal within **seven (7) days**.

Issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly

Chief Psychiatrist, Queensland Health

22 May 2020

Definitions and abbreviations

Term	Definition
Advance Health Directive (AHD)	• AHD – a document stating the person's wishes and directions about their health care that comes into effect when the person does not have capacity to make health care decisions. The directions may include consent to special health care e.g. electroconvulsive therapy2. • Attorney under an AHD – an individual/s appointed by the person to exercise power for a health matter in the event that directions in an AHD prove inadequate. A health matter is a matter relating to health care, other than special health care.
Alternate Decision Maker	An individual/s who is/are authorised to make health care decisions for a person who lacks capacity to consent including, a parent if the person is a minor, an attorney appointed under an Advance Health Directive (AHD) or an Enduring Power of Attorney (EPOA), a guardian appointed by the Queensland Civil and Administrative Tribunal (QCAT), or a statutory health attorney. Additional definitions/explanation of terms is provided in Attachment **Error! Reference source not found.** (**Error! Reference source not found.**).
AMHS	Authorised Mental Health Service - a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
Attorney under an Enduring Power of Attorney (EPOA)	Attorney under an EPOA - an individual/s appointed by the person to do anything in relation to personal matters that the person could have done if the person had capacity for the matter. A personal matter is a matter relating to the person's care including health care or welfare, excluding special health care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Detention/Detained	Means that the person is prevented from leaving the AMHS or PSHSF (for example prevented from leaving an unlocked inpatient unit or refusing the person's request to leave a locked inpatient unit).

[2] See *Guide to Advance Health Directives, Enduring Powers of Attorney and Guardians* for further information

Exceptions to informing support person	Means circumstances where: • the patient requests that communication with the support person not occur and the authorised doctor considers the patient has capacity to make the request • the support person is not readily available or is not willing to communicate • or communication with the support person is likely to be detrimental to patient's health and wellbeing.
Guardian	Guardian - a person appointed by the Queensland Civil and Administrative Tribunal (QCAT) to do, in accordance with the terms of appointment, anything in relation to a personal matter that the individual could have done if the individual had capacity. The person may be appointed to make decisions about all personal matters or specified personal matters e.g. health care (excluding special health care), accommodation, provision of services.
Parent (for a minor)	Minor – a person under the age of 18 years. Parent – includes: • a natural or adoptive parent • someone who is subject of a parenting order for the child (under the Family Law Act 1975 (Cwlth)) • a guardian of the minor (under the Child Protection Act 1999) • an individual who exercises parental responsibility for the minor, other than on a temporary basis (e.g. child minding) • for an Aboriginal minor – an individual who, under Aboriginal tradition, is regarded as a parent of the minor, and for a Torres Strait Islander minor – an individual who, under Island custom, is regarded as a parent of the minor.
Purpose of Limited Community Treatment (LCT)	Is to support a patient's recovery by transitioning the patient to living in the community with appropriate treatment and care.
QCAT	Queensland Civil and Administrative Tribunal
Relevant Circumstances	Includes all of the following: • the person's mental state and psychiatric history • any intellectual disability of the person, the person's social circumstances e.g. family and social support • the person's response to treatment and care and their willingness to receive appropriate treatment and care • if relevant, the person's response to previous treatment in the community.
EPOA	Enduring Power of Attorney
Clinical director	Senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the clinical director functions and responsibilities.

Patient	• An involuntary patient, or • A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and Advance Health Directive or with the consent of a personal guardian or attorney.
Statutory Health Attorney	Statutory health attorney – for a health matter, the first in listed order of the following people who is readily available and culturally appropriate for the matter: • a spouse of the person if the relationship is close and continuing • an adult (i.e. 18 years or more) who has care of the person and is not a paid carer for the person • an adult who is a close friend or relation of the person and is not a paid carer for the person. If none of the above listed people is available and culturally appropriate, the Public Guardian is the person's statutory health attorney for the matter.
Support person	An appointed nominated support person or, if the person does not have a nominated support person, a family member, carer or other support person

Referenced forms, clinical notes and templates

- Involuntary Patient and Voluntary High Risk Patient Summary clinical note
- Limited Community Treatment (LCT) Access and Return form
- Clinical Report - Treatment Authority Review clinical note (available at www.mhrt.qld.gov.au)
- Order / Authority Amendment form
- Revocation of Treatment Authority form

Referenced documents and sources

- Chief Psychiatrist Policy: Treatment criteria, assessment of capacity, less restrictive way and advance health directives
- Chief Psychiatrist Policy: Examination and assessment
- Chief Psychiatrist Policy: Managing involuntary patient absences
- Guide to Advance Health Directives, Enduring Powers of Attorney and Guardians

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Date of Chief Psychiatrist approval:	22 May 2020
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Attachment 1 – Key contacts

Key contacts	
Office of the Chief Psychiatrist	Ph: 1800 989 451 Email: MHA2016@qhealth.qld.gov.au
Clinical Director/Administrator	Phone: Email:
Mental Health Administration Delegate	Phone: Email
Independent Patient Rights Adviser	Phone: Email
Local Aboriginal and Torres Strait Islander Cultural or Case work unit	Phone: Email
Multicultural Mental Health	Phone: Email
	Phone: Email
	Phone: Email
	Phone: Email

Attachment 2 – Alternate consent options

Alternate consent options (to be considered in the order listed below)	
1	For a minor – a parent
2	Advance Health Directive (AHD)
3	Guardian
4	Attorney under an Enduring Power of Attorney (EPOA)
5	Statutory Health Attorney

See also the Guide to Advance Health Directives, Enduring Powers of Attorney and Guardians for further information.

Mental Health Act 2016

Chief Psychiatrist Policy

Treatment criteria, assessment of capacity, less restrictive way and advance health directives

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General

If a person is not able to consent to treatment of their mental illness, an authorised doctor may make a Treatment Authority to authorise involuntary treatment for the person, if:

- the treatment criteria apply to the person, and
- there is no less restrictive way for the person to receive treatment and care for their mental illness.

The person's views, wishes and preferences **must** be considered.

Scope

This policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner (AMHP), AMHS administrator, or other person performing a function or exercising a power under *Mental Health Act 2016* (the Act) **must** comply with this policy.

This policy only applies in circumstances where a health practitioner assesses that a person does not have capacity to make decisions about their own healthcare.

This policy **does not** apply to persons on a Forensic Order (Mental Health) or a Treatment Support Order. However, this policy applies to persons on a Forensic Order (Disability) who require treatment for a mental illness.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

Policy

1 Treatment criteria

The Act clearly defines the treatment criteria which form the basis for a person being placed on a Treatment Authority. An authorised doctor can only make a Treatment Authority if satisfied that:

- the treatment criteria apply to the person, and
- there is no less restrictive way for the person to receive treatment and care for the mental illness.

Key points

The treatment criteria for a person are the following:

- The person has a mental illness, and
- The person does not have capacity to give or withhold consent to be treated for the illness, and
- because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in:
    - imminent serious harm to the person or others, or
    - the person suffering serious mental or physical deterioration.

All criteria **must** be fully met for a person to be placed on a Treatment Authority.

