ANNUAL REPORT
2015–2016

Queensland Health
Director of Mental Health

Queensland Government

Communication objective

This annual report details the administration of the *Mental Health Act 2000* and the associated activities and achievements for the 2015-2016 financial year in an open and transparent manner to inform the Minister for Health and Minister for Ambulance Services, the Queensland Parliament and members of the public.

2015 – 2016 Annual Report of the Director of Mental Health

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An electronic version of this document is available at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/plans-strategic/default.asp

To:

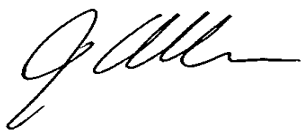
The Honourable Cameron Dick MP

Minister for Health and Minister for Ambulance Services

Dear Minister

It is with much pleasure that I present the 2015–2016 Annual Report of the Director of Mental Health. This report is provided in accordance with section 494 of the *Mental Health Act 2000 (Queensland)*.

Yours sincerely



Associate Professor John Allan
Director of Mental Health

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Message from the Director of Mental Health

I am pleased to present the 15th annual report of the Director of Mental Health in accordance with my appointment on 1 July 2015 to the position of the Director of Mental Health.

This report sets out key activities in the administration of the *Mental Health Act 2000* (the Act). In addition, it outlines Queensland's progress with mental health legislative reform and some significant safety and quality improvement initiatives in accordance with the Act.

Legislative reform

The comprehensive review of Queensland's mental health legislation, which commenced in June 2013, culminated in the *Mental Health Act 2016* (2016 Act). The new legislation was passed by Parliament on 18 February 2016 and will commence on 5 March 2017. Until then, the current Act, the *Mental Health Act 2000*, remains in place.

The review was informed by broad consultation across mental health services and others administering the Act, government and non-government organisations, statutory agencies, consumers and carers and other interested parties. I thank all those involved for their generous contributions to the review process.

The 2016 Act is similar to the current Act, but there are several key differences that better align the legislation with good clinical practice. When the 2016 Act takes effect, it will represent a major step forward for patient rights and will strengthen the role of family and support persons. I welcome the commencement of the 2016 Act as a significant advancement in mental health reform.

A dedicated Mental Health Implementation Team is working with the Department of Health's Mental Health Alcohol and Other Drugs Branch (MHAODB), mental health services, clinicians, consumers, carers and other key stakeholders in implementing the new legislation.

A large range of resources have been developed to assist with the implementation of the 2016 Act, notably a guide which summarises key areas of the 2016 Act and provides references for those who want to refer to the legislation for a more detailed understanding. There is also an 'Introduction to the 2016 Act' video which explains key features and provisions of the 2016 Act.

Other resources include the Comparison of Key Provisions—*Mental Health Act 2000* and *Mental Health Act 2016* and the Overview of the 2016 Act fact sheet.

These resources are available on the Queensland Health internet site at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/2016/resources/default.asp

Online training resources have been developed for clinicians and those administering the 2016 Act. These resources include a competency-based eLearning package for clinicians, a training video for Administrators of Authorised Mental Health Services (AMHSs) and a training package for emergency services personnel i.e. police officers, ambulance officers and emergency department staff.

More information about these resources can be found at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/2016/training/default.asp

Two key reforms were made to the existing mental health legislation during 2015-2016.

The *Queensland Mental Health Regulation 2002* (the Regulation) was amended to update the schedule of corresponding laws so as to align with legislative changes in other jurisdictions. Ministerial interstate agreements for planned transfers and the apprehension and return of involuntary mental health patients rely on the declaration of corresponding laws in the Regulation. These amendments commenced on 6 November 2015.

An amendment was also made to the definition of psychiatrist in the Act. The amended definition enables medical practitioners who are undertaking postgraduate training or supervised practice in a specialist position in psychiatry to perform duties as an authorised psychiatrist under the Act. This amendment aligns with the limited registration category under the Australian Health Practitioner Regulation Agency. This amendment commenced on 1 September 2015.

Safety and quality improvement initiatives

A range of quality and safety initiatives were undertaken during 2015-2016, which reflect the collaborative work between Queensland Health and other stakeholders.

I am very pleased to report that, while there are fluctuations in AWOP data, the significant overall decrease in AWOP activity, particularly from adult inpatient units, has been sustained since September 2013.

I thank mental health services for their continued efforts in this regard through a range of evidence-based, recovery-oriented interventions. More information is provided in the chapter, 'Supporting quality improvements in mental health service delivery' in this report.

During 2015-2016, two significant cross-government agreements which provide for information sharing arrangements in the treatment and care of persons with a mental illness were revised. The revised agreements are a result of the goodwill between Queensland Health and relevant agencies, and confirm a mutual commitment towards best practice mental health service delivery.

The Memorandum of Understanding between Queensland Health and the Queensland Police Service for Mental Health Collaboration allows confidential information to be shared between Queensland Health and the Queensland Police Service for the purposes of responding to a mental health incident and/or developing a mental health intervention strategy.

The Memorandum of Understanding has been updated to reflect current legislation and to better support the proactive work undertaken by Queensland Health and the Queensland Police Service to reduce the likelihood of a mental health incident from occurring, and to strengthen responses when a mental health incident does occur. The Memorandum of Understanding was signed by Queensland Health and the Queensland Police Service on 16 June 2016.

The Memorandum of Understanding between Queensland Health and Queensland Corrective Services for Confidential Information Disclosure, established in 2011, has been revised to reflect current legislation and management practices across the parties. The Memorandum of Understanding

enables the sharing of confidential information between Queensland Health and Queensland Corrective Services regarding persons in custody with a mental illness in circumstances where other legislative avenues of obtaining confidential information, particularly through obtaining consent of the person, have been exhausted. The Memorandum of Understanding was signed by Queensland Health and the Queensland Corrective Services on 16 May 2016.

Both Memoranda of Understanding have been prescribed in the *Hospital and Health Boards Regulation 2012* (HHB Regulation) and commenced on 25 November 2016.

Of key importance is the success of the Suicide Risk Assessment and Management in Emergency Department settings training program, which has been developed through a partnership between my office and Queensland Health's Centre for Mental Health Learning and Clinical Skills Development Service. This essential program is designed to help emergency department staff and other front-line acute mental health care staff to recognise, respond to, and provide care for people presenting to health services with suicide risk. The program is being delivered across the state. Feedback from participants so far indicates the program has greatly assisted them in improving their skills in suicide risk assessment and in engaging vulnerable people with the health system.

In April 2016, an independent expert Sentinel Events Review Committee completed a statewide review of sentinel events that occurred between January 2013 and April 2015 involving people with a known or suspected mental illness, who were in receipt of Queensland public mental health services. The review report, *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*, makes a number of recommendations which will inform strategic directions, policy development and clinical practice to better provide for the treatment and care of people with mental illness and prevent or reduce the reoccurrence of such events. My office is collaborating with mental health services, patients, families and carers in implementing the recommendations arising from the review.

An evaluation of the implementation of the interagency agreement—Safe Transport of People with a Mental Illness: a Queensland Interagency Agreement across Hospital and Health Services (HHSs)—was conducted by my office in June 2016. The Agreement was developed in collaboration with the Queensland Ambulance Service and the Queensland Police Service, and was implemented in 2014. It clarifies the roles and responsibilities of the agencies, and provides a framework for local agreements and protocols to support safe mental health patient transport. The evaluation found the majority of HHSs consider the Agreement provides a statewide interagency approach and defines consistent decision making and communication processes regarding coordinated transport arrangements for people with a mental illness. I commend the goodwill evident in local communication networks and arrangements, which frequently requires the consideration of conflicting demands on resources in providing a timely and safe response to requests for mental health patient transport.

The Queensland Health Guideline, information sharing between mental health workers, consumers, carers, family and significant others, has been revised to reflect the confidentiality provisions of the *Hospital and Health Boards Act 2011* (HHB Act) and contemporary practice in relation to appropriate information sharing. The Guideline is recognised as an important resource which supports the meaningful engagement of carers, family and significant others in the treatment of people with a mental illness. It also provides information about circumstances in which clinicians are required or permitted by law to share information for the safety and protection of others, and circumstances in which they should exercise their clinical judgement in deciding what information may be shared and with whom.

I look forward to an exciting year ahead as my office continues to collaborate with HHSs and other key stakeholders including consumers, carers, mental health services, clinicians, primary care agencies,

government and non-government agencies and the Queensland Mental Health Commission in implementing and progressing reforms and strategic developments in Queensland mental health service delivery.

I take this opportunity to express my sincere thanks to the dedicated health staff at service and corporate levels for their contribution to the administration of the Act and their ongoing commitment to advancing quality mental health treatment and care in Queensland.

Associate Professor John Allan

Director of Mental Health

Statutory roles and facilities

Director of Mental Health

On 1 July 2015, His Excellency the Honourable Paul de Jersey, Governor of Queensland, approved the appointment of Associate Professor John Allan to the position of Director of Mental Health, for a two year term of office commencing on 1 July 2015.

Powers and functions

The Department of Health administers the Act. The Act establishes broad monitoring and oversight functions for the Director of Mental Health including:

- ensuring the protection of rights of involuntary patients
- ensuring involuntary admission, assessment, and treatment and care of persons complies with the Act
- facilitating the proper and efficient administration of the Act
- promoting community awareness and understanding of the administration of the Act
- advising and reporting to the Minister on any matter relating to the administration of the Act.

More specific powers and functions of the Director of Mental Health relating to the administration of the Act include:

- powers to issue policies and practice guidelines
- declaring Authorised Mental Health Services (AMHSs) and high security units to provide treatment and care for persons with mental illness
- declaring Administrators of AMHSs and high security units appointing authorised mental health practitioners (AMHP)
- appointing approved officers to conduct investigations under the Act
- developing a Statement of Rights for involuntary patients and their allied persons
- approving forms used under the Act, excluding those required by the Mental Health Review Tribunal (the Tribunal) or the Mental Health Court.

The Director of Mental Health also has powers and functions in relation to involuntary patients who are, or have been, subject to criminal justice system processes. These include:

- receiving expert psychiatric reports in relation to involuntary patients charged with an offence and referring these matters to the Director of Public Prosecutions or the Mental Health Court for determination

- ordering the transfer of classified patients (patients admitted to a health service from a court or place of custody) and forensic patients (patients found to be of unsound mind or unfit for trial in relation to a criminal offence)
- facilitating return to court or custody for classified patients who no longer need to be detained for assessment/treatment of a mental illness
- approving limited community treatment (LCT) for classified patients
- determining the need for a monitoring condition to be applied to certain patients detained under the Act who are undertaking LCT.

Delegation of Director of Mental Health's powers

The Director of Mental Health can delegate certain powers under the Act to an appropriately qualified public service or health service employee. This delegation may include all the Director of Mental Health's powers except those relating to the declaration of AMHSs, high security units and administrators.

During 2015–2016, the Director of Mental Health was assisted by a number of psychiatrists who performed duties as delegated.

In addition, the Director of Mental Health has delegated powers relating to the publication of information about a patient in specified circumstances to Health Service Chief Executives of HHSs (HSCEs). This power aligns with, and may be used in conjunction with, the power of Chief Executives to disclose information under the HHB Act.

To assist with administrative processes in fulfilling the Director of Mental Health's statutory responsibilities, the Director of Mental Health has made a small number of limited delegations to specified positions within MHAODB.

A list of delegates and delegated powers and functions as at 30 June 2016 is set out in Appendix 1.

Administrators of authorised mental health services and high security units

The Act provides for the Director of Mental Health, by gazette notice, to declare a person or the holder of a stated office to be the Administrator of an AMHS or a high security unit.

The Administrator of an AMHS, including a high security unit, is responsible for a range of administrative responsibilities relating to involuntary patients under the Act. This position plays a critical role in coordinating and overseeing the operation of the Act at the service delivery level.

Powers and functions of the Administrator include:

- giving notice to patients and other parties, e.g. an allied person or the Tribunal, of various matters relating to the patient's involuntary status or changes to their involuntary status

- ensuring patients receive treatment in accordance with their treatment plan, including regular assessment by an authorised psychiatrist
- choosing an allied person for patients who do not have capacity to choose their own allied person
- ensuring the Statement of Rights is prominently displayed in the AMHS or high security unit and is provided to all involuntary patients and their allied person
- ensuring policies and practice guidelines about the treatment and care of patients are given effect
- giving notice of various matters to the Director of Mental Health in relation to an involuntary patient charged with an offence
- refusing a visitor's access to a patient if the Administrator is satisfied that such a visit would adversely affect the person's treatment
- giving agreement to the admission of a person who is in custody or before a court
- assuming responsibility for the legal custody of classified patients, forensic patients who are found temporarily unfit for trial and patients for whom a court order has been made for the person's detention, treatment or care in an AMHS
- appointing authorised doctors for an AMHS or high security unit
- maintaining records and registers and providing information on involuntary patients to the Director of Mental Health.

The schedule of AMHS Administrators as at 30 June 2016 is set out in Appendix 2.

Authorised doctors

Under the Act, certain decisions relating to involuntary patients must be made by an authorised doctor.

Authorised doctors are appointed by the Administrator of an AMHS. In appointing an authorised doctor, the Administrator must believe that the doctor has the experience and expertise needed to undertake this specialist role. Most authorised doctors are psychiatrists or psychiatric registrars.

The functions performed by an authorised doctor require a good understanding of the provisions of the Act. The Director of Mental Health has established a policy[1] to standardise procedures in relation to the appointment of authorised doctors. This policy sets out the skills and training required to undertake statutory responsibilities under the Act.

The functions and powers of an authorised doctor include assessing a patient to determine whether the involuntary treatment criteria apply, and if so:

1 See Appendix 2 of the Mental Health Act 2000 Resource Guide and Appendix 2 of this report for further information

- making an involuntary treatment order (ITO)
- determining where a patient subject to an ITO is to receive treatment in an inpatient facility or in the community
- ensuring a treatment plan is prepared for an involuntary patient
- requiring a patient to be taken to an AMHS when the patient is receiving treatment in the community and has not complied with the requirements of their ITO
- authorising LCT for an involuntary patient receiving treatment in an inpatient facility
- documenting the requirement to return a patient who is absent without permission
- revoking a patient's ITO, if satisfied that the treatment criteria no longer apply.

The Act also requires that an authorised doctor, who is a psychiatrist (an authorised psychiatrist), undertakes certain functions. For example, an ITO must be made or confirmed by an authorised psychiatrist and all involuntary patients are required to be examined by an authorised psychiatrist at regular intervals, as specified in the patient's treatment plan.

The number of authorised doctors at each AMHS (including authorised psychiatrists) as at 30 June 2016 is set out in Appendix 3.

Authorised mental health practitioners

Authorised Mental Health Practitioners (AMHP) play an important role in initiating involuntary assessment.

An AMHP may, if satisfied that the assessment criteria apply to a person, make a recommendation for assessment. The recommendation, together with a request for assessment, authorises the taking of the person to an AMHS for assessment.

The Director of Mental Health appoints AMHP. Nominations are made by the administrator of the relevant AMHS.

The Director of Mental Health has established a policy[2] for appointment of AMHP. This policy outlines the minimum requirements for appointment as an AMHP, including:

- being a health practitioner, as defined under the Act
- being a health service employee of an AMHS or another officer or employee of the Department of Health

2 See Appendix 1 of the Mental Health Act 2000 Resource Guide and Appendix 3 of this report for further information

- a minimum of two years' experience working in mental health service provision, including training and expertise required to assess persons believed to have a mental illness
- participating in regular clinical supervision
- awareness of potential conflicts of interest and the importance of not exercising powers in circumstances where such conflicts exist.

In addition, the policy provides for annual renewal of appointments. The renewal process is intended to ensure AMHP maintain up-to-date knowledge of legislative changes and associated policies and procedures.

The number of AMHP as at 30 June 2016 is set out in Appendix 4.

Authorised mental health services

AMHSs are health services authorised under the Act to provide involuntary examination, assessment, treatment and care for persons with mental illness. AMHSs include both public and private sector health services.

In authorising an AMHS, the Director of Mental Health takes into account the professional expertise required in the assessment and treatment of people with a mental illness, as well as the need to ensure appropriate access to services across the state. In most instances, AMHSs comprise inpatient and community components. Inpatient facilities are generally based in metropolitan and regional centres, while community components are established in rural and remote locations as well as major centres.

In addition, section 15 of the Act provides that a public hospital may be an AMHS for the purpose of a person's examination or assessment under the Act if there is no AMHS readily accessible, e.g. in remote or rural areas of the state.

In June 2015, the Director of Mental Health issued the policy for declaration of an AMHS facility (limited functions) under sections 309A and 493A of the Act. This policy enables the Director of Mental Health to apply specific limitations on the extent of involuntary treatment services provided at a specified AMHS, for the purposes of providing short-term and/or emergency mental health treatment only, pending transfer if required, to a larger AMHS with a dedicated inpatient mental health unit.

The purpose of this policy is to enable involuntary patients in rural and remote locations to receive short-term and/or emergency mental health treatment in their local community, in keeping with the Act's principle of least restriction. People requiring ongoing treatment as an inpatient admission should be transferred to an AMHS facility with a dedicated inpatient mental health unit.

As at 30 June, 2016 the Director of Mental Health has applied this policy to one facility. The Mount Isa Base Hospital Department of Emergency Medicine was declared by gazette notice as a component facility of the Townsville Network AMHS. Specific limitations have been applied by the Director of Mental Health on the services provided under the Act by this facility in accordance with the policy.

Appendix 5 sets out AMHS abbreviations.

The schedule of AMHS as at 30 June 2016 is set out in Appendix 6.

High security units

High security units are AMHSs that provide the highest level of security and containment. The Act applies special requirements to these units to protect the rights of patients and the interests of the wider community, including those related to the admission and discharge of patients and security of the facility.

The facilities declared as high security units as at 30 June 2016 are set out in Appendix 7.

Authorised mental health services administering electroconvulsive therapy

A small number of private sector health services have been declared as AMHSs for the specific purpose of administering electroconvulsive therapy (ECT) to patients who have given informed consent, see Appendix 8. This declaration ensures that private sector patients continue to have appropriate access to ECT. The private sector facilities established for this purpose are licensed under the *Private Health Facilities Act 1999* and have demonstrated that their practices comply with legislative requirements.

Authorised mental health services administering psychosurgery

St Andrew's War Memorial Hospital has been declared an AMHS for the purpose of performing psychosurgery on a person who has given informed consent, and the Tribunal has given approval to the treatment.

St Andrew's War Memorial Hospital has been licenced by the Chief Health Officer under the *Private Health Facilities Act 1999* at Level 3 of the Clinical Services Capability Framework to provide deep brain stimulation as a treatment for obsessive compulsive disorder to patients aged 18 years and over. Deep brain stimulation comes within the definition of psychosurgery under the Act. Psychosurgery is a regulated treatment under the Act and it is an offence to perform psychosurgery for treatment of a mental illness other than in accordance with the Act.

Reporting on the Mental Health Act 2000

Most people with a mental illness are able to make decisions about their treatment. However, there are times when a person is unable to make these decisions due to the nature of their illness. In these circumstances, involuntary treatment may be required. The Act provides the legislative framework for the involuntary assessment, treatment and protection of people with a mental illness, under both civil and forensic systems, while safeguarding their rights and freedoms and balancing these with the rights of others.

Civil involuntary provisions may apply to a person who is believed to represent a risk to their own safety or that of others, or is likely to suffer serious mental or physical deterioration due to their illness.

Forensic provisions provide for the diversion of people with a mental illness and/or intellectual or cognitive disability who are charged with an indictable offence from court or custody to the mental health system and decisions about criminal responsibility where the person has mental illness. The Act also provides for information orders for victims of mentally ill offenders and non-contact provisions for family members, victims of crime and other interested persons, as well as provisions addressing community safety.

Classified patient provisions provide for the secure management of a person brought to an AMHS from court or custody for assessment and/or treatment of a mental illness.

A fundamental human rights principle underpinning the Act is that a person's liberty and rights should only be adversely affected if there is no less restrictive way to protect their health and safety or to protect others.

Approximately 24,000 people have an open patient record at a public mental health service on any given day. Involuntary patients comprise approximately 21 per cent of the total number of people receiving public mental health services.

This chapter details the involuntary provisions and related legislative processes that applied between 1 July 2015 and 30 June 2016. Data on these activities is recorded in the Consumer Integrated Mental Health Application (CIMHA) and the Queensland Hospital Admitted Patient Data Collection (QHADPDC) and records maintained by the MHAODB.

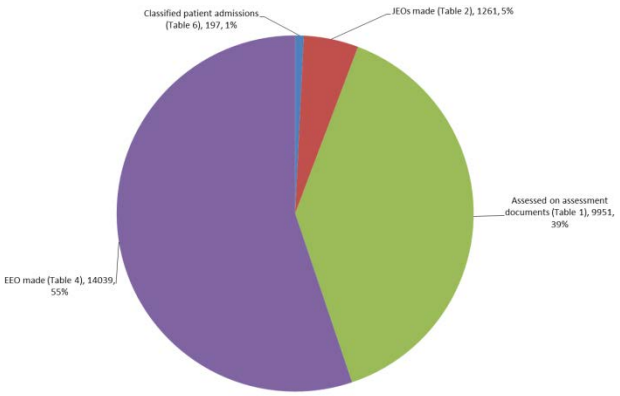
Overview of examination and assessment activity

The following sections focus on the involuntary examination and assessment processes under the Act and associated activity during the 2015–2016 reporting period.

There are four avenues to commence the involuntary examination and assessment processes. These are:

- assessment documents alone—request for assessment and recommendation for assessment
- justices examination order (JEO)
- emergency examination order (EEO)
- classified patient admission from custody or court.

Figure 1: Breakdown of involuntary examination and assessment processes 2015–2016



* Percentages in tables have been rounded up or down as required to be presented as whole numbers

Involuntary Assessment

The Act allows for the involuntary assessment[3] of a person who may have a mental illness. Two separate forms must be completed, each declared by a different person, to initiate an involuntary assessment. Together, these forms are known as the 'assessment documents'.

The assessment documents authorise a health practitioner or ambulance officer to take the person to an AMHS. This must occur within seven days of the recommendation for assessment form being completed.

Involuntary assessment under the Act may also arise when a person has been voluntarily receiving treatment at an AMHS and it is determined that the assessment criteria under the Act apply.

For the purposes of assessment, a public hospital may be considered an AMHS where no other AMHS is readily available.

On arrival at the AMHS, the person becomes an involuntary patient and may be detained for an initial period of 24 hours for assessment by an authorised doctor to determine whether the treatment criteria

3 See Chapter 2 of the Act and Chapter 3 of the *Mental Health Act 2000* Resource Guide for further information

apply[4]. If satisfied that the treatment criteria under the Act apply, the authorised doctor may make an ITO for the patient.

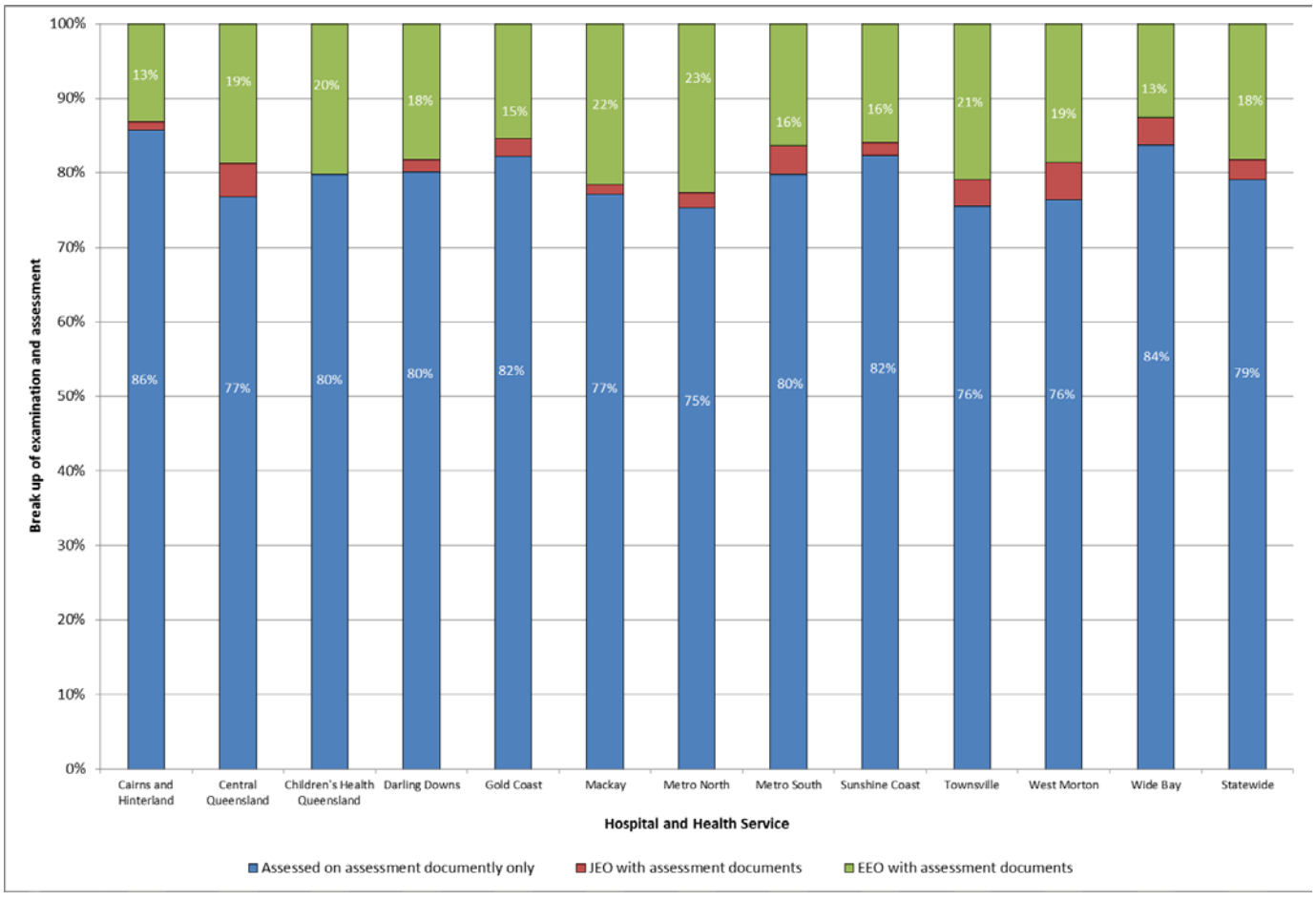
If the assessment cannot be completed during the initial 24 hours, the assessment period can be extended by 24 hours. The total assessment period must not exceed 72 hours.

Involuntary assessment entry pathways

As discussed earlier, the involuntary assessment provisions apply when a request and recommendation for assessment are made. In some instances, it may not be possible for the person to be examined by a doctor or AMHP e.g. the person refuses to see a doctor or AMHP or requires more urgent examination. In these instances, an involuntary assessment may be preceded by a JEO or an EEO.

Figure 2 identifies patients assessed under the involuntary assessment provisions, and whether the assessment commenced with involuntary assessment documents or followed the issuing of a JEO or EEO. For technical reasons, data is presented by HHS rather than AMHS. While there is variation between HHSs, the significant proportion of patient assessments are based on assessment documents alone without the need for an EEO or JEO.

Figure 2: Entry pathway for assessment by Hospital and Health Service 2015–2016



[4] See Section 14 of the Act

Involuntary assessment commenced with assessment documents

A total of 9951 involuntary assessments were conducted following a request for assessment and recommendation for assessment during the 2015–2016 reporting period, representing a 10 per cent increase from the previous year. Of these assessments, 6208 (62 per cent) resulted in an ITO being made, and 3665 (37 per cent) did not result in an ITO being made before the end of the assessment period[5].

In some circumstances an ITO is not made because the person is already subject to the involuntary provisions of the Act at another AMHS. The existing involuntary status becomes apparent when CIMHA records are checked by mental health practitioners. The patient's ongoing treatment may be provided at the original AMHS or the AMHS where they have presented. In 2015–2016, there were 78 instances in which an ITO was not made because of pre-existing involuntary status, representing one per cent of the total assessments.

The data in Table 1 and Figure 3 does not include instances where involuntary assessment was preceded by other processes such as an EEO or JEO.

5 See section 48 of the Act for further information

Table 1: Involuntary assessment: involuntary processes commenced with assessment documents 2015–2016