1.1 Presence of a mental illness

A comprehensive mental health assessment will involve a clinical assessment and information gathering across a number of areas, including presenting problems, current functioning, medical, family, developmental history, cultural background, health related history and forensic and legal history.

The unique cultural, communication and other needs of Aboriginal and Torres Strait Islander peoples and those from a culturally and linguistically diverse background **must** always be recognised and taken into account.

A mental state examination **must** also be conducted. The Act provides a clear definition of mental illness, including examples of matters that do not indicate the presence of a mental illness.

Key points

Mental Illness (section 10).

Mental illness is a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.

However, a person must not be considered to have a mental illness merely because:

- the person holds or refuses to hold a particular religious, cultural, philosophical or political belief or opinion; or
- the person is a member of a particular racial group; or
- the person has a particular economic or social status; or
- the person has a particular sexual preference or sexual orientation; or
- the person engages in sexual promiscuity; or
- the person engages in immoral or indecent conduct; or
- the person takes drugs or alcohol; or

- the person has an intellectual disability; or
- the person engages in antisocial behaviour or illegal behaviour; or
- the person is or has been involved in family conflict; or
- the person has previously been treated for a mental illness or been subject to involuntary assessment or treatment.

A decision that a person has a mental illness **must** be made in accordance with internationally accepted medical standards.

Collateral information forms a crucial component of the assessment and should be sought where available and appropriate from relevant others, including carers, family members and other health professionals and relevant documents such as the person's medical record.

The clinical formulation, an essential component of mental health assessment, **must** be clearly documented, along with the assessment in the patient's health record.

Outcomes and decisions arising from assessment **must** be communicated with the person and their relevant support persons.

1.2 Assessment of capacity to consent to be treated

The Act requires that clinicians presume that a person has capacity to give or withhold informed consent to treatment.

A clinician **must** seek the informed consent of the person before administering treatment for a mental illness.

An Independent Patient Rights Adviser should also be involved where possible to enable independent provision of advice to the patient in relation to their rights and assist the person with informed decision making.

The principles of supported decision-making apply to assessing capacity, i.e. the person is taken to have capacity to make decisions if the person has capacity with the assistance of someone else. Further information on supported decision making can be found in the Less Restrictive Way Guidelines.

The presumption of capacity can be rebutted, under the test provided in the Act, if it is shown that the person does not have capacity to give informed consent at the time the treatment decision needs to be made.

See Assessment of capacity and less restrictive way flowchart for more information.

Key points

Capacity to consent to be treated (s14, the Act)

The Act provides the following test for capacity, outlining all of the elements that must be addressed in a capacity assessment.

A person has capacity to consent to be treated if the person:

- is capable of understanding in general terms:
    - that the person has a mental illness, or symptoms of an illness, that affects mental health and wellbeing, and
    - the nature and purpose of the treatment for the illness, and
    - the benefits and risks of the treatment and alternatives, and
    - the consequences of not receiving treatment, and
- is capable of making a decision and communicating it in some way.

A person may have capacity to consent to be treated even though the person decides not to receive treatment.

A person may be supported or assisted by another person to have capacity.

This section does not affect the common law in relation to:

- the capacity of a minor to consent to be treated, or
- a parent of a minor consenting to treatment of the minor.

Clinicians **must** be aware that capacity is specific to the decision that needs to be made at the time (e.g. a person's capacity to consent to treatment is distinct from their capacity in relation to managing their finances).

Support **must** be provided to assist the person in making decisions about their treatment, as far as practicable. This includes providing the person and their support person/s with all relevant information (e.g. clinical formulation, nature of treatment proposed, options for less restrictive forms of treatment, etc.). Information **must** be provided in a format that best assists the person to understand including the use of interpreters, visual aids, simple language, etc.

Clinicians **must** ensure the person has been given:

- a reasonable period of time and opportunity to:
    - consider matters involved in the decision,
    - discuss the decision with the health practitioner,
    - to seek advice, support and assistance, and
    - adequate information on the treatment, alternatives, advantages, disadvantages, and beneficial alternative treatments.

A person **must** be provided the opportunity to provide consent at a time, and in a place, that best supports the person's decision-making.

For example, while a busy emergency department during a crisis presentation might be the necessary setting for immediate decisions about acute treatment, it may not be the most desirable timing or location to make an assessment on the person's capacity to consent to subacute or longer-term treatment. These decisions might best be re-assessed in the days following an acute presentation.

1.2.1 Fluctuating capacity

Clinicians **must** be aware that a person's capacity to make treatment decisions can fluctuate over time.

Cross-sectional assessments may not accurately reflect a person's capacity beyond that point in time. Accordingly, capacity assessments must be conducted across a number of examinations to facilitate stability in the clinical opinion.

Notwithstanding the need for a longitudinal view of capacity, decisions under the Act relating to capacity **must** be made on the basis of the assessment at the time of the decision. The only exception to this is where an authorised doctor is considering revoking a Treatment Authority (see section 1.4).

1.2.2 Withholding consent

Clinicians **must** be aware that not consenting to treatment does not necessarily imply a lack of capacity. A person may have capacity to make a decision about treatment but still not consent to it.

While this may result in risks for the person (including clinical risks) if the person has capacity to consent to be treated, the treatment criteria **do not** apply.

Clinicians **must** be aware that a person who meets the treatment criteria for harm can receive treatment as a voluntary patient if the person has capacity to consent to treatment.

Clinicians **must** always consider a person's views, wishes and preferences, including any that might have been formally expressed in an advance health directive (AHD) or in an informal way to treating teams.

Clinicians **must** always consider the views of families, carers, and other support persons.

Clinicians should be cautious of basing an assessment of capacity on 'implied consent'. A person may imply consent by actions such as accepting a tablet into a hand, however, there are limits to implied consent and it should be not be relied on as informed consent.

Informed consent **must** be freely given. A clinician **must** not pressure a person to give consent.

At times a person may lack capacity but not meet any of the other criteria for involuntary treatment. In these circumstances, even though the person may be impaired in many aspects of their functioning, there may still be insufficient grounds to make a Treatment Authority. Alternatives to providing treatment should be explored in these circumstances, including for example the involvement of the Public Guardian.

1.3 Risk assessment

In order for the treatment criteria to be met, the Act requires that:

- because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in:
  - imminent serious harm to the person or others, or
  - the person suffering serious mental or physical deterioration.

In practice this is ascertained by a risk assessment. Clinicians should be aware that that even where a person has a mental illness and lacks capacity to consent to treatment, if the criteria for harm are not met then the treatment criteria are not met.

Harm is not limited to physical injury or deterioration in physical health. Clinicians should consider mental health, as well as adverse financial or social impacts, particularly where these are of a significant nature.

Key points

In regard to risk assessment clinicians must:

- assess whether due to the mental illness, the absence of involuntary treatment is likely to result in harm to the person or someone else, or a deterioration of the person's physical or mental health,
- be satisfied that the risk is imminent and results from the patient's mental illness,
- clearly document the risk of harm, how this is attributed to the patient's illness, and the basis for the view that the risk of harm is imminent,
- assess if serious mental or physical deterioration is 'likely' in the absence of treatment, and
- clearly document the basis for decisions, including, for example, the nature and course of the illness and the patient's clinical history.