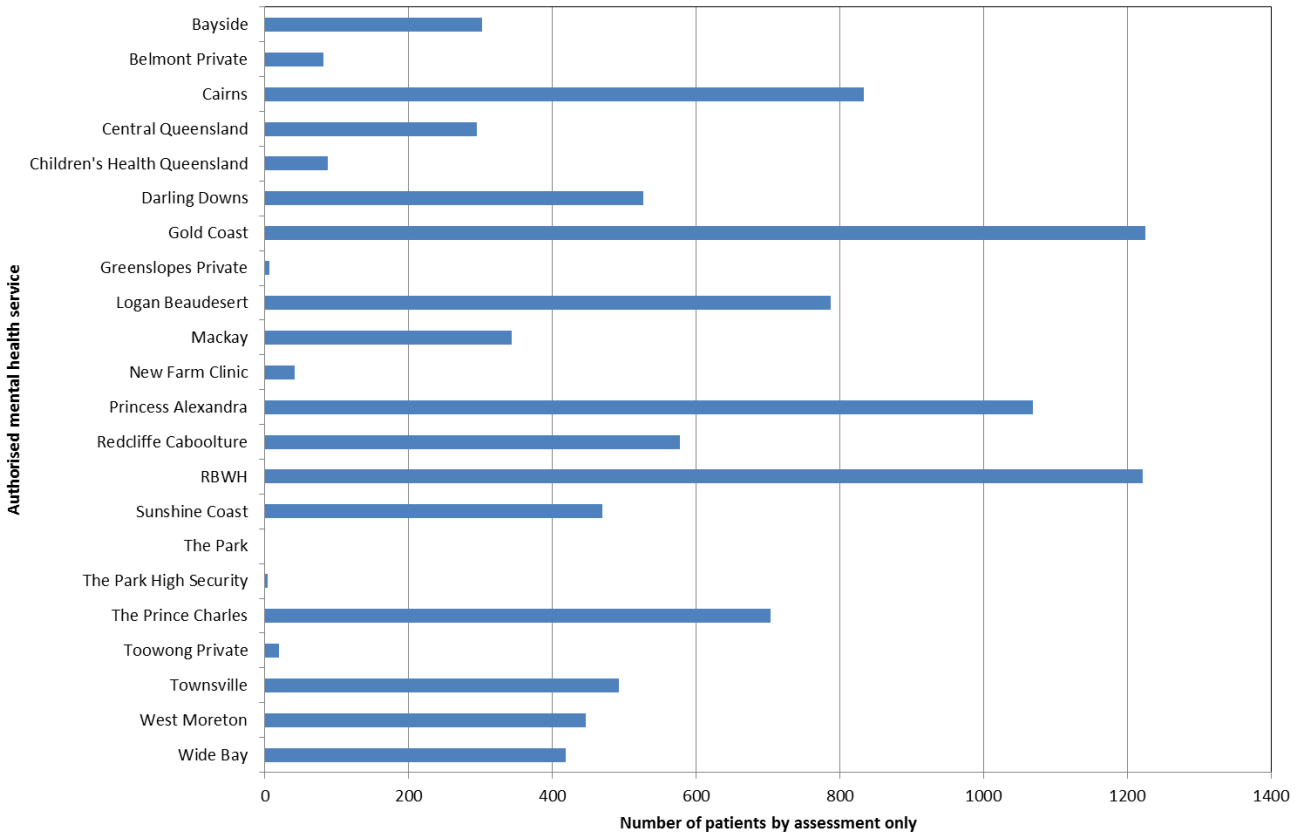
Authorised Mental health Service	Assessed on assessment documents only	ITO made as a result of involuntary assessment		ITO not made before end of assessment period		Pre-existing involuntary status	
Bayside	302	195	65%	99	33%	8	3%
Belmont Private	82	66	80%	16	20%	0	0%
Cairns	833	502	60%	321	39%	10	1%
Central Queensland	295	172	58%	123	42%	0	0%
Children's Health Queensland	87	45	52%	41	47%	1	1%
Darling Downs	527	328	62%	197	37%	2	0%
Gold Coast	1225	861	70%	355	29%	9	1%
Greenslopes Private	6	5	83%	1	17%	0	0%
Logan Beaudesert	787	444	56%	335	43%	8	1%
Mackay	344	184	53%	157	46%	3	1%
New Farm Clinic	41	38	93%	3	7%	0	0%
Princess Alexandra	1069	654	61%	408	38%	7	1%
Redcliffe Caboolture	577	395	69%	180	31%	2	0%
RBWH	1221	752	62%	458	38%	11	1%
Sunshine Coast	470	386	82%	84	18%	0	0%
The Park	0	0	0%	0	0%	0	0%
The Park High Security	4	4	100%	0	0%	0	0%
The Prince Charles	704	487	69%	210	30%	7	1%
Toowong Private	20	18	90%	2	10%	0	0%
Townsville	492	192	39%	298	61%	2	0%
West Moreton	446	264	59%	178	40%	4	1%
Wide Bay	419	216	52%	199	47%	4	1%
Total	**9951**	**6208**	**62%**	**3665**	**37%**	**78**	**1%**

*** Percentages in tables have been rounded up or down as required to be presented as whole numbers**

**** See Appendix 5 for full AMHS title**

Figure 3 is a graphical representation of the number of instances in which involuntary processes commenced with assessment documents at each AMHS in the reporting period.

Figure 3: Total number of instances in which involuntary processes commenced with assessment documents 2015–2016



**** See Appendix 5 for full AMHS title**

Justices examination orders

A member of the community who believes a person requires involuntary assessment may apply for a JEO[6]. The application must detail the grounds for seeking the order and be sworn under oath. A Magistrate or Justice of the Peace may make the order if they reasonably believe that the person subject to the application has a mental illness and the order is necessary to ensure the person is examined by a doctor or AMHP.

Table 2 identifies that 1231 (98 per cent) of the 1261 JEOs made during the 2015–2016 reporting period were made by a Justice of the Peace and 30 (two per cent) were made by a Magistrate.

Table 2: Justices examination orders 2015–2016

Authorised Mental Health Service**	Justice of the Peace	Magistrate	Total
Bayside	44	4	48
Belmont Private	0	0	0
Cairns	41	11	52
Central Queensland	69	1	70
Children's Health Queensland	9	0	9
Darling Downs	92	0	92
Gold Coast	93	0	93
Greenslopes Private	0	0	0
Logan Beaudesert	97	0	97
Mackay	59	0	59
New Farm Clinic	0	0	0
Princess Alexandra	145	1	146
Redcliffe Caboolture	94	0	94
RBWH	39	0	39
Sunshine Coast	51	1	52
The Park	0	0	0
The Park High Security	0	0	0
The Prince Charles	83	5	88
Toowong Private	0	0	0
Townsville	105	7	112
West Moreton	105	0	105
Wide Bay	105	0	105
Total	**1231**	**30**	**1261**

**** See Appendix 5 for full AMHS title**

6 See Division 2, Chapter 2 of the Act and Chapter 3 of the *Mental Health Act 2000 Resource Guide* for further information

Table 3 illustrates the outcomes of JEOs made in the reporting period. A total of 1261 JEOs were made during 2015–2016. This represents an 11 per cent increase from the 2014–2015 reporting period where the total was 1136.

Table 3: Justices examination orders and outcomes 2015–2016

Authorised Mental Health Service**	Assessment documents made				Assessment documents not made						Total
	ITO made as a result of involuntary assessment		ITO not made before end of assessment period		Assessment criteria not met		JEO ended before examination		Pre-existing Involuntary Status		
Bayside	9	19%	1	2%	35	73%	1	2%	2	4%	48
Belmont Private	0	0%	0	0%	0	0%	0	0%	0	0%	0
Cairns	11	21%	0	0%	34	65%	7	13%	0	0%	52
Central Queensland	14	20%	3	4%	47	67%	6	9%	0	0%	70
Children's Health Queensland	0	0%	0	0%	9	100%	0	0%	0	0%	9
Darling Downs	11	12%	0	0%	67	73%	13	14%	1	1%	92
Gold Coast	36	39%	1	1%	43	46%	12	13%	1	1%	93
Greenslopes Private	0	0%	0	0%	0	0%	0	0%	0	0%	0
Logan Beaudesert	26	27%	3	3%	56	58%	12	12%	0	0%	97
Mackay	6	10%	0	0%	43	73%	7	12%	3	5%	59
New Farm Clinic	0	0%	0	0%	0	0%	0	0%	0	0%	0
Princess Alexandra	59	40%	5	3%	67	46%	13	9%	2	1%	146
Redcliffe Caboolture	23	24%	1	1%	54	57%	13	14%	3	3%	94
RBWH	11	28%	2	5%	22	56%	4	10%	0	0%	39
Sunshine Coast	10	19%	0	0%	29	56%	12	23%	1	2%	52
The Park	0	0%	0	0%	0	0%	0	0%	0	0%	0
The Park High Security	0	0%	0	0%	0	0%	0	0%	0	0%	0
The Prince Charles	26	30%	2	2%	49	56%	9	10%	2	2%	88
Toowong Private	0	0%	0	0%	0	0%	0	0%	0	0%	0
Townsville	22	20%	1	1%	79	71%	9	8%	1	1%	112
West Moreton	26	25%	3	3%	64	61%	11	10%	1	1%	105
Wide Bay	17	16%	2	2%	68	65%	14	13%	4	4%	105
Total	**307**	**24%**	**24**	**2%**	**766**	**61%**	**143**	**11%**	**21**	**2%**	**1261**

* **Percentages in tables have been rounded up or down as required to be presented as whole numbers**

**** See Appendix 5 for full AMHS title**

Of the 1261 JEOs made, 331 (26 per cent) resulted in assessment documents being made. Of these, 307 (24 per cent) resulted in an ITO being made following assessment and 24 (two per cent) did not result in an ITO being made.

Of the total JEOs made in the 2015–2016 reporting period, 930 (74 per cent) did not result in assessment documents being made. Of these, 766 (82 per cent) were found to not meet the assessment criteria. For example, the doctor or AMHP found the person did not appear to have a mental illness, or the person agreed to engage voluntarily with the mental health service.

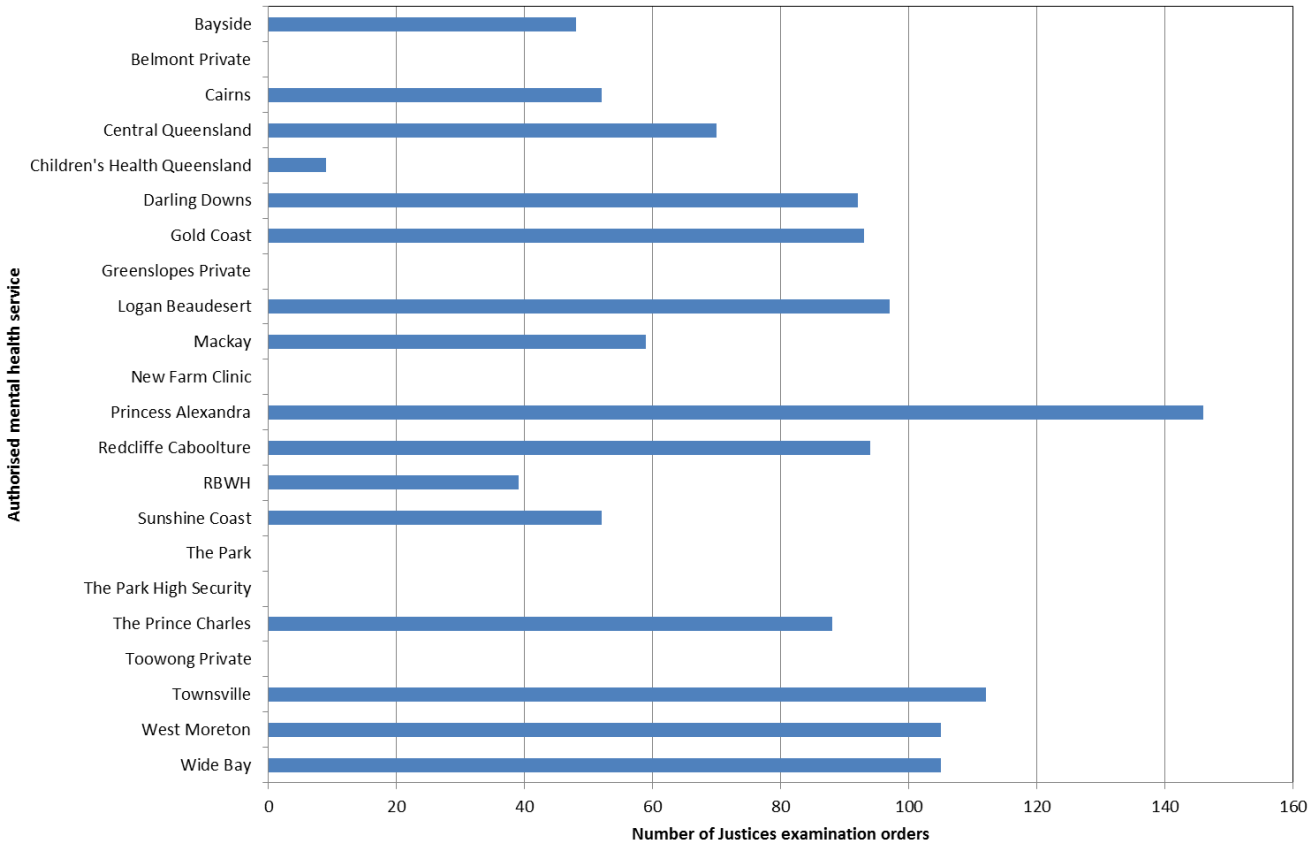
In some instances, the JEO expires prior to an examination being conducted under the JEO. This situation may occur when the person is unable to be located, or voluntarily attends an AMHS within the seven day period covered by the order, and is examined as part of this attendance.

In 2015–2016, 143 (11 per cent) of JEOs ended before an examination was conducted.

In 2015–2016, 21 (two per cent) of all JEOs were made for people already subject to the involuntary provisions of the Act, that is, an ITO or forensic order (FO). An existing involuntary status is usually identified from CIMHA records prior to examining the person.

Figure 4 shows the number of JEOs received at each AMHS in the reporting period.

Figure 4: Total number of justices examination 2015–2016



**** See Appendix 5 for full AMHS title**

Emergency examination orders

Ambulance officers, police officers, and psychiatrists are empowered to act in emergency circumstances to take a person to an AMHS for examination under an EEO[7]. The purpose of the examination is to determine if involuntary assessment is required.

Table 4 sets out the details of EEO made in 2015–2016. A total of 14,039 EEO were made during the reporting period. This represents a 12 per cent increase from 2014–2015 where the total was 12,487.

Ambulance officers made 6268 (45 per cent) of the total number of EEO in 2015–2016. This figure represents a 13 per cent increase on the total number of EEO made by ambulance officers in the 2014-2015 reporting period (5530).

Police officers made 7749 (55 per cent) of the total number of EEO in 2015–2016. This figure represents a 12 per cent increase on the total number of EEO made by police officers in the 2014–2015 reporting period (6931).

Psychiatrists made less than one per cent of the EEO in 2015–2016 (22). This figure is comparable to 2014–2015 results.

7 See Division 3, Chapter 2 of the Act and Chapter 3 of the *Mental Health Act 2000* Resource Guide for further information

Table 4: Emergency examination orders made 2015–2016*

Authorised Mental Health Service**	Ambulance Officer		Police Officer		Psychiatrist		Total
Bayside	353	49%	366	51%	0	0%	719
Belmont Private	0	0%	0	0%	0	0%	0
Cairns	226	35%	423	65%	1	0%	650
Central Queensland	400	47%	449	53%	4	>1%	853
Children's Health Queensland	196	51%	185	49%	0	0%	381
Darling Downs	236	33%	471	67%	0	0%	707
Gold Coast	405	31%	892	69%	4	0%	1301
Greenslopes Private	0	0%	0	0%	0	0%	0
Logan Beaudesert	621	61%	393	39%	1	0%	1015
Mackay	518	62%	314	38%	0	0%	832
New Farm Clinic	0	0%	0	0%	0	0%	0
Princess Alexandra	804	48%	853	51%	3	0%	1660
Redcliffe Caboolture	350	44%	440	56%	0	0%	790
RBWH	508	44%	633	55%	6	>1%	1147
Sunshine Coast	280	50%	275	49%	2	0%	557
The Park	0	0%	0	0%	0	0%	0
The Park High Security	0	0%	0	0%	0	0%	0
The Prince Charles	401	44%	515	56%	1	0%	917
Toowong Private	0	0%	0	0%	0	0%	0
Townsville	469	37%	793	63%	0	0%	1262
West Moreton	332	43%	448	57%	0	0%	780
Wide Bay	169	36%	299	64%	0	0%	468
Total	**6268**	**45%**	**7749**	**55%**	**22**	**0%**	**14039**

*** Percentages in tables have been rounded up or down as required to be presented as whole numbers**

**** See Appendix 5 for full AMHS title**

Table 5 illustrates the outcomes of the EEO made in 2015–2016.

Of the 14,050 EEO ended in the reporting period, 2262 (16 per cent) resulted in assessment documents being made and 11,788 (84 per cent) did not result in assessment documents being made.

The total 14,050 EEO includes a small number of EEO which were made immediately prior to the end of the 2014-2015 reporting period but not ended until after the commencement of the 2015–2016 reporting period.

Of the 2262 assessment documents made, 1575 resulted in an ITO being made following assessment, while 687 did not result in an ITO being made.

Table 5: Emergency examination orders and outcomes 2015–2016*

Authorised Mental Health Service**	Assessment Documents Made				Assessment Documents Not Made						Total
	ITO made as a result of involuntary assessment		ITO not made as a result of involuntary assessment		Assessment criteria not met		EEO ended before examination		Pre-existing involuntary status		
Bayside	76	11%	35	5%	548	76%	39	5%	23	3%	721
Belmont Private	0	0%	0	0%	0	0%	0	0%	0	0%	0
Cairns	111	17%	17	3%	487	75%	15	2%	20	3%	650
Central Queensland	50	6%	22	3%	714	84%	53	6%	14	2%	853
Children's Health Queensland	13	3%	9	2%	357	93%	1	0%	2	1%	382
Darling Downs	93	13%	27	4%	563	80%	9	1%	14	2%	706
Gold Coast	193	15%	36	3%	921	71%	126	10%	25	2%	1301
Greenslopes Private	0	0%	0	0%	0	0%	0	0%	0	0%	0
Logan Beaudesert	75	7%	44	4%	648	64%	234	23%	15	1%	1016
Mackay	82	10%	14	2%	703	84%	7	1%	26	3%	832
New Farm Clinic	0	0%	0	0%	0	0%	0	0%	0	0%	0
Princess Alexandra	162	10%	51	3%	992	60%	423	25%	32	2%	1660
Redcliffe Caboolture	101	13%	65	8%	600	76%	18	3%	9	1%	793
RBWH	205	18%	166	14%	718	63%	30	3%	28	2%	1147
Sunshine Coast	78	14%	13	2%	433	78%	19	3%	15	3%	558
The Park	0	0%	0	0%	0	0%	0	0%	0	0%	0
The Park High Security	0	0%	0	0%	0	0%	0	0%	0	0%	0
The Prince Charles	166	18%	49	5%	682	74%	17	2%	7	1%	921
Toowong Private	0	0%	0	0%	0	0%	0	0%	0	0%	0
Townsville	47	4%	89	7%	1053	83%	42	3%	31	2%	1262
West Moreton	78	10%	32	4%	613	79%	45	6%	12	2%	780
Wide Bay	45	10%	18	4%	317	68%	79	17%	9	2%	468
Total	**1575**	**11%**	**687**	**5%**	**10349**	**74%**	**1157**	**8%**	**282**	**2%**	**14050**

*** Percentages in tables have been rounded up or down as required to be presented as whole numbers**

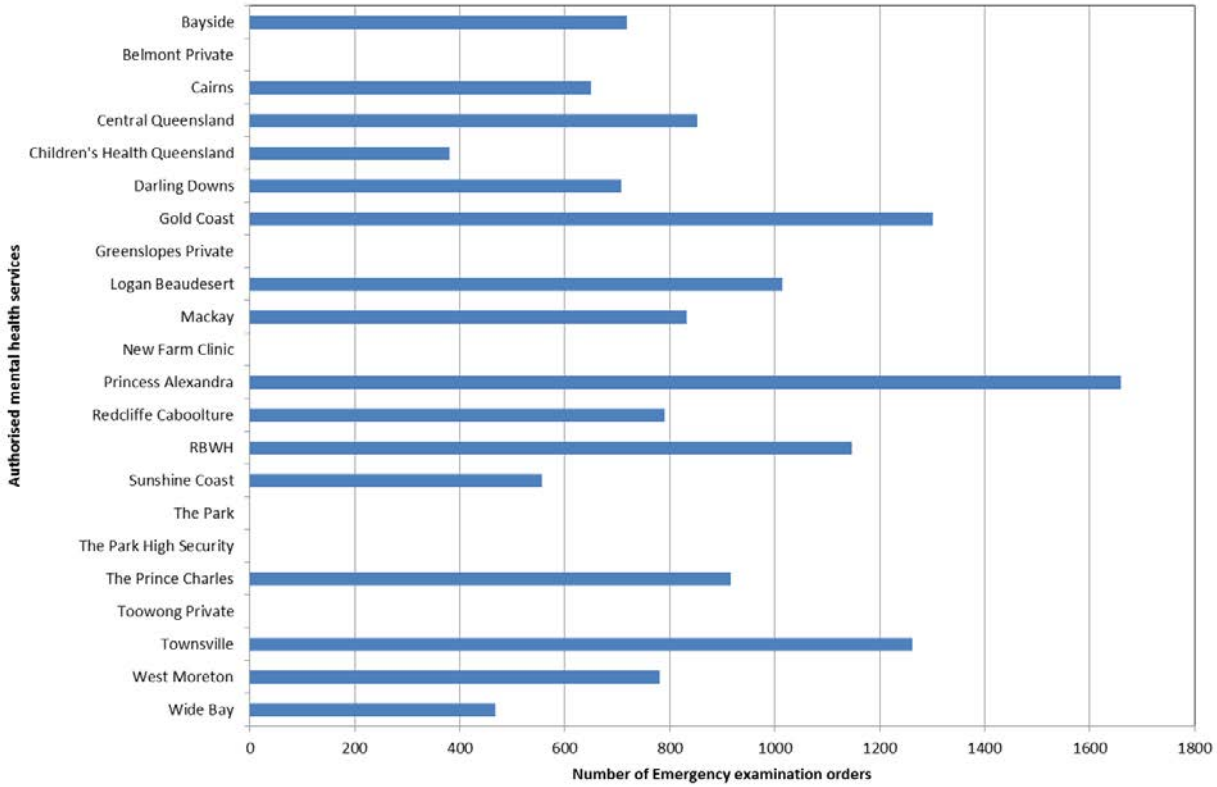
**** See Appendix 5 for full AMHS title**

***** Note that totals differ from Table 4 as emergency examination orders commenced in 2014-2015 may have outcomes which occurred on the 2015-2016 period**

The EEO expires six hours after the person arrives at the AMHS. In some instances, the person cannot be examined within this period e.g. due to alcohol intoxication or other substance use. In 1157 instances (eight per cent of all EEOs) the EEO expired before a doctor or AMHP was able to examine the person. However, the person may voluntarily remain at the AMHS until they can be appropriately examined. In 282 instances (two per cent of all EEOs) the person was already subject to the involuntary provisions of the Act. The person's existing involuntary status is identified when CIMHA records are checked after the person's presentation at the AMHS.

Figure 5 is a graphical representation of the number of EEO made at each AMHS in the reporting period.

Figure 5: Total number of emergency examination orders 2015–2016



**** See Appendix 5 for full AMHS title**

Classified patient admissions

The Act contains provisions that allow for the involuntary assessment of a person detained in custody or appearing before a court[8]. A person becomes a classified patient when they are brought to an AMHS from court or custody. The classified patient provisions enable secure management of the person while they receive assessment and/or treatment.

A classified patient can be treated voluntarily if they consent to treatment or under an ITO if the requirements for involuntary treatment are satisfied.

Table 6 sets out the details of classified patient admissions during the 2015–2016 reporting period.

During the reporting period, 197 classified patients were admitted to an AMHS. This figure represents a two per cent increase from the previous reporting period, when the total was 193.

Of the 197 classified patient admissions, two (one per cent) were transferred from a court, 27 (14 per cent) were transferred from a watch-house, and 168 (85 per cent) were transferred from a correctional centre.

8 See Chapter 3 of the Act and Chapter 5 of the *Mental Health Act 2000* Resource Guide for further information

Table 6: Classified patient admissions 2015–2016*

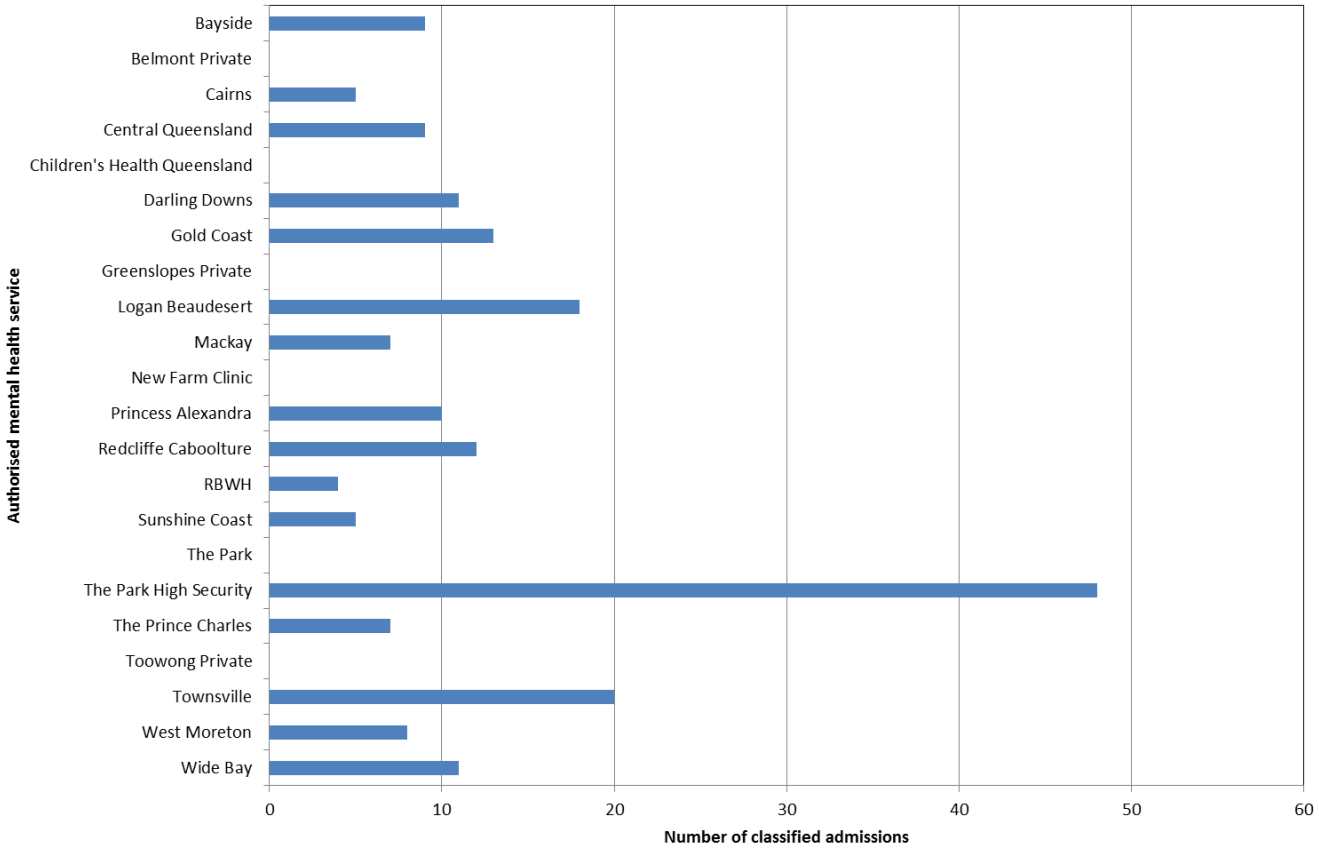
Authorised Mental Health Service**	Court		Watch-house		Queensland Correctional Centres		Total
Bayside	0	0%	0	0%	9	100%	9
Belmont Private	0	0%	0	0%	0	0%	0
Cairns	0	0%	1	20%	4	80%	5
Central Queensland	0	0%	0	0%	9	100%	9
Children's Health Queensland	0	0%	0	0%	0	0%	0
Darling Downs	0	0%	4	36%	7	64%	11
Gold Coast	0	0%	5	38%	8	62%	13
Greenslopes Private	0	0%	0	0%	0	0%	0
Logan Beaudesert	2	11%	1	6%	15	83%	18
Mackay	0	0%	1	14%	6	86%	7
New Farm Clinic	0	0%	0	0%	0	0%	0
Princess Alexandra	0	0%	1	10%	9	90%	10
Redcliffe Caboolture	0	0%	4	33%	8	67%	12
RBWH	0	0%	0	0%	4	100%	4
Sunshine Coast	0	0%	0	0%	5	100%	5
The Park	0	0%	0	0%	0	0%	0
The Park High Security	0	0%	2	4%	46	96%	48
The Prince Charles	0	0%	2	29%	5	71%	7
Toowong Private	0	0%	0	0%	0	0%	0
Townsville	0	0%	3	15%	17	85%	20
West Moreton	0	0%	2	25%	6	75%	8
Wide Bay	0	0%	1	9%	10	91%	11
Total	**2**	**1%**	**27**	**14%**	**168**	**85%**	**197**

*** Percentages in tables have been rounded up or down as required to be presented as whole numbers**

**** See Appendix 5 for full AMHS title**

Figure 6 sets out the total number of classified patient admissions by AMHS in the 2015–2016 reporting period.

Figure 6: Total number of classified patient admissions 2015–2016



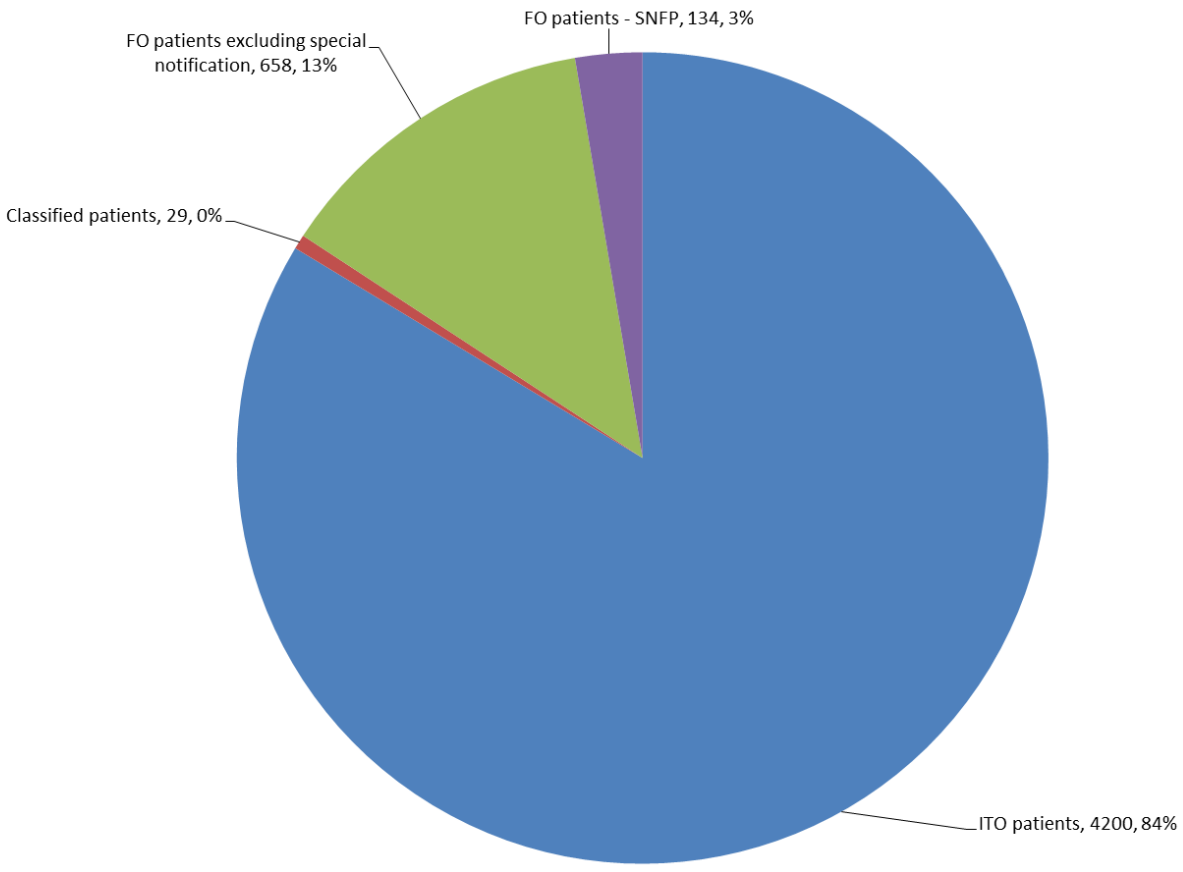
**** See Appendix 5 for full AMHS title**

Snapshot of involuntary status as at 30 June 2016

Figure 7 and Table 7 provide a snapshot of patients with involuntary status, excluding patients subject to involuntary assessment documents, as at 30 June 2016. The total number of ITO, Forensic Orders (FO) and classified patients as at 30 June 2016 is 5021, which represents a 2 per cent increase from the previous reporting period (4924). The percentage across each of the streams is consistent with the previous reporting period.