1.4 Regular assessment and revocation of Treatment Authorities

The following requirements relate to regular assessment of a Treatment Authority once confirmed by an authorised psychiatrist. Refer to the Chief Psychiatrist Policy Treatment Authorities for more information on assessments for the purpose of making or revoking a Treatment Authority.

Key points

Authorised doctors must:

- undertake regular assessments, at least every three (3) months, to determine if the treatment criteria still apply and a Treatment Authority should continue.
- assess a person if at any time it appears that the treatment criteria no longer apply or there may be a less restrictive way of treatment.

After an assessment, an authorised doctor must revoke a Treatment Authority if the treatment criteria no longer apply or there is a less restrictive way to provide treatment.

- If the authorised doctor is not a psychiatrist, the doctor must consult with an authorised psychiatrist before revoking an authority.

The only exception to this is if a person's capacity is not stable. To avoid a person with fluctuating capacity 'cycling' on and off Treatment Authorities, they may remain on a Treatment Authority until their capacity becomes stable. It is intended that this would apply over a relatively short period of time.

In determining whether capacity is stable, the authorised doctor **must** consider the nature of the mental illness and the functional approach to the capacity assessment.

- Where the person has an established mental illness, and the findings of mental state examinations are consistent over time, repeated capacity assessments **must** show consistent outcomes (i.e. that the person has capacity at each assessment, to establish that their capacity is stable).
- For example, most clinical circumstances would require a minimum of two capacity assessments over a period of up to 3-4 weeks. However, this does not prevent a stable capacity assessment being made in a shorter timeframe if the clinical circumstances warrant it.

See Chief Psychiatrist Policy – Treatment Authorities for more information.

2 Less restrictive way

Treating a person voluntarily with their own consent is the least restrictive form of health care. Where persons lack capacity to make decisions about their own health care, alternative mechanisms are needed to obtain consent to health care.

A Treatment Authority cannot be made for a person if there is a less restrictive way for the person to receive treatment and care for the person's mental illness.

The Act defines the 'less restrictive way' as alternatives to consent that facilitate treatment and care of persons other than under the Act. Specifically, the Act requires that consideration be given to the following mechanisms, to facilitate treatment and care that is reasonably necessary for the person's mental illness:

- if the person is a minor—with the consent of the minor's parent,
- if the person has made an advance health directive—under the advance health directive,
- if a personal guardian has been appointed for the person—with the consent of the personal guardian,
- if an attorney has been appointed by the person—with the consent of the attorney,
- otherwise—with the consent of the person's statutory health attorney (limitations apply, see section 2.5.2).

The above are listed in the order of priority. If more than one of the above apply, the person is to be treated in accordance with the first of the listed order.

This ordered approach is supported by the *Powers of Attorney Act 1998* and the *Guardianship and Administration Act 2000* which outline a hierarchy of consent arrangements if a person does not have capacity to consent to health care at the relevant time.

- Under an advance health directive (AHD), a person may consent to future health care and/or appoint an 'attorney' to consent to the person's health care if the person does not have capacity at a future time. A person may also express their views, wishes and preferences in the way health care is to be provided in an AHD.
- Alternatively, a person may appoint an attorney under an Enduring Power of Attorney (EPOA) to consent to personal matters, such as future health care, if the person does not have capacity at a future time.
- The Queensland Civil and Administrative Tribunal (QCAT) may appoint a 'guardian' to consent to the person's future health care if the person does not have capacity to make health care decisions. (Under the *Mental Health Act 2016*, a guardian is referred to as a 'personal guardian' to distinguish them from parental guardians).
- If none of the above apply, a statutory health attorney (for example, a spouse) can consent to a person's health care if the person does not have capacity (limitations apply, see section 2.5.2).

The requirement to treat a person in a less restrictive way is subject to this policy, which outlines circumstances where the requirement does not apply (see section 2.5).

See Guideline to Advance Health Directives, Enduring Powers of Attorney, Guardians and Administrators for more information.

2.1 Obligations of health practitioners

A health practitioner **must**, to the greatest extent possible, follow an AHD if it is consistent with appropriate and safe clinical practice.

- If some elements of an AHD cannot be followed, this does not remove the obligation of a practitioner to consider other elements of the directive.

A health practitioner **must**:

- always make treatment decisions which aim to benefit a person's health and wellbeing. In making treating decisions health practitioners need to consider a person's views, wishes and preferences.
- minimise any adverse impacts on the person's rights and liberties.
- not be unduly influenced by an attorney or guardian to treat a person in a way that is contrary to good clinical practice.

Treating a person under an AHD, or with the consent of an attorney or guardian, does not affect a health practitioner's clinical, ethical, and legal obligations to the person in any way.

If there is a disagreement between a treating practitioner and a support person or the patient (when the person has recovered) over a health practitioner not following an AHD, a Clinical Director should be asked to assist in relation to any clinical matters.

An Independent Patient Rights Adviser should also be informed in these circumstances to enable independent provision of advice to the patient in relation to their rights.

2.2 Requirement to consider a less restrictive way of treatment

2.2.1 If the person is a minor and does not have capacity due to a mental illness

If the person is a minor (under 18 years of age), the doctor or AMHP **must** seek the consent of the minor's parent for treatment if the parent is reasonably available. This would apply, for example, if a minor was brought into hospital by concerned parents. For the purposes of the Act, a parent includes:

- a guardian of the minor (under the *Child Protection Act 1999*)
- a person who exercises parental responsibility for the minor, other than on a temporary basis (e.g. child minding)
- for an Aboriginal minor – a person who, under Aboriginal tradition, is regarded as a parent of the minor, and
- for a Torres Strait Islander minor – a person who, under Island custom, is regarded as a parent of the minor.

See Chief Psychiatrist Policy – Treatment and Care of Minors for more information.

2.2.2 If the person has made an AHD, appointed an attorney, or has a personal guardian

Key points

A doctor or AMHP **must** take reasonable steps to find out if the person has made an AHD, appointed an attorney or has a guardian for healthcare appointed.

The doctor or AMHP **must** search the person's health records on the Consumer Integrated Mental Health Application (CIMHA).

The doctor or AMHP **must** also ask any support persons who are with the person whether the person has made an AHD, appointed an attorney, or has a guardian for healthcare appointed.

- The Act authorises QCAT to disclose the name and contact details of a personal guardian.

If an AHD has been made giving consent to health care, the doctor or AMHP **must** decide if the person's treatment and care needs can be reasonably met by the consent stated in the directive.

If an attorney has been appointed under an AHD, the attorney's consent to treatment **must** be sought if the directions are inadequate or if the AHD only appoints an attorney and does not provide any directions.

If an attorney is appointed under an Enduring Power of Attorney (EPOA) or a guardian for healthcare has been appointed, the attorney or guardian's consent to treatment **must** be sought.

2.2.3 Statutory health attorney

If a person is accompanied by a support person, the doctor or AMHP may ask the person if their relationship with the person enables him or her to act as a statutory health attorney for the person (see Guide to advance health directives, enduring powers of attorney, guardians and administrators).

A statutory health attorney can only make decisions for a person without capacity if the person does not have an AHD, or a personal guardian or attorney for the relevant matters. Limitations apply for treatment with consent of a statutory health attorney – see section 2.5.2.

2.2.4 If a less restrictive way becomes available at a future time

The requirements under the Act, and in this policy, to treat a person in a less restrictive way have ongoing application.

For example, if a Treatment Authority was initially made for a person, but an attorney becomes available at the health service at a later time, an authorised doctor **must** ask the attorney if they will consent to the person's treatment and care.

2.3 Use of physical restraint in providing treatment and care

The use of physical restraint to provide treatment to a person **must** only occur if less restrictive options are not possible. Where physical restraint is used in providing health care, it **must** be the minimum force necessary in the circumstances.

See Chief Psychiatrist Policy – Physical Restraint for further detail.

Seclusion and mechanical restraint are specifically regulated under the Act and **cannot** be authorised under an AHD or with the consent of a guardian, attorney or, if the person is a minor, the consent of the minor's parents.

See Chief Psychiatrist Policy – Seclusion and Chief Psychiatrist Policy – Mechanical Restraint.

2.4 Treatment as an inpatient

An authorised doctor should only treat a person as an inpatient if satisfied it is necessary for the person's health, well-being and safety, and only for as long as is necessary.

Health care planning for a person who is an inpatient should plan for the person's return to the community as soon as practicable.

Key points

The Act requires that a person under a Treatment Authority **must** be placed on a community category unless the person's treatment and care needs cannot be met that way.

- This principle also applies to a person being treated under an AHD, or with the consent of an attorney or guardian.

A person may be treated as an inpatient if:

- the person is an inpatient on a Treatment Authority under the Act
- an AHD expressly consents to being treated as an inpatient
- an attorney appointed by the person or a guardian for healthcare expressly consents to the person being treated as an inpatient, or
- a person requests they remain as an inpatient when they are admitted to hospital, if the person is concerned that their condition may deteriorate and that being treated this way would be beneficial for their own safety and well-being.
- With the consent of a statutory health attorney (limitations apply - see s2.5.2 inpatient with the consent of a statutory health attorney).

2.5 When requirement to treat in a less restrictive way does not apply

2.5.1 Inpatient under an advance health directive or with the consent of an attorney or guardian

Key points

If a person is an inpatient under an AHD or with the consent of an attorney or guardian for **fourteen (14) days** or more, the treatment and care of the person must be reviewed by a Clinical Director at or around **fourteen (14) days** after admission.

- The Clinical Director may determine if the person should remain as an inpatient or if treatment in the community would be more appropriate.

If the person is to remain an inpatient, the authorised doctor also needs to decide the mechanisms for the person's ongoing treatment.

If the criteria for treating the person under an AHD or with the consent of an attorney or guardian and the criteria for treating the person under a Treatment Authority both apply, then the authorised doctor may make a choice as to which of these mechanisms to use, having regard to:

- The person's treatment needs, and
- The person's views, wishes and preferences

If the person continues to be treated as an inpatient under an AHD or with the consent of an attorney or guardian, the authorised doctor should set a further review time to reconsider the mechanisms to use, having regard to the person's circumstances.

2.5.2 Inpatient with consent of a statutory health attorney

A statutory health attorney is not appointed by the person. Therefore, consideration should be given to treating the person as an inpatient under a Treatment Authority and the extensive oversight and protections afforded by the Act, rather than providing inpatient treatment and care with consent of a statutory health attorney. The decision to treat a patient under a Treatment Authority or with the consent of a statutory health attorney in these circumstances should be made on a case-by-case basis.

In making this decision, the authorised doctor must have regard to:

- the person's treatment needs, and
- the person's views, wishes and preferences.

If the person is to be treated as an inpatient with consent of a statutory health attorney, the authorised doctor should ensure frequent review of this arrangement to reconsider the mechanisms to use, having regard to the person's circumstances.

As a minimum, the treatment and care of the person **must** be reviewed by a Clinical Director at or around **fourteen (14) days** after admission. The Clinical Director may determine if the person should remain as an inpatient or if treatment in the community would be more appropriate. A decision about further review timeframe must also be made.

2.6 Ongoing lack of capacity

Situations may arise where a person lacks capacity in an ongoing way. This may apply if the person is being treated under a Treatment Authority, AHD or with the consent of an attorney.

Where this applies, an authorised doctor **must** contact the Office of the Public Guardian to consider whether guardianship arrangements are appropriate for the person.

2.7 Making of an AHD for future health care

Where a person with a mental illness is being discharged from hospital, health service staff are to inform the person of the options to make an AHD or an EPOA for their future health care.

This is also one of the functions of Independent Patient Rights Advisers under the Act.

2.8 Urgent health care

The less restrictive way provisions do not affect the legal authority to treat a person in urgent circumstances without consent under section 63 of the *Guardianship and Administration Act 2000* (Urgent health care).

Consent of an attorney appointed under an AHD or EPOA, or a guardian for healthcare, is not required in urgent circumstances if the attorney or guardian is not available.

3 Records

The Act requires the Chief Psychiatrist to establish and maintain a record system for AHD and EPOAs related to a person's future treatment and care for a mental illness.

This system is established on the Consumer Integrated Mental Health Application (CIMHA).

A person may request an administrator to keep a copy of an AHD or an EPOA related to the future treatment and care for a mental illness on CIMHA.

This applies whether or not the AHD or EPOA deals with other health care. The administrator **must** comply with the request.

CIMHA should also record the appointment of a guardian for a person who has the authority to consent to healthcare.

Refer to the Mental Health Act 2016 website under 'Treatment and care' for AHD information and templates for consumers.

3.1 Recording of consent

An authorised doctor **must** record in the person's health records (i.e. CIMHA) the fact that a person is being treated under an AHD or with the consent of an attorney or guardian.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly

Chief Psychiatrist, Queensland Health

22 May 2020

Definitions and abbreviations

Term	Definition
AHD	Advance health directive
AMHP	Authorised mental health practitioner
AMHS	Authorised Mental Health Service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Clinical Director	Senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the clinical director functions and responsibilities.
EPOA	Enduring power of attorney
Patient	An involuntary patient, or A person receiving treatment and care for a mental illness in an AMHS, other than as an involuntary patient, including a person receiving treatment and care under and advance health directive or with the consent of a personal guardian or attorney.

Referenced documents and sources

- Chief Psychiatrist Policy – Treatment Authorities.
- Chief Psychiatrist Policy – Child and Youth: Treatment and Care of Minors
- Chief Psychiatrist Policy – Physical Restraint
- Chief Psychiatrist Policy – Seclusion
- Chief Psychiatrist Policy – Mechanical Restraint
- Less restrictive way guidelines
- Guide to advance health directives, enduring powers of attorney, guardians and administrators
- Flowchart – Assessment of capacity and less restrictive way flowchart
- *Child Protection Act 1999*
- *Guardianship and Administration Act 2000*

Guardianship and Administration Act 2000
Mental Health Act 2016
Powers of Attorney Act 1998

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Attachment 1 – Key contacts

Key contacts	
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Local Independent Patient Rights Adviser	Phone: Email:
Office of the Public Guardian	Phone: Email:
	Phone: Email:
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	Phone: Email:
	Phone: Email:
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Mental Health Act 2016

Guide to Advance Health Directives, Enduring Powers of Attorney, Guardians and Administrators

April 2020

Queensland Government

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General

The purpose of this Guide is to summarise the provisions of the *Powers of Attorney Act 1998* (POAA) and the *Guardianship and Administration Act 2000* (GAA) of most relevance to clinicians treating patients with a mental illness.