At 30 June 2016, 4200 people were subject to an ITO, 792 were subject to a FO and 29 were classified patients.

Figure 7: Breakdown of involuntary status as at 30 June 2016



*** Percentages in tables have been rounded up or down as required to be presented as whole numbers**

Table 7: Number of involuntary patients, excluding people subject to assessment documents as at 30 June 2016

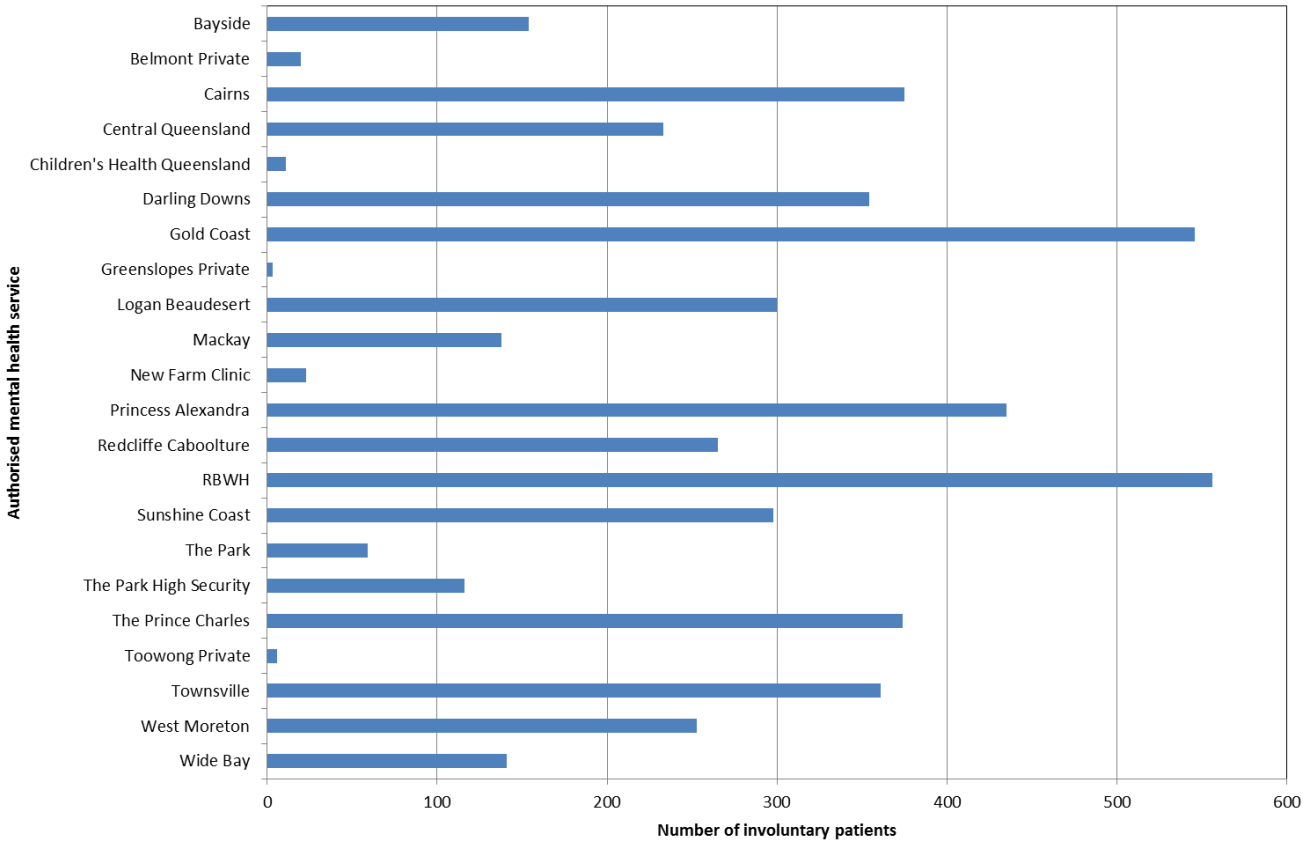
Authorised Mental Health Service**^	ITO patients	Classified patients	FO patients excluding special notification	FO patients – SNFP	Total
Bayside	140	0	13	1	154
Belmont Private	20	0	0	0	20
Cairns	331	1	39	4	375
Central Queensland	205	1	23	4	233
Children's Health Queensland	11	0	0	0	11
Darling Downs	283	3	65	3	354
Gold Coast	483	1	57	5	546
Greenslopes Private	3	0	0	0	3
Logan Beaudesert	248	0	46	6	300
Mackay	117	0	18	3	138
New Farm Clinic	23	0	0	0	23
Princess Alexandra	355	1	67	12	435
Redcliffe Caboolture	230	0	30	5	265
RBWH	490	0	58	8	556
Sunshine Coast	259	0	33	6	298
The Park	18	1	24	16	59
The Park High Security	55	16	19	26	116
The Prince Charles	315	2	44	13	374
Toowong Private	6	0	0	0	6
Townsville	294	1	56	10	361
West Moreton	203	1	37	12	253
Wide Bay	111	1	29	0	141
Total	**4200**	**29**	**658**	**134**	**5021**

**** See Appendix 5 for full AMHS title**

^ Excluding patients subject to involuntary assessment documents

Figure 8 is a graphical representation of the total number of involuntary patients, excluding patients who are subject to involuntary assessment documents, by AMHS as at 30 June 2016.

Figure 8: Total number of involuntary patients as at 30 June 2016



**** See Appendix 5 for full AMHS title**

Involuntary treatment orders

An ITO authorises treatment of a person's mental illness[9] without the person's consent. Under an ITO, a patient can receive treatment as an inpatient or in the community.

The Act allows an authorised doctor to make an ITO for a patient who is subject to involuntary assessment, or for a classified patient. In making an ITO, the authorised doctor must be satisfied that all treatment criteria[10] are met.

The treatment criteria are as follows:

- the person has a mental illness—mental illness is defined in Chapter 1 of the Act as a condition characterised by a clinically significant disturbance of thought, mood, perception or memory
- the person's illness requires immediate treatment
- the proposed treatment is available at an AMHS
- because of the person's illness:
  - there is an imminent risk that the person may cause harm to himself or herself or someone else
  - the person is likely to suffer serious mental or physical deterioration
- there is no less restrictive way of ensuring the person receives appropriate treatment or care for the illness
- the person:
  - lacks capacity to consent to be treated for the illness; or
  - has unreasonably refused proposed treatment for the illness.

As a safeguard, a second examination by a psychiatrist is required if the authorised doctor making the ITO is not a psychiatrist, or if the initial examination was conducted by audio-visual link. If a second examination is required, it must be conducted within 72 hours of the first examination. The psychiatrist undertaking the second examination must determine whether the treatment criteria apply and confirm or revoke the ITO accordingly.

The Act requires that a psychiatrist must regularly review the patient to assess whether the criteria for involuntary treatment continue to apply. If any of the criteria no longer apply, the ITO must be revoked.

Patients subject to an ITO must also be regularly reviewed by the Tribunal. A patient must be reviewed within six weeks of the order being made and thereafter at intervals of not more than six months.

9 See Section 12 of the Act for the definition of 'mental illness'

10 See Section 14 of the Act for the defined 'treatment criteria'

Patients can also apply for review within these statutory time frames. When reviewing the patient's ITO, the Tribunal must consider whether the treatment criteria apply, and confirm or revoke the order accordingly.

The total number of ITO made in the 2015–2016 reporting period, and the means by which they were made is set out in Table 8.

Table 8: Number of involuntary treatment orders made 2015–2016*

Authorised Mental Health Service**	Category of initial order				Second examination required		Second examination				Total ITO made
	Community		Inpatient				ITO confirmed		ITO not confirmed		
Bayside	7	2%	286	98%	220	75%	151	69%	69	31%	293
Belmont Private	0	0%	69	100%	11	16%	11	100%	0	0%	69
Cairns	7	1%	621	99%	245	39%	225	92%	20	8%	628
Central Queensland	13	6%	221	94%	153	65%	143	94%	10	7%	234
Children's Health Queensland	0	0%	63	100%	48	76%	33	69%	15	31%	63
Darling Downs	2	1%	433	100%	261	60%	209	80%	52	20%	435
Gold Coast	26	2%	1075	98%	907	82%	672	74%	235	26%	1101
Greenslopes Private	0	0%	5	100%	0	0%	0	0%	0	0%	5
Logan Beaudesert	15	3%	548	97%	435	77%	290	67%	145	33%	563
Mackay	2	1%	273	99%	161	59%	119	74%	42	26%	275
New Farm Clinic	0	0%	41	100%	19	46%	17	90%	2	11%	41
Princess Alexandra	7	1%	846	99%	649	76%	517	80%	132	20%	853
Redcliffe Caboolture	4	1%	517	99%	409	79%	287	70%	122	30%	521
RBWH	9	1%	946	99%	840	88%	658	78%	182	22%	955
Sunshine Coast	12	3%	460	98%	339	72%	264	78%	75	22%	472
The Park	0	0%	0	0%	0	0%	0	0%	0	0%	0
The Park High Security	0	0%	22	100%	8	36%	8	100%	0	0%	22
The Prince Charles	6	1%	673	99%	502	74%	367	73%	135	27%	679
Toowong Private	0	0%	19	100%	2	11%	2	100%	0	0%	19
Townsville	18	7%	252	93%	142	53%	136	96%	6	4%	270
West Moreton	5	1%	365	99%	291	79%	216	74%	75	26%	370
Wide Bay	17	6%	267	94%	185	65%	130	70%	55	30%	284
Total	**150**	**2%**	**8002**	**98%**	**5827**	**72%**	**4455**	**76%**	**1372**	**24%**	**8152**

*** Percentages in tables have been rounded up or down as required to be presented as whole numbers**

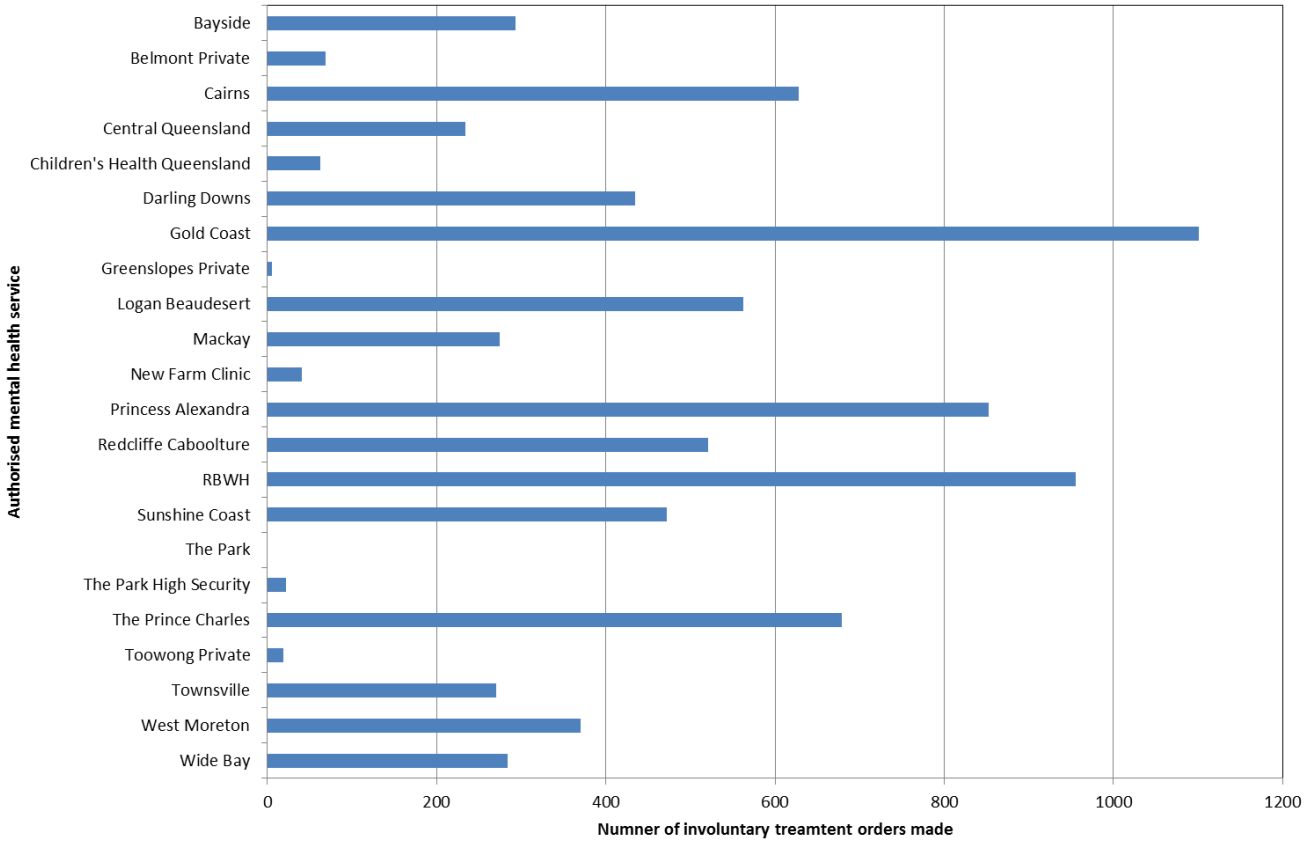
**** See Appendix 5 for full AMHS title**

A total of 8152 ITO were made in 2015–2016. This figure represents a nine per cent increase from the 2014–2015 reporting period. The majority of ITO, 8002 (98 per cent), were initiated as inpatient category as opposed to community category.

Of the 8152 ITO made, 5827 (72 per cent) required a second examination, of which 4455 (76 per cent) were confirmed and 1372 (24 per cent) were revoked.

Figure 9 is a graphical representation of the total number of ITO made at each AMHS in the reporting period.

Figure 9: Total number of involuntary treatment orders made 2015–2016



**** See Appendix 5 for full AMHS title**

An ITO ceases in the following circumstances:

- the ITO is revoked by an authorised doctor, the Tribunal or the Mental Health Court
- the ITO ceases to have effect because the person did not receive involuntary treatment for a period of at least six months e.g. the patient was absent without permission
- a FO is made
- an ITO already exists
- the person is transferred interstate
- the patient is deceased
- the ITO is revoked or not confirmed when the second examination is conducted.