Clinicians should work collaboratively with and in partnership with patients to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

Overview

The POAA and GAA provide a legal framework for decisions to be made in relation to an adult person (18 years or over):

- by the person, when the person has capacity to make a decision, to apply at a future time when the person does not have capacity, or
- by another person, when the person does not have capacity to make a decision.

Under the POAA and GAA, a person has capacity to make a decision about a matter if the person is capable of:

(a) understanding the nature and effect of decisions about the matter

(b) freely and voluntarily making decisions about the matter, and

(c) communicating the decisions in some way (See section 3.4 'Capacity').

The POAA and GAA apply to decisions made about:

- 'personal matters', which includes health matters, and
- financial matters.

Under these Acts, 'health care' means the care or treatment of, or a service or a procedure for, an adult:

(a) to diagnose, maintain, or treat the adult's physical or mental condition, and

(b) carried out by, or under the direction or supervision of, a health provider.

The Acts also specify 'special personal matters' and 'special health matters', where different decision-making frameworks apply. Electroconvulsive therapy is an example of a special health matter.

Attachment 1 (from Schedule 2 of the POAA and GAA) defines personal matters, special personal matters, health care, and special health care.

There are several ways that decisions may be made in relation to a person, either by the person when the person has capacity, or by another person when the person does not have capacity, namely:

- for health matters and special health matters - under an Advance Health Directive (AHD),
- for health matters - with the consent of an attorney appointed by a person under an AHD,
- for personal matters (including health matters), and financial matters - with the consent of an attorney appointed by a person under an Enduring Power of Attorney (EPOA),
- for health matters – with the consent of a statutory health attorney,
- for personal matters (including health matters) – by a guardian appointed by the Queensland Civil and Administrative Tribunal (QCAT), and
- for financial matters – an administrator appointed by the QCAT.

In addition, healthcare can be provided without consent if it is permitted under another Act (e.g. the *Mental Health Act 2016*) or by a court.

Refer to section 1.5 'Order of Priority'.

1 Consent to health care

1.1 Advance health directives

A person may make an AHD at any time they are well and have capacity to make decisions.[1]

An AHD acts as a record of a person's consent to receive (or not receive) particular health care, which applies at any time when the person does not have capacity to make these decisions. An AHD may also include the person's views, wishes and preferences about their future health care (see section 222(2) of the *Mental Health Act 2016*). Directions under an AHD may relate to special health matters, such as consent to receive electroconvulsive therapy.

An AHD may appoint one or more persons to be an attorney for the person in addition to, or instead of, giving directions under an AHD. Attorneys may be appointed to make decisions in different ways, for example – decisions **must** be made jointly, a second attorney is only to make decisions of the first attorney is not available, or either attorney can make a decision. The AHD may specify or place limits or conditions on the decisions an attorney can make.

An attorney may make decisions relating to the person's health care at a time when the person does not have capacity. However, the attorney's decisions cannot be inconsistent with the person's directions in an AHD. Also, an attorney does not have power to make decisions for special health matters, including electroconvulsive therapy.

[1] The Chief Psychiatrist has approved an advance health directive form for the use of persons with a mental illness. (See Advance Health Directive for Mental Health – Guide and Form).

1.2 Attorney appointed under an Enduring Power of Attorney

An adult may appoint an attorney under an EPOA.

An EPOA must be made in the approved form under the POAA.

A person may, under an EPOA, appoint one or more persons to be an attorney for the person for personal matters, includes health matters2. As with attorneys appointed under AHDs, attorneys may be appointed to make decisions in different ways. The appointment may specify or place limits or conditions on the decisions an attorney can make.

An attorney may make decisions relating to the person's health care at a time when the person does not have capacity. An attorney does not have power to make decisions for special health matters, including electroconvulsive therapy.

1.3 Statutory health attorneys

A 'statutory health attorney' may make decisions relating to a person's treatment and care at a time when the person does not have capacity. A statutory health attorney is the first, in listed order, of the following people who is readily available and culturally appropriate to make decisions for the person:

- a spouse of the adult if the relationship between the adult and the spouse is close and continuing,[3]
- a person who is 18 years or more and who has the care of the adult and is not a paid carer for the adult, and
- a person who is 18 years or more and who is a close friend or relation of the adult and is not a paid carer for the adult.

If none of the above are readily available and culturally appropriate to make decisions for a person, the Public Guardian is the person's statutory health attorney.

No appointment is required for the person to perform the function of a statutory health attorney.

A statutory health attorney cannot consent to health care if an AHD giving a direction about the matter is in place for the relevant matter, or an attorney or guardian has been appointed for the matter (see section 2.5 'Order of Priority' below).

[2] An attorney may also be appointed for financial matters under an EPOA.

[3] A spouse includes a de facto partner and a civil partner under the *Civil Partnerships Act 2011*.

1.4 Guardians

The Queensland Civil and Administrative Tribunal (QCAT) may appoint one or more guardians for a personal matter, including health matters, for a person who does not have capacity for the matter.

In making this appointment, the QCAT sets the terms and conditions of the appointment.

Subject to the terms of the appointment, a guardian may consent to the person's treatment and care at a time when the person does not have capacity. A guardian does not have the power to consent for special health matters, such as electroconvulsive therapy.

1.5 Order of priority

It is possible that one or more of the above decision-making arrangements are in place for a person at any one time. To clarify how these arrangements work together, the POAA and GAA establish an order of priority in dealing with these decision-making arrangements, by reference to 'health care' and 'special health care'[4].

In summary, consent for health care (not special health care) is dealt with as follows:

1) if the person has made an Advance Health Directive giving a direction about a particular matter, the matter may only be dealt with under the direction
2) if (1) does not apply and the QCAT has appointed one or more guardians for the matter or made an order about the matter, the matter may only be dealt with by the guardian(s) or under the order
3) if (1) or (2) do not apply, an attorney appointed under an Advance Health Directive or an EPOA may consent to the matter, and
4) if (1) to (3) does not apply, a statutory health attorney may consent to the matter.

[4] Attachment 2 details this order of priority.

2 Matters Related to Consent to Health Care

2.1 Use of physical restraint and requiring a person to remain an inpatient

There are various scenarios where physical restraint may be used in relation to a patient.

Section 75 of the GAA provides that:

> A health provider and a person acting under the health provider's direction or supervision may use the minimum force necessary and reasonable to carry out health care authorised under this Act. For example, an agitated patient may be held so that an injection can be administered safely and effectively.

A doctor may treat a patient without capacity in an inpatient unit from which the patient cannot leave only if it is necessary for the patient's health and wellbeing, and an AHD, attorney or guardian for health care expressly consents to this treatment (noting that this power may also be exercised under a Treatment Authority made under the *Mental Health Act 2016*).[5]

It should be noted that the POAA and GAA only apply where the reason for the use of force or restraint is the provision of health care. The Acts do not apply in circumstances where physical restraint is used only to protect the patient and others from harm.

2.2 Objections to health care

> Section 67 of the GAA provides that: Generally, the exercise of power for a health matter or special health matter is ineffective to give consent to health care of an adult if the health provider knows, or ought reasonably to know, the adult objects to the health care.

However, this does not apply if:

(a) the adult has minimal or no understanding of what the health care involves or why the health care is required, and

(b) the health care is likely to cause the adult no distress, or temporary distress that is outweighed by the benefit to the adult of the proposed health care.

[5] The Advance Health Directive form approved by the Chief Psychiatrist expressly provides for a person to consent, or not to consent to this treatment, including a maximum time period for the treatment.

As such, health practitioners need to be cognisant of any objections made while the person had capacity, including for example, in an AHD.

However, there are circumstances when a patient's objection will not be sufficient to prevent the provision of healthcare. If the patient lacks capacity to make decisions about their healthcare, and the criteria in section 67 of the GAA are met, the healthcare can be provided despite the objection.

2.3 Urgent health care

The fact that a person has an AHD, or has an attorney or guardian appointed, does not affect the legal authority to treat a person in urgent circumstances without consent under section 63 of the GAA (Urgent health care).

This provision allows health care (but not special health care) to be carried out for an adult without consent if the health provider reasonably considers the person does not have capacity for the health matter and one of the two scenarios applies.

Firstly, where the health care should be carried out urgently to meet imminent risk to the adult's life or health. However, in these circumstances, health care may not be carried out if the health provider knows the adult objects to the health care in an AHD.

Alternatively, where the healthcare should be carried out urgently to prevent significant pain or distress to the adult and it is not practicable to obtain consent. This health care may not be carried out if the health provider knows the person objects to the health care unless the person has minimal or no understanding of:

- what the health care involves or why the health care is required, and
- the health care is likely to cause the adult no distress, or temporary distress that is outweighed by the benefit to the adult of the health care.

The health provider **must** certify in the person's clinical records as to the matters enabling the health care to be carried out under this section.

2.4 Capacity

Under the *Mental Health Act 2016*, a person has capacity to consent to be treated if the person is capable of understanding, in general terms:

- that the person has an illness, or symptoms of an illness, that affects the person's mental health and wellbeing
- the nature and purpose of the treatment for the illness
- the benefits and risks of the treatment, and alternatives to the treatment, and
- the consequences of not receiving the treatment.

This definition of 'capacity' is more specific and detailed compared to its definitions in the POAA and GAA. Because of this, it is likely that a person who is found to lack capacity under the *Mental Health Act 2016* will also lack capacity under the POAA and GAA. The definition of capacity in the *Mental Health Act 2016* should be followed for patients receiving care under that Act.

The person **must** also be capable of making a decision about the treatment and communicating the decision in some way.

Health practitioners need to decide whether or not a person has capacity for the purposes of deciding whether:

- a Treatment Authority can be made for the person (under the *Mental Health Act 2016*), and
- whether a person can be treated under an AHD or with the consent of an attorney or guardian (under the POAA and GAA).

2.5 Responsibilities of Guardians and Attorneys

The POAA and GAA place strict obligations on attorneys and guardians, namely:

- in making a health care decision, an attorney or guardian **must** apply the general principles and the health care principle (see attachment 3)
- an attorney or guardian **must**:
  - make decisions honestly and with reasonable diligence to protect the person's interests
  - act in accordance with any terms or conditions of their appointment, and
- a guardian **must** comply with any order made by the QCAT.

2.6 Right to information

The POAA and GAA provide that an attorney or guardian has a right to all information that the relevant person would have been entitled to if the person had capacity at the time. The information **must** be necessary for the attorney or guardian to make a decision for the person that they are authorised to make.

These Acts provide that this requirement overrides any duty of confidentiality under legislation or the common law.

2.7 Protections for health practitioners

Health practitioners are provided with substantial protections under the POAA and GAA (see attachment 4).

Summary

- a person is entitled to rely on the certificate of the witness to the document as evidence of the patient's capacity at the time of making an AHD or EPOA,
- a person who acts under an AHD or a decision by an attorney under an AHD or EPOA does not incur any liability if the health practitioner did not know the directive or the power to make the decision were invalid,
- where a health practitioner gives health care to a patient with the consent of a person (attorney or guardian) who represented that they had the right to consent for the person, the health practitioner is taken to have the patient's consent (unless the health practitioner knew or should have known the person did not have the power to consent), and
- a person who acts under an AHD or a decision by an attorney is not liable to any act or omission to any greater extent than if the act or omission happened with the person's consent when the person had capacity.

3 Administrators for financial matters

The QCAT may appoint an administrator for a financial matter for a person who does not have capacity for the matter.

In making this appointment, the QCAT sets the terms and conditions of the appointment.

Subject to the terms of the appointment, an administrator can deal with any financial matter that the person could have done if they had capacity.

Issued under section 305 of the *Mental Health Act 2016*.

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 April 2020

Attachment 1 - Types of matters (POAA, Schedule 2 (extract) and GAA Schedule 2 (extract))

Personal matter

A personal matter, for a principal, is a matter, other than a special personal matter or special health matter, relating to the principal's care, including the principal's health care, or welfare, including, for example, a matter relating to 1 or more of the following—

(a) where the principal lives;
(b) with whom the principal lives;
(b)a) services provided to the principal;
(c) whether the principal works and, if so, the kind and place of work and the employer;
(d) what education or training the principal undertakes;
(e) whether the principal applies for a license or permit;
(f) day-to-day issues, including, for example, diet and dress;
(g) whether to consent to a forensic examination of the principal[6];
(h) health care of the principal;
(i) a legal matter not relating to the principal's financial or property matters;

Special personal matter

A special personal matter, for a principal, is a matter relating to 1 or more of the following—

(a) making or revoking the principal's will;
(b) making or revoking a power of attorney, EPOA or AHD of the principal;
(c) exercising the principal's right to vote in a Commonwealth, State or local government election or referendum;
(d) consenting to adoption of a child of the principal under 18 years;
(e) consenting to marriage of the principal;
(f) consenting to the principal entering into a civil partnership;
(g) consenting to the principal terminating a civil partnership;
(h) entering into, or agreeing to enter into, a surrogacy arrangement under the *Surrogacy Act 2010*;
(i) consenting to the making or discharge of a parentage order under the *Surrogacy Act 2010*.

[6] See also section 104 (Protection for person carrying out forensic examination with consent).

Health care

(1) Health care, of a principal, is care or treatment of, or a service or a procedure for, the principal—

(a) to diagnose, maintain, or treat the principal's physical or mental condition; and

(b) carried out by, or under the direction or supervision of, a health provider.

(2) Health care, of a principal, includes withholding or withdrawal of a life-sustaining measure for the principal if the commencement or continuation of the measure for the principal would be inconsistent with good medical practice.