The number of ITO ended in the reporting period and the ways in which they were ended are detailed in Table 9.

A total of 8024 ITO ended in the reporting period. Of these, 7567 (94 per cent) were revoked, either by an authorised doctor, the Tribunal or through an appeal to the Mental Health Court. This proportion is consistent with the previous reporting period.

A total of 43 ITO (less than one per cent) ended because they were deemed invalid or the patient did not receive treatment within a six month period, resulting in the order ceasing to have effect. The latter outcome is usually the result of a patient being absent without permission for an extended period.

A total of 28 (less than one per cent) patients were already subject to an ITO when a subsequent order was made. This may arise from a patient's use of an alias, or when a patient is already receiving treatment at another AMHS.

A total of 58 ITO (almost one per cent) ended when a FO was made by the Mental Health Court.

A total of three ITO (less than one per cent) were ended due to the patient being transferred interstate, e.g. to be closer to family or other support systems.

During the reporting period, 276 ITO (three per cent) ended in circumstances where a second examination was required, and the order was not confirmed or revoked.

Of the total ITO ended, 49 (less than one per cent) were the result of a patient death. The death of any patient of a mental health service is reported by a number of mechanisms.

Any suspected suicide or unexplained death of a patient who is either an inpatient or residing in the community is a reportable death under the *Coroners Act 2003* and is referred to the Coroner by the Queensland Police Service. The treating team also reports the death to the Department of Health Patient Safety and Quality Improvement Service through the PRIME Clinical Incident (PRIME CI) electronic system.

Table 9: Involuntary treatment orders ended 2015–2016*

Authorised Mental Health Service**	ITO revoked by authorised doctor, Tribunal or Mental Health Court		ITO ceased to have effect		Patient deceased		ITO already exists		ITO neither revoked nor confirmed within the initial 72 hour period		FO made		Transferred Interstate		Total
Bayside	290	90%	4	1%	2	1%	2	1%	26	8%	0	0%	0	0%	324
Belmont	90	96%	0	0%	0	0%	0	0%	4	4%	0	0%	0	0%	94
Cairns	612	97%	4	1%	1	0%	1	0%	7	1%	4	1%	0	0%	629
Central Queensland	192	96%	3	2%	4	2%	0	0%	1	1%	0	0%	0	0%	200
Children's Health Queensland	68	94%	0	0%	0	0%	0	0%	4	6%	0	0%	0	0%	72
Darling Downs	385	96%	1	0%	3	1%	0	0%	6	2%	5	1%	0	0%	400
Gold Coast	1005	94%	5	0%	6	1%	5	1%	37	3%	8	1%	2	0%	1068
Greenslopes Private	4	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	4
Logan Beaudesert	574	92%	2	0%	1	0%	2	0%	42	7%	4	1%	0	0%	625
Mackay	260	98%	2	1%	1	0%	1	0%	0	0%	1	0%	0	0%	265
New Farm Clinic	43	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	43
Princess Alexandra	794	93%	7	1%	7	1%	6	1%	30	4%	7	1%	0	0%	851
Redcliffe Caboolture	461	95%	0	0%	2	0%	4	1%	17	3%	4	1%	0	0%	488
RBWH	744	94%	5	1%	10	1%	2	0%	26	3%	8	1%	0	0%	795
Sunshine Coast	456	96%	3	1%	1	0%	0	0%	10	2%	2	0%	1	0%	473
The Park	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0
The Park High Security	19	79%	0	0%	0	0%	0	0%	0	0%	5	21%	0	0%	24
The Prince Charles	655	93%	3	0%	6	1%	2	0%	35	5%	3	0%	0	0%	704
Toowong Private	24	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	24
Townsville	239	98%	1	0%	2	1%	1	0%	0	0%	2	1%	0	0%	245
West Moreton	385	94%	1	0%	2	1%	0	0%	20	5%	2	1%	0	0%	410
Wide Bay	267	93%	2	1%	1	0%	2	1%	11	4%	3	1%	0	0%	286
Total	**7567**	**94%**	**43**	1%	**49**	**1%**	**28**	**0%**	**276**	3%	**58**	**1%**	**3**	**0%**	**8024**

*** Percentages in tables have been rounded up or down as required to be presented as whole numbers**

**** See Appendix 5 for full AMHS title**

Table 10 sets out the statewide rate of ITO made per 10,000 population over the past five reporting periods. As identified, there is approximately 17.1 ITO for every 10,000 population in Queensland. The rate has increased steadily over the past five reporting periods, with an average annual increase of 5.8 per cent.

Table 10: Proportion of involuntary treatment orders made per 10,000 population—five year trend

Reporting period	Population	ITO made	ITO made per 10,000 population	Five year average annual change
2011-2012	4,479,778	6125	13.7	
2012-2013	4,568,205	6508	14.2	
2013-2014	4,651,359	6601	14.2	+5.8%
2014-2015	4,719,925	7458	15.8	
2015-2016	4,778,854	8152	17.1	

***The data presented above may differ from data reported in previous years due to changes in methodology. The methodology used to calculate rates for 2015-2016 has been applied to previous years' data to enable comparison**

While the number of ITO made has increased by an average of 5.8 per cent per annum, cross sectional data demonstrates a less significant increase. Table 11 details the statewide rate of ITO per 10,000 population as at 30 June, for the past five reporting periods. The rate of patients remaining on an ITO per 10,000 population has increased by an average of 2.12 per cent over this period.

Table 11: Proportion of population remaining on involuntary treatment orders as at 30 June—five year trend

Reporting Period	Population	ITO at 30 June	ITO at 30 June per 10,000 population	Five year average annual change
2011-2012	4,479,778	3620	8.1	
2012-2013	4,568,205	3638	8.0	
2013-2014	4,651,359	3828	8.2	+2.12%
2014-2015	4,719,925	4110	8.7	
2015-2016	4,778,854	4200	8.8	

***The data presented above may differ from data reported in previous years due to changes in methodology. The methodology used to calculate rates for 2015-2016 has been applied to previous years' data to enable comparison**

Forensic orders

The Act contains provisions for making a FO. The FO is usually made by the Mental Health Court following a finding that the person was of unsound mind at the time of the offence for which they are charged, or is unfit for trial. A person on a FO is a forensic patient under the Act.

Activity relating to FO for the reporting period is represented in Table 12. Figure 10 is a graphical representation of the number of new FO made in respect of each AMHS in the reporting period. The total number of FO made during 2015–2016 was 118, which was 14 less than 2014–2015 and represents an 11 per cent decrease from this period.

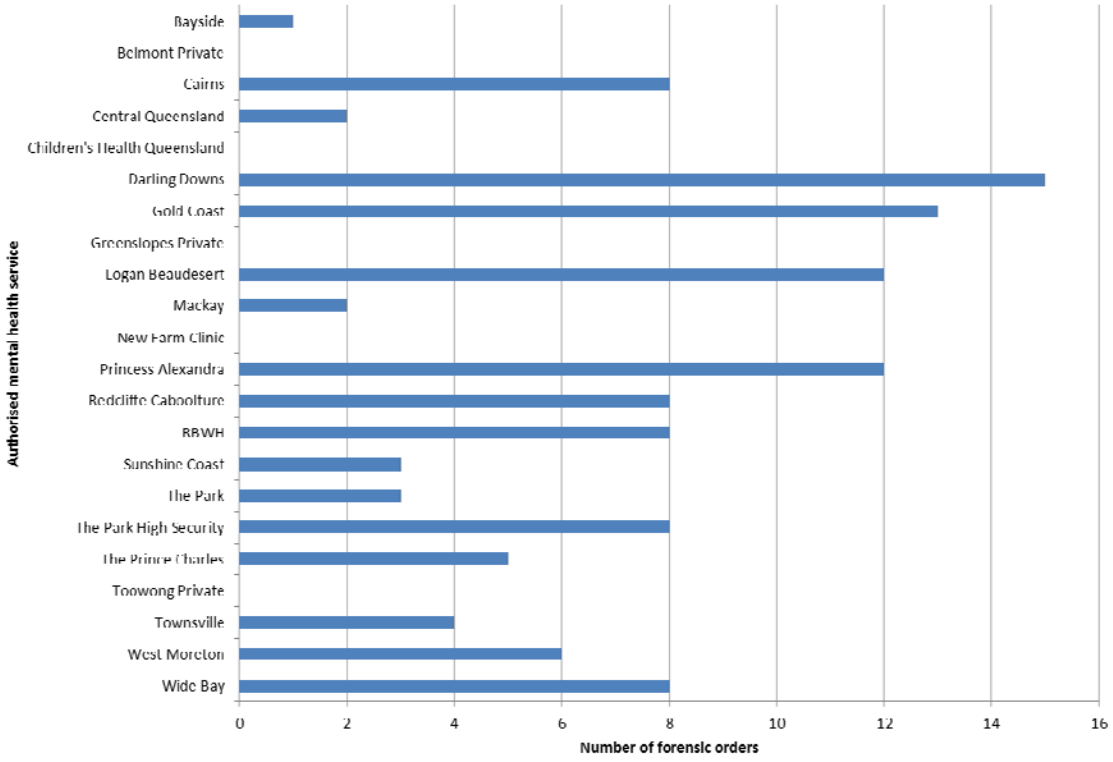
The number of patients on FO as at 30 June 2016 was 792, which represents a 2.9 per cent increase on the previous year's total of 770.

Special notification forensic patients

A special sub-category of FO was introduced in 2008 in line with recommendations of the *Promoting balance in the forensic mental health system—Final Report—Review of the Queensland Mental Health Act 2000*. The special notification forensic patient (SNFP) category refers to patients who have been charged with unlawful homicide, attempted murder, dangerous operation of a motor vehicle involving the death of another person, rape or assault with the intent to commit rape.

As at 30 June 2016, there was a total of 134 SNFP in Queensland compared to 139 as at 30 June 2015.

Figure 10: Total number of forensic orders made 2015–2016



**** See Appendix 5 for full AMHS title**

Table 12: Forensic orders made and ended in 2015–2016 and number of forensic patients and special notification forensic patients as at 30 June 2016

Authorised Mental Health Service**	FO made	FO ended	Number of SNFPs at 30 June***	Total Forensic patients at 30 June
Bayside	0	2	1	14
Belmont Private	0	0	0	0
Cairns	8	10	4	43
Central Queensland	3	5	4	27
Children's Health Queensland	0	0	0	0
Darling Downs	16	8	3	68
Gold Coast	13	6	5	62
Greenslopes Private	0	0	0	0
Logan Beaudesert	12	7	6	52
Mackay	2	3	3	21
New Farm Clinic	0	0	0	0
Princess Alexandra	13	10	12	79
Redcliffe Caboolture	6	4	5	35
RBWH	9	8	8	66
Sunshine Coast	3	6	6	39
The Park	2	3	16	40
The Park High Security	8	1	26	45
The Prince Charles	6	1	13	57
Toowong Private	0	0	0	0
Townsville	4	6	10	66
West Moreton	6	6	12	49
Wide Bay	7	4	0	29
Total	**118**	**90**	**134**	**792**

**** See Appendix 5 for full AMHS title**

*****Patients represented in this column are also in column four, 'Total Forensic patients at 30 June'**

Forensic Order–Disability

Amendments to the Act which commenced on 1 July 2011 enabled the Mental Health Court to make a new type of FO for people with an intellectual or cognitive disability.

A FO (Mental Health Court–Disability) authorises a person to be detained for care in an AMHS or the Forensic Disability Service at Wacol (administered under the *Forensic Disability Act 2011* by the Department of Communities, Child Safety and Disability Services).

A FO (Mental Health Court–Disability) enables a person to receive care appropriate to their individual needs, including rehabilitation, habilitation, support and other services.

As at 30 June 2016, there were 66 people subject to a FO (Mental Health Court–Disability) who were receiving care at an AMHS.

Table 13 details the statewide rate of FO per 10,000 population, as at 30 June for the past five reporting periods. As identified, the rate of FO per 10,000 population has seen an average annual increase of 1.52 per cent over this period.

Table 13: Proportion of population on forensic orders 30 June – five year trend

Reporting period	Population	FO at 30 June	FO at 30 June per 10,000 population	Five year average annual change
2011-2012	4,479,778	719	1.6	
2012-2013	4,568,205	734	1.6	
2013-2014	4,651,359	741	1.6	+1.52%
2014-2015	4,719,925	770	1.6	
2015-2016	4,778,854	792	1.7	

***The data presented above may differ from data reported in previous years due to changes in methodology. The methodology used to calculate rates for 2015-2016 has been applied to previous years' data to enable comparison**

Patient information orders

A person who is the victim of an offence committed or allegedly committed by a classified patient may apply to the Director of Mental Health to receive certain information about the detention of the classified patient. After reviewing the application, the Director of Mental Health may make a classified patient information order (CPIO) which enables specified information to be provided to the victim. A parallel scheme exists for forensic patients, enabling victims or other interested persons to apply to the Tribunal for a forensic information order (FIO)[11].

The Director of Mental Health administers the victim information registers for classified and forensic patients and is responsible for providing information to registered persons. The system allows victims to receive certain information[12] about a patient's status under the Act which is relevant to the victim's safety and wellbeing.

In practice, information is provided to holders of FIO and CPIO through the Queensland Health Victim Support Service (QHVSS). The QHVSS provides support and information to victims and their families.

As at 30 June 2016:

- No CPIO were in effect for classified patients
- 120 FIO were in effect for forensic patients.

During the reporting period:

- 3 CPIO applications were received
- 3 CPIO applications were approved
- 4 CPIO ended during the reporting period due to the patient's classified status ending.

11 For further information relating to the FIO application process, contact the Mental Health Review Tribunal, www.mhrt.qld.gov.au

12 See Section 318C (1) and section 318O (1) of the Act for further information

Patients charged with an offence

When a person who is subject to an ITO or a FO is charged with an offence, the provisions under Chapter 7, Part 2 of the Act apply. These provisions aim to ensure that due consideration is given to issues of culpability and fitness for trial.

Table 14 sets out activity under Chapter 7, Part 2 of the Act for the 2015–2016 reporting period and identifies that these provisions applied to 1387 patients. This figure represents a nine per cent increase from the previous reporting period (1267 patients).

Table 14: Actions taken under Chapter 7, Part 2 (patients charged with an offence) 2015–2016

Authorised Mental Health Service**	Number of patients for whom Chapter 7 provisions were commenced	Number of occasions in which activity under the Chapter 7 provisions were commenced
Bayside	27	35
Belmont Private	0	0
Cairns	131	228
Central Queensland	68	115
Children's Health Queensland	4	4
Darling Downs	82	106
Gold Coast	164	264
Greenslopes Private	0	0
Logan Beaudesert	100	148
Mackay	48	71
New Farm Clinic	0	0
Princess Alexandra	110	190
Redcliffe Caboolture	79	109
RBWH	113	205
Sunshine Coast	96	152
The Park	5	5
The Park High Security	26	27
The Prince Charles	89	133
Toowong Private	0	0
Townsville	126	197
West Moreton	87	144
Wide Bay	32	39
Total	**1387**	**2172**

**** See Appendix 5 for full AMHS title**

A patient may come under the Chapter 7, Part 2 provisions on more than one occasion. This is reflected in the difference between the number of patients (1387) and the number of occasions in which activity under these provisions commenced (2172). To help decide the matters for a patient subject to these provisions, the Act provides that a psychiatrist must examine the patient for the purposes of preparing a report, referred to as a section 238 report[13]. The Administrator of the AMHS must provide the section 238 report to the Director of Mental Health within 21 days of Chapter 7, Part 2 being applied.