(3) Health care, of a principal, does not include—

a) first aid treatment; or

b) a non-intrusive examination made for diagnostic purposes[7]; or

c) the administration of a pharmaceutical drug if—

i. a prescription is not needed to obtain the drug; and

ii. the drug is normally self-administered; and

iii. the administration is for a recommended purpose and at a recommended dosage level; or

d) psychosurgery for the principal.

Special health care

Special health care, of a principal, is health care of the following types—

a) removal of tissue from the principal while alive for donation to someone else[8];

b) sterilisation of the principal;

c) termination of a pregnancy of the principal;

d) participation by the principal in special medical research or experimental health care;

e) electroconvulsive therapy or a non-ablative neurosurgical procedure for the principal;

f) prescribed special health care of the principal.

[7] *Example of paragraph (b)*—a visual examination of a principal's mouth, throat, nasal cavity, eyes or ears

[8] *Note:* For the situation after the principal has died, see the *Transplantation and Anatomy Act 1979*, particularly section 22.

Attachment 2 - Order of priority in dealing with health matters and special health matters (GAA, sections 65 and 66).

Adult with impaired capacity—order of priority in dealing with health matter

1. If an adult has impaired capacity for a health matter, the matter may only be dealt with under the first of the following subsections to apply.

2. If the adult has made an AHD giving a direction about the matter, the matter may only be dealt with under the direction.

3.If subsection (2) does not apply and the QCAT has appointed 1 or more guardians for the matter or made an order about the matter, the matter may only be dealt with by the guardian or guardians or under the order[9].

4. If subsections (2) and (3) do not apply and the adult has made 1 or more enduring documents appointing 1 or more attorneys for the matter, the matter may only be dealt with by the attorney or attorneys for the matter appointed by the most recent enduring document.

5. If subsections (2) to (4) do not apply, the matter may only be dealt with by the statutory health attorney.

6. This section does not apply to a health matter relating to health care that may be carried out without consent under division 1.

Adult with impaired capacity—order of priority in dealing with special health matter

1. If an adult has impaired capacity for a special health matter, the matter may only be dealt with under the first of the following subsections to apply.

2. If the adult has made an AHD giving a direction about the matter, the matter may only be dealt with under the direction.

3. If subsection (2) does not apply and an entity other than the QCAT is authorised to deal with the matter, the matter may only be dealt with by the entity.

4. If subsections (2) and (3) do not apply and the QCAT has made an order about the matter, the matter may only be dealt with under the order[10].

[9] *Note:* If, when appointing the guardian or guardians, the [QCAT] was unaware of the existence of an enduring document giving power for the matter to an attorney, see section23 (Appointment without knowledge of enduring document), particularly subsection (2).

[10] Note: However, the [QCAT] may not consent to electroconvulsive therapy or psychosurgery—see section 68(1).

Attachment 3 - General Principles and Health Care Principle (POAA and GAA)

General Principles (POAA, Schedule 1, Part 1 and GAA, Schedule 1, Part 1)

Presumption of capacity

An adult is presumed to have capacity for a matter.

Same human rights

1. The right of all adults to the same basic human rights regardless of a particular adult's capacity **must** be recognised and taken into account.
2. The importance of empowering an adult to exercise the adult's basic human rights **must** also be recognised and taken into account.

Individual value

An adult's right to respect for his or her human worth and dignity as an individual **must** be recognised and taken into account.

Valued role as member of society

1. An adult's right to be a valued member of society **must** be recognised and taken into account.
2. Accordingly, the importance of encouraging and supporting an adult to perform social roles valued in society **must** be taken into account.

Participation in community life

The importance of encouraging and supporting an adult to live a life in the general community, and to take part in activities enjoyed by the general community, must be taken into account.

Encouragement of self-reliance

The importance of encouraging and supporting an adult to achieve the adult's maximum physical, social, emotional and intellectual potential, and to become as self-reliant as practicable, **must** be taken into account.

Maximum participation, minimal limitations and substituted judgment

1. An adult's right to participate, to the greatest extent practicable, in decisions affecting the adult's life, including the development of policies, programs and services for people with impaired capacity for a matter, **must** be recognised and taken into account.

2. Also, the importance of preserving, to the greatest extent practicable, an adult's right to make his or her own decisions **must** be taken into account.

3. So, for example—

a) the adult **must** be given any necessary support, and access to information, to enable the adult to participate in decisions affecting the adult's life; and

b) to the greatest extent practicable, for exercising power for a matter for the adult, the adult's views and wishes are to be sought and taken into account; and

c) a person or other entity in performing a function or exercising a power under this Act **must** do so in the way least restrictive of the adult's rights.

4. Also, the principle of substituted judgment **must** be used so that if, from the adult's previous actions, it is reasonably practicable to work out what the adult's views and wishes would be, a person or other entity in performing a function or exercising a power under this Act **must** take into account what the person or other entity considers would be the adult's views and wishes.

5. However, a person or other entity in performing a function or exercising a power under this Act **must** do so in a way consistent with the adult's proper care and protection.

6. Views and wishes may be expressed orally, in writing or in another way, including, for example, by conduct.

Maintenance of existing supportive relationships

The importance of maintaining an adult's existing supportive relationships **must** be taken into account.

Maintenance of environment and values

1. The importance of maintaining an adult's cultural and linguistic environment, and set of values (including any religious beliefs), **must** be taken into account.

2. For an adult who is a member of an Aboriginal community or a Torres Strait Islander, this means the importance of maintaining the adult's Aboriginal or Torres Strait Islander cultural and linguistic environment, and set of values (including Aboriginal tradition[11] or Island custom[12]), **must** be taken into account.

Appropriate to circumstances

Power for a matter should be exercised by a guardian or administrator for an adult in a way that is appropriate to the adult's characteristics and needs.

Confidentiality

An adult's right to confidentiality of information about the adult **must** be recognised and taken into account.

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[11] ***Aboriginal tradition*** has the meaning given by the *Acts Interpretation Act 1954*, schedule 1.

[12] ***Island custom*** has the meaning given by the *Acts Interpretation Act 1954*, schedule 1.

Health Care Principle (POAA, Schedule 1, Part 2 and GAA, Schedule 1, Part 2)

1. The health care principle means that power for a health matter for an adult should be exercised by an attorney [or guardian]—

    (a) in the way least restrictive of the adult's rights; and
    (b) only if the exercise of power—
    (i) is necessary and appropriate to maintain or promote the adult's health or wellbeing; or
    (ii) is, in all the circumstances, in the adult's best interests.
    Example of exercising power in the way least restrictive of the adult's rights—
    If there is a choice between a more or less intrusive way of meeting an identified need, the less intrusive way should be adopted.

2. In deciding whether the exercise of a power is appropriate, the attorney [or guardian] must, to the greatest extent practicable—

    (a) seek the adult's views and wishes and take them into account; and
    (b) take the information given by the adult's health provider into account.
    Note—
    See section 81 (Right of attorney to information).

3. The adult's views and wishes may be expressed orally, in writing (for example, in an AHD) or in another way, including, for example, by conduct.

4. The health care principle does not affect any right an adult has to refuse health care.

Attachment 4 - Protections for health practitioners

Powers of Attorney Act 1998

Protection for persons dealing with attorney and next person if unaware of invalidity (extract)

1. A person who—
   (a) deals with an attorney under a general power of attorney made under this Act, or an enduring document, (the ***document***), and
   (b) does not know, or have reason to believe, the principal did not have capacity to make the document

   is entitled to rely on the certificate of the witness to the document as evidence of the principal's capacity to make the document.

Additional protection if unaware of invalidity in health context

A person, other than an attorney, who, without knowing an AHD or a power for a health matter under an enduring document [an AHD or an EPOA] is invalid, acts in reliance on the directive or purported exercise of the power, does not incur any liability, either to the adult or anyone else, because of the invalidity.

No less protection than if adult gave health consent

A person, other than an attorney, acting in accordance with a direction in an AHD, or a decision of an attorney for a health matter, is not liable for an act or omission to any greater extent than if the act or omission happened with the principal's consent and the principal had capacity to consent.

Protection of health provider unaware of Advance Health Directive

A health provider is not affected by an adult's AHD to the extent the health provider does not know the adult has an AHD.

Protection of health provider for non-compliance with Advance Health Directive

1. This section applies if a health provider has reasonable grounds to believe that a direction in an AHD is uncertain or inconsistent with good medical practice or that circumstances, including advances in medical science, have changed to the extent that the terms of the direction are inappropriate.

2. The health provider does not incur any liability, either to the adult or anyone else, if the health provider does not act in accordance with the direction.

3. However, if an attorney is appointed under the AHD, the health provider has reasonable grounds to believe that a direction in the AHD is uncertain only if, among other things, the health provider has consulted the attorney about the direction.

Under the POAA, 'good medical practice' for the medical profession in Australia consists of the nationally recognised ethical standards, as well as medical standards, practices and procedures.

Guardianship and Administration Act 2000

Protection of health provider

1. To the extent a health provider giving health care to an adult complies with a purported exercise of power for a health matter or special health matter by a person who represented to the health provider that the person had the right to exercise the power, the health provider is taken to have the adult's consent to the exercise of power.

2. Subsection (1) does not apply if the health provider knew, or could reasonably be expected to have known, the person did not have the right to exercise the power.

Offence to exercise power for adult if no right to do so

It is an offence for a person who knows he or she has no right to exercise power for a health matter or special health matter for an adult, or who is recklessly indifferent about whether he or she has a right to exercise power for a health matter or special health matter for the adult, to—

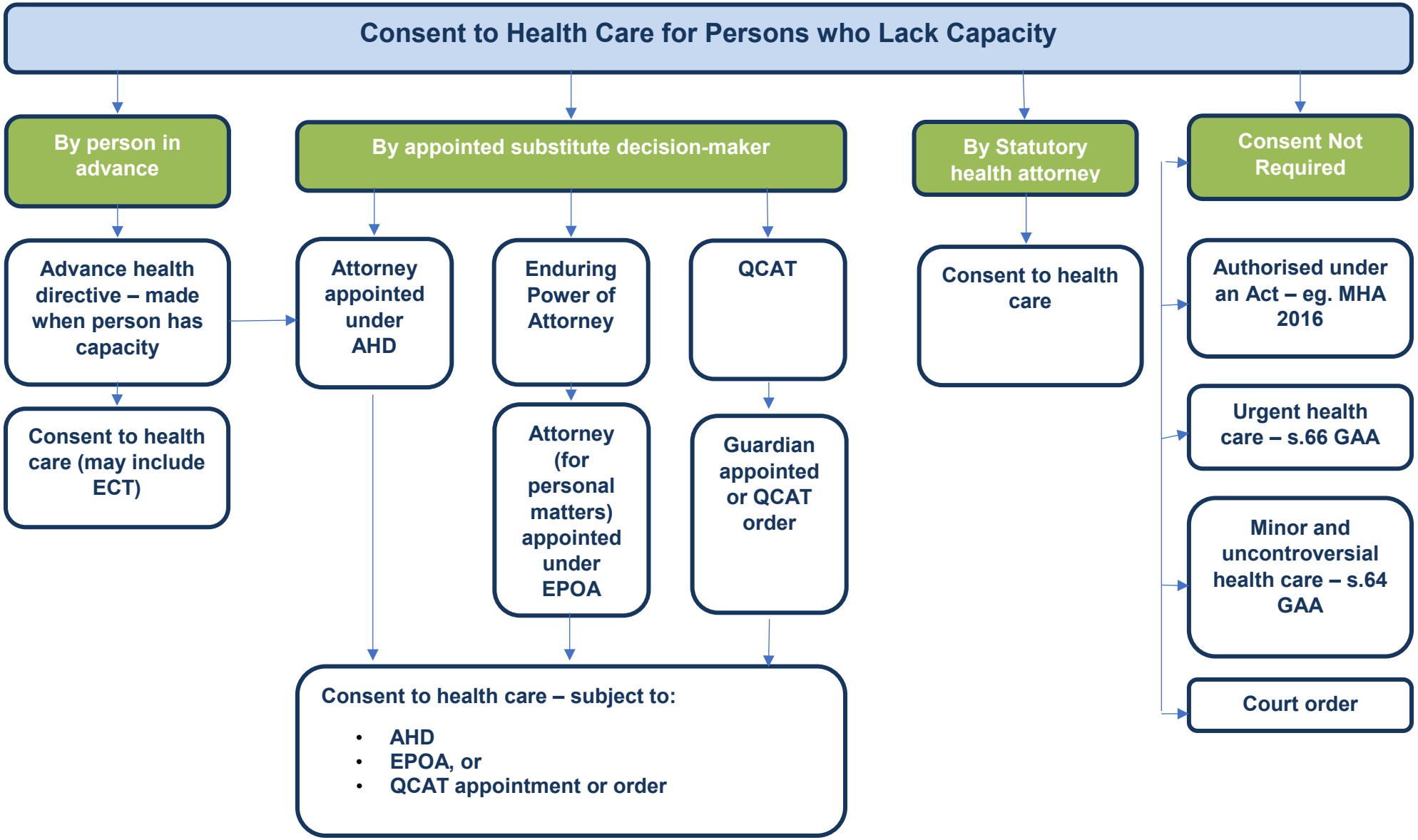
(a) purport to exercise power for a health matter or special health matter for the adult; or
(b) represent to a health provider for the adult that the person has a right to exercise power for a health matter or special health matter for the adult.

Maximum penalty—

(a) for special health matter—300 penalty units; or
(b) for health matter—200 penalty units.

No less protection than if adult gave health consent

A person carrying out health care of an adult that is authorised by this or another Act is not liable for an act or omission to any greater extent than if the act or omission happened with the adult's consent and the adult had capacity to consent.


Consent to Health Care for Persons who Lack Capacity
By person in advance
By appointed substitute decision-maker
By Statutory health attorney
Consent Not Required
Advance health directive – made when person has capacity
Consent to health care (may include ECT)
Attorney appointed under AHD
Enduring Power of Attorney
QCAT
Attorney (for personal matters) appointed under EPOA
Guardian appointed or QCAT order
Consent to health care
Authorised under an Act – eg. MHA 2016
Urgent health care – s.66 GAA
Minor and uncontroversial health care – s.64 GAA
Court order
Consent to health care – subject to:
AHD
EPOA, or
QCAT appointment or order