The Director of Mental Health cannot make a reference to the Director of Public Prosecutions (DPP) or the Mental Health Court until the section 238 report is completed to the standard required under the Act. Delays in receiving section 238 reports increase delays in court processes and consequently may have adverse impacts on patients, families and victims.

Timeframes for completion of section 238 reports may be impacted by a number of factors including:

- the nature of the offence, with additional time being required for more serious offences or where there is a complex relationship between the patient's mental illness and their offending behaviour
- delays in receiving material from other agencies
- delays in being able to interview the patient about the charges which may, for example, result from the patient being unwell for an extended period of time.

The total number of section 238 reports received in the reporting period (1745) represents a 17 per cent increase from the previous reporting period (1495).

The MHAODB provides Administrators of AMHSs with a weekly report advising of section 238 reports due within the week and monthly reports on overdue section 238 reports.

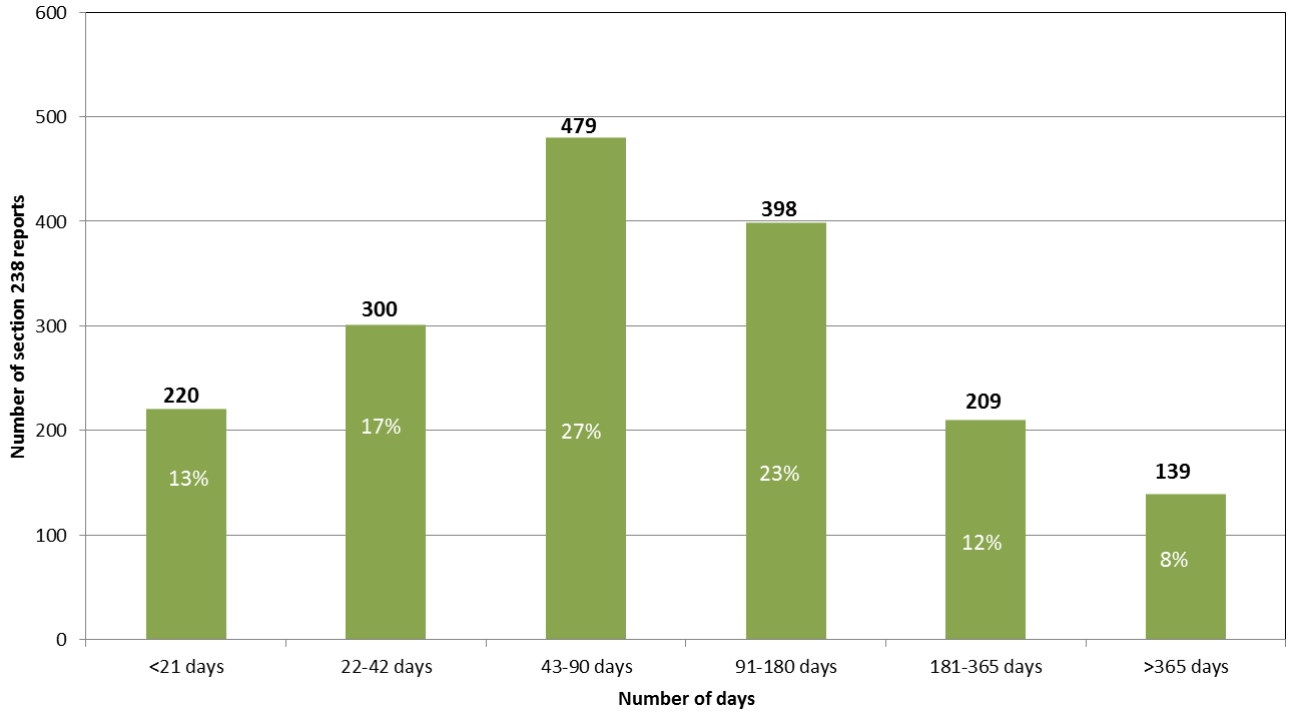
Figure 11 provides a breakdown of timeframes for the receipt of section 238 reports in 2015–2016. These range from the statutory timeframe of up to 21 days, to more than 365 days.

The MHAODB maintains a continual focus on reducing the number of overdue section 238 reports. A sustained reduction is noted for reports that are significantly overdue i.e. from 12 months or more which have been the focus of MHAODB communication with individual AMHSs since late 2015.

Psychiatrist reports are not mandatory for persons on an order or authority under the 2016 Act who are charged with an offence. Persons on an order or authority charged with a 'serious offence' will be offered a psychiatrist report at no cost to the individual. A 'serious offence' under the new legislation is an indictable offence, other than an offence that, under the Criminal Code, must be heard by a magistrate (e.g. common assault). A request for a report may also be made by a nominated support person, lawyer, parent, guardian or attorney.

13 See Section 238 of the Act and the Director of Mental Health *Guidelines for preparing forensic reports (section 238 reports)* for further information

Figure 11: Timeframes for receipt of section 238 reports 2015–2016



On receiving the section 238 report, the Director of Mental Health is required to refer the matter within 14 days to the DPP or the Mental Health Court. A copy of the psychiatrist's report is provided with the Director of Mental Health's reference. The Director of Mental Health may elect to defer the reference on the grounds that the patient is unfit for trial but is likely to become fit for trial.

Matters that the Director of Mental Health may refer to the DPP are:

- offences the Director of Mental Health considers to be not of a serious nature
- offences of a serious nature where the psychiatrist reports the person was not of unsound mind at the time of the offence and is fit for trial.

Matters referred to the Mental Health Court must include indictable offences.

During 2015–2016, the Director of Mental Health referred 1736 matters to the DPP or Mental Health Court, which represents an increase of 21 per cent from 2014–2015 (1433). Of these references, 1548 were made to the DPP, which represents an increase of 25 per cent from 2014–2015 (1242). The remaining 188 matters were referred to the Mental Health Court, which was a decrease of less than two per cent from 2014–2015 (191).

Table 15 details all references made by the Director of the Mental Health to the DPP and the Mental Health Court for the reporting period.

Table 15: References made by the Director of Mental Health 2015–2016

Authorised Mental Health Service**	Number of references to DPP	Number of references to Mental Health Court	Total number of references made by the Director of Mental Health
Bayside	30	1	31
Belmont Private	0	0	0
Cairns	112	18	130
Central Queensland	116	4	120
Children's Health Queensland	2	0	2
Darling Downs	88	6	94
Gold Coast	148	28	176
Greenslopes Private	0	0	0
Logan Beaudesert	126	7	133
Mackay	48	4	52
New Farm Clinic	0	0	0
Princess Alexandra	213	22	235
Redcliffe Caboolture	63	11	74
RBWH	147	15	162
Sunshine Coast	114	4	118
The Park	7	4	11
The Park High Security	9	11	20
The Prince Charles	73	9	82
Toowong Private	0	0	0
Townsville	148	22	170
West Moreton	74	11	85
Wide Bay	30	11	41
Total	**1548**	**188**	**1736**

**** See Appendix 5 for full AMHS title**

As previously identified, the Director of Mental Health is required to refer the matter to the DPP or Mental Health Court within 14 days of receiving the section 238 report.

Table 16 indicates that in the 2015–2016 reporting period, there was an average of 15.2 days for a matter to be referred to the DPP, and an average of 11.8 days for a matter to be referred to the Mental Health Court. These figures represent an increase from 2014–2015, where the average number of days for a matter to be referred to the DPP was 9.5, and the average number of days for a matter to be referred to the Mental Health Court was nine days.

Table 16: Reference timeframes for section 238 reports received by the Director of Mental Health 2015–2016

Referred to	Average length in days	Median in days
Director of Public Prosecutions	15.2	5
Mental Health Court	11.8	6

Patients absent without permission

The Act contains provisions to enable a patient to be returned to an inpatient facility of an AMHS for assessment, treatment or care.

An authorised doctor may issue an authority to return, which is provided to police to assist in the patient's return to the AMHS. Data on absent without permission events is based on instances where an authority to return is issued.

An authority to return may be issued in relation to:

- a patient who leaves an inpatient facility of an AMHS without the required authority or leaves a community facility while being detained for involuntary assessment
- a patient who is authorised to be in the community on LCT or on a community category of an ITO, but is required to return to the inpatient facility because of their mental health needs
- a patient who is authorised to be in the community on LCT, but fails to return to their inpatient facility at the conclusion of the authorised leave.

Table 17 sets out the number of authorities to return issued at each AMHS for patients who were absent from inpatient and community settings for the reporting period.

The total number of authorities to return issued has increased from the previous reporting period, with 3167 authorities issued for a total of 1838 patients in 2015–2016, compared to 2510 authorities issued for a total of 1588 patients in 2014–2015. However, there is a sustained overall decrease in inpatient absence without permission activity since September 2013.

Table 18 identifies whether the patient was absent from an inpatient facility or required to return from the community. 'Inpatient' includes patients who left an acute or extended treatment facility, other specialist facility, or emergency department without approval or became absent without permission while accessing escorted or unescorted day leave, or approved temporary absence.

From 1 July 2016, the data count for inpatient absence without permission events will be limited to those events where the patient was absent from a general acute inpatient mental health unit (including older persons' units) i.e. a secure unit, or from escorted or unescorted day leave, or approved temporary absence from a general acute inpatient mental health unit. It is considered that the revised data count will provide a more accurate indication of absence without permission events.

This approach aligns with the proposed Service Agreement Performance Indicator Measure on rate of incidence of inpatient absent without permission per 1000 acute involuntary accrued days. It is expected that this indicator will be implemented in early 2017.

During the 2015–2016 reporting period, there has been a continued focus on reducing absence without permission events, particularly from Queensland Health inpatient mental health services. For further information, refer to the chapter, 'Supporting quality improvements in mental health service delivery' in this report.

Table 17: Authority to return activity 2015–2016

Authorised Mental Health Service**	Number of patients	Number of authorities to return issued
Bayside	56	96
Belmont Private	3	3
Cairns	163	363
Central Queensland	79	133
Children's Health Queensland	3	5
Darling Downs	96	148
Gold Coast	209	386
Greenslopes Private	0	0
Logan Beaudesert	157	227
Mackay	74	155
New Farm Clinic	5	9
Princess Alexandra	160	267
Redcliffe Caboolture	95	139
RBWH	220	384
Sunshine Coast	117	194
The Park	17	20
The Park High Security	2	2
The Prince Charles	121	209
Toowong Private	2	2
Townsville	122	209
West Moreton	78	140
Wide Bay	59	76
Total	**1838**	**3167**

**** See Appendix 5 for full AMHS title**

Table 18: Number of authorities to return issued 2015–2016

Authorised Mental Health Service**	Inpatient absences^			Community absences^	Total
	Absconded from inpatient mental health unit[1]	Absconded from other unit[2]	Other inpatient absences[3]		
Bayside	10	11	31	44	96
Belmont Private	3	0	0	0	3
Cairns	133	20	44	166	363
Central Queensland	19	22	21	71	133
Children's Health Queensland	1	1	1	2	5
Darling Downs	23	6	28	91	148
Gold Coast	58	17	125	186	386
Greenslopes Private	0	0	0	0	0
Logan Beaudesert	16	49	40	122	227
Mackay	17	17	58	63	155
New Farm Clinic	9	0	0	0	9
Princess Alexandra	31	28	29	179	267
Redcliffe Caboolture	8	28	37	66	139
RBWH	2	29	75	278	384
Sunshine Coast	15	21	59	99	194
The Park	1	0	14	5	20
The Park High Security	0	0	0	2	2
The Prince Charles	49	11	45	104	209
Toowong Private	2	0	0	0	2
Townsville	38	25	28	118	209
West Moreton	8	24	33	75	140
Wide Bay	3	20	12	41	76
Total	**446**	**329**	**680**	**1712**	**3167**

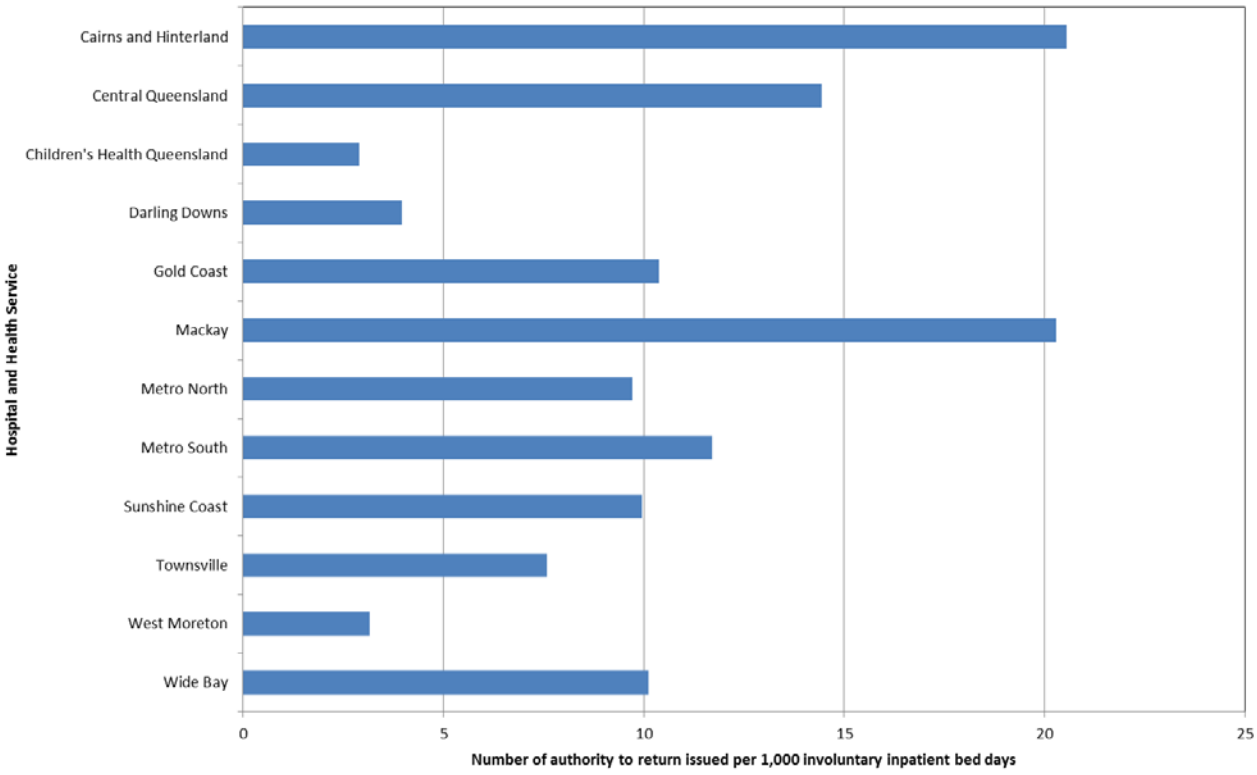
****See Appendix 5 for full AMHS title**
^An absent without permission event commences when an authority to return form is completed
1 Includes those events where a patient absconded from an inpatient mental health unit
2 Includes those events where a patient absconded from another inpatient unit i.e. emergency department, medical ward, community mental health facility etc.
3 Includes those events where a patient absconded while being transported between AMHS, whilst on an approved temporary absence, or didn't return from approved escorted or unescorted leave

A monthly statewide report showing the number of authorities to return per 1000 involuntary inpatient bed days is generated by the MHAODB for the purposes of benchmarking between HHSs. This approach allows for more accurate comparison between HHSs, taking account of their involuntary inpatient population.

Involuntary inpatient bed days are the total number of days of stay that were accrued for all admitted patients who were recorded in CIMHA as being subject to an ITO, FO or detained on a court order, assessment documents or as a classified patient.

Figure 12 provides a comparison of HHS patient absence activity per 1,000 involuntary inpatient bed days.

Figure 12: Number of authorities to return issued per 1,000 involuntary inpatient bed days 2015–2016



Monitoring conditions

Amendments to the Act in 2013 established new mechanisms to assist with identifying and/or responding to risk that may arise in relation to involuntary patients.

These mechanisms include power for the Director of Mental Health to apply a monitoring condition to the treatment plan for a forensic patient, classified patient and a patient detained to an AMHS under a court order who may be at high risk of absconding when they are accessing LCT. The Act precludes young patients from this monitoring.

On review of a forensic patient, the Tribunal may order or approve LCT subject to conditions the Tribunal considers appropriate, or make an order amending or revoking a monitoring condition included in the patient's treatment plan.

The majority of involuntary mental health patients are able to access LCT without the need for additional monitoring arrangements. However, in some instances, these arrangements may facilitate management of risk and may enable a person to access LCT that would not otherwise be approved.

Examples of a monitoring condition include:

- specific telephone contact requirements
- supervision requirements regarding with whom the patient may undertake LCT
- specific requirements regarding places to which the patient may or may not travel while on LCT
- application of a global positioning system (GPS) location device while the patient is undertaking LCT.

In 2015–2016, no patient had a monitoring condition applied to their treatment plan by the Director of Mental Health, although the LCT event notification process for certain patients accessing LCT remains in place. This process, established by the Director of Mental Health policy, enables the Director of Mental Health to oversee access to LCT by these patients.

The reduction in application of monitoring conditions by the Director of Mental Health since this power was established in 2013 is considered to be an outcome of the increased focus by the MHAODB and AMHSs on the management of patients who are assessed as being high risk of becoming absent without permission or who have repeat absence without permission events.

Director of Mental Health policy was amended in 2015-2016 to require all AMHSs to have systems in place for complex case reviews of repeat absence without permission patients and planning and review processes for patients accessing LCT for the first time.

No patients were required to use a GPS device in 2015-2016.

Seclusion and mechanical restraint

Reducing and, where possible, eliminating the use of seclusion and restraint, is one of the four priority areas of the *National Safety Priorities in Mental Health: a national plan for reducing harm.* To support this priority, seclusion and mechanical restraint activity is monitored by the office of the Director of Mental Health and reported annually.

Seclusion

Table 19 details the three clinical indicators relating to the use of seclusion in acute and extended treatment settings for 2015–2016 as well as the previous four reporting periods.

In acute inpatient settings, the data demonstrates a decrease in seclusion events per 1000 accrued patient bed days from the previous reporting period (i.e. from 11.4 to 9.4 events per 1000 accrued patient days) and a significant overall reduction in this indicator over the five year period. In addition, the downward trend of the proportion of inpatient episodes with one or more seclusion events and the mean duration of seclusion events has continued in the current reporting period.

In extended treatment settings, there is a reduction in seclusion events per 1000 accrued patient bed days from the previous reporting period (i.e. from 16.6 to 15.9 events per 1000 accrued patient days). However, this indicator has fluctuated over the five year reporting period. There is a downward trend in the proportion of inpatient episodes with one or more seclusion events over the five year period. While there is an increase in the mean duration of seclusion events in the current reporting period (11.3 hours) when compared to 2014-2015 (nine hours), there is a reduction in this indicator over the five year period.

Table 19: Statewide clinical indicators of seclusion—five year trend

	Indicator	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Acute	Seclusion events per 1000 bed days	13.3	12.7	10.9	11.4	9.4
	Proportion of episodes with one or more seclusion events	5.5%	5.6%	5.4%	4.8%	3.8%
	Average (mean) duration of seclusion events (hours)	4.1	4	3.8	3.4	3.4
Extended treatment	Seclusion events per 1000 bed days	19.1	19.3	24	16.6	15.9
	Proportion of episodes with one or more seclusion events	10.6%	10.9%	10.3%	7.1%	5.6%
	Average (mean) duration of seclusion events (hours)	12.2	8.9	7.2	9	11.3

Mechanical restraint

Mechanical restraint is the use of an appliance to prevent free movement of a person's body or a limb. The Act provides that mechanical restraint can only be applied if a doctor is satisfied that it is the most clinically appropriate way of preventing injury to the person or someone else[14].

Only an appliance that secures a person's wrists to a band around their waist has been approved by the Director of Mental Health. A doctor cannot authorise the use of any other appliance without approval from the Director of Mental Health.

In the 2015–2016 reporting period, there were 76 authorisations of mechanical restraint for 11 patients, which represents a significant decrease from 2014-2015, where there were 219 authorisations for 19 patients.

Seclusion and Restraint Minimisation Plans

A specific program established under Director of Mental Health policy enables the Director of Mental Health to approve Seclusion and Restraint Minimisation Plans for individual patients in The Park High Security Program AMHS. The main aim of these plans is to assist in reducing, and where possible, eliminating the use and duration of seclusion and restraint and to ensure statutory oversight by the Director of Mental Health of seclusion and restraint use.

A total of 186 Seclusion and Restraint Minimisation Plans, each for a duration of one week, were approved for 14 patients in the 2015-16 reporting period.

None of the 11 patients for whom mechanical restraint was used in 2015–2016 had a Seclusion and Restraint Minimisation Plan.

Seclusion and Restraint Minimisation Plans were in place continuously throughout the reporting period for three patients *, totalling 152 plans over the 2015–2016 reporting period. The remaining 34 plans were for 11 patients.

*One of the three patients for whom a Plan was in place continuously throughout the reporting period spent four weeks entirely out of seclusion early in the reporting period during recovery from a severe physical illness.

[14] See Section 162D of the Act

Electroconvulsive therapy

ECT is a regulated treatment under the Act and may only be performed in a facility that has been authorised by the Director of Mental Health. It is an offence to perform ECT other than in accordance with the Act. The authorised facilities in 2015–2016 include all AMHSs and those private facilities as set out in Appendix 8.

ECT may be performed on a patient at an AMHS only if informed consent[15] has been given by the patient, or the Tribunal has given approval for the treatment[16].

A psychiatrist may make an application to the Tribunal if the psychiatrist is satisfied that:

- ECT is the most clinically appropriate treatment for the patient having regard to the patient's clinical condition and treatment history, and
- the patient is incapable of giving informed consent to the treatment.

The Tribunal must hear and decide the treatment application within a reasonable time after it is made. If the Tribunal approves the application, its decision must state the number of treatments that may be given and the period in which the treatments may be given.

ECT may be performed on an involuntary patient in emergency circumstances without prior approval of the Tribunal if:

- a psychiatrist has made a treatment application to the Tribunal, and
- the psychiatrist and the medical superintendent at the AMHS where the treatment is to be given have certified in writing that it is necessary to perform emergency ECT to save the patient's life, or prevent the patient from suffering irreparable harm.

Table 20 sets out the number of Tribunal applications approved and the number of emergency ECT treatment applications made at each AMHS during 2015–2016. There was a total of 560 Tribunal approvals for ECT and 127 emergency ECT applications.

15 See Sections 133-137 of the Act

16 See Section 139 of the Act

Table 20: Number of Mental Health Review Tribunal applications approved and emergency electroconvulsive therapy applications 2015–2016

Authorised Mental Health Service**	Number of Tribunal applications approved	Number of emergency ECT applications
Bayside	8	10
Belmont Private	18	8
Cairns	39	4
Central Queensland	8	5
Children's Health Queensland	0	0
Darling Downs	16	2
Gold Coast	56	13
Greenslopes Private	4	0
Logan Beaudesert	25	5
Mackay	13	2
New Farm Clinic	3	2
Princess Alexandra	67	24
Redcliffe Caboolture	19	1
RBWH	104	21
Sunshine Coast	19	4
The Park	11	0
The Park High Security	12	0
The Prince Charles	72	9
Toowong Private	2	2
Townsville	43	6
West Moreton	9	6
Wide Bay	12	3
Total	**560**	**127**

**** See Appendix 5 for full AMHS title**

Monitoring and Compliance

Under section 489 of the Act, the Director of Mental Health is responsible for monitoring and auditing legislative compliance, and has established formal mechanisms for monitoring all AMHS compliance with the Act and associated policy requirements as part of an ongoing quality improvement process.

These mechanisms examine whether patient assessment, treatment and care is consistent with the requirements of the Act and associated Director of Mental Health policies. They also aim to identify processes that are working well and those that need to be improved.

The Director of Mental Health maintains a compliance register to assist in monitoring and auditing compliance, quality improvement activities and associated reporting processes. In addition, regular automated reports are provided to AMHS Administrators to facilitate local and statewide monitoring, and to inform self-monitoring and review processes.

The Director of Mental Health is made aware of legislative compliance breaches or potential breaches of the Act through a variety of means including:

- routine notifications and reports in relation to the administration of Act
- advice from AMHSs and other stakeholders on Act related matters
- notifications by AMHSs or other organisations of compliance breaches
- consumer feedback/complaints.

These breaches are typically minor in nature and are the result of processes not being followed (policy or procedure), administrative error (a form not being completed or not completed correctly), or non-compliance with statutory timeframes (an examination not conducted within the specified time or a report not provided within the required timeframe).

In all cases of non-compliance that were brought to the attention of the Director of Mental Health during 2015-2016, the matter was raised with the relevant AMHS and where appropriate, action was taken to identify and implement corrective measures, e.g. changes to local procedures or staff training. These matters have assisted in identifying opportunities for broader statewide improvements, e.g. policy or system development. The MHAODB continues to support mental health services to develop and monitor self-auditing processes to ensure safe clinical practice.

Long standing concerns continue regarding compliance with the 21 day statutory timeframe for psychiatrist reports required when an involuntary patient is charged with an offence. Delays in receiving these reports increase delays in court processes and consequently have adverse impacts on patients, families and victims. The MHAODB provides Administrators of AMHSs with a weekly report advising of section 238 reports due within the week and monthly reports on overdue section 238 reports.

Concerns about the statutory requirements for these reports were highlighted in the review of the Act. Under the 2016 Act, psychiatrist reports are no longer mandatory for persons on an order or authority.

For further information, refer to the chapter, *'Reporting on the Mental Health Act 2000'* in this report.

Investigations

The Director of Mental Health has statutory powers to commission investigations under the Act into the assessment, treatment and detention of patients in an AMHS. An investigation under the Act may arise in response to an event or complaint relating to the admission, assessment, examination, detention, treatment or care of a person in an AMHS. Not all complaints or issues will trigger an investigation. If an investigation highlights potential breaches of legislation, other than the Act, the Director of Mental Health refers the matter to the appropriate agency.

The primary purpose of an investigation under the Act is to understand what occurred and, where relevant, to identify systemic issues with a view to minimising the potential for recurrence of such an event.

An Act investigation is conducted by one or more 'approved officers' appointed by the Director of Mental Health, taking account of the expertise and skills relevant to the matter. The investigation team provides the Director of Mental Health with a written report on the investigation findings, an analysis of the issues and recommendations for improvement. Recommendations may relate to matters requiring attention at service or statewide level.

In 2015-2016, the Director of Mental Health implemented the guideline, Investigations under the *Mental Health Act 2000,* which provides a framework for planning and conducting investigations under the Act. In addition, the factsheet, Investigations under the *Mental Health Act 2000* Information for participants, was developed to assist health service employees who are requested to participate in investigations.

During the course of the 2015–2016 reporting period, three matters came to the attention of the Director of Mental Health that warranted an investigation under the Act.

As at 30 June 2016, the investigation report had been finalised for one of these investigations. The report made a number of recommendations regarding clinical management practices and system improvement at local and statewide levels which are being progressed.

Legislative reform

Mental Health Act 2016

The review of Queensland's mental health legislation, which commenced in June 2013, has been completed. The 2016 Act was passed by Parliament on 18 February 2016 and will commence on 5 March 2017.

The 2016 Act represents a major step forward in recognising patient rights, acknowledging the significant role that family and support persons play in a patient's recovery, and aligning the legislation with contemporary mental health clinical practice. Patients, clinicians, the legal fraternity and the wider community will all benefit from the 2016 Act's improved and simplified practices and increased focus on patient rights and recovery.

The main objects of the 2016 Act are to improve and maintain the health and wellbeing of people with a mental illness who do not have the capacity to consent to treatment, to enable people to be diverted from the criminal justice system if found to have been of unsound mind at the time of an alleged offence or to be unfit for trial, and to protect the community if people diverted from the criminal justice system may be at risk of harming others.

The objects of the Act will be achieved in a way that safeguards the rights of people, is least restrictive of a person's rights and liberties, and promotes the recovery of a person with a mental illness and their ability to live in the community without the need for involuntary treatment or care.

Implementation

Implementation of the 2016 Act is well underway and is being overseen by the Mental Health Act 2016 Implementation Committee. The Committee is chaired by the Executive Director of the MHAODB and includes nominees from Queensland Health, the Tribunal and the Private Hospital Association of Queensland.

An inter-departmental executive committee has also been established to ensure effective implementation of activities that affect other government agencies. This group is chaired by the Deputy Director-General, Clinical Excellence Division, Department of Health. Membership includes representatives of Queensland Health, the Queensland Police Service, HHSs, the Queensland Mental Health Commission, the Department of the Premier and Cabinet, and the Department of Communities, Child Safety and Disability Services.

Several working groups which include representatives from consumer and carer groups, AMHSs, the MHAODB and other relevant agencies have provided focussed input into key policy areas and processes under the 2016 Act.

Key stakeholders, including peak mental health consumer and carer groups, are being continuously engaged and involved in the implementation. Each AMHS has at least one 'champion', who is a key contact, and who assists with implementation within the AMHS.

A large range of resources have been developed to assist with the implementation of the 2016 Act.

These resources are available on the Queensland Health internet site at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/2016/resources/default.asp

Online training resources have been developed for clinicians and other people administering the 2016 Act. More information about these resources is at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/2016/training/default.asp

Statewide Coordinator for the Independent Patient Rights Advisers

Implementation of the 2016 Act has also included the establishment of the Statewide Coordinator for the Independent Patient Rights Advisers (Rights Advisers) Network. This is a new position created under the 2016 Act to provide support and leadership for the network of Rights Advisers across all HHSs. The Statewide Coordinator is an independent position that sits within the Office of the Chief Psychiatrist, MHAODB and reports directly to the Chief Psychiatrist.[17].

The Statewide Coordinator's responsibilities include coordinating the statewide network of Rights Advisers, oversight and leadership to ensure the Rights Advisers are performing their functions under the 2016 Act, coordinating training and support for the Rights Advisers, assisting the Chief Psychiatrist in ensuring compliance with the 2016 Act and protecting the rights of patients and support persons.

Amendment of the definition of psychiatrist in the *Mental Health Act 2000*

The definition of psychiatrist has been amended in the Act to allow medical practitioners with limited registration under the Australia Health Practitioner Regulation Agency to undertake postgraduate training or supervised practice in a specialist position in psychiatry to perform duties as an authorised psychiatrist under the Act. The amended definition commenced on 1 September 2015.

While this amendment does not substantially alter the range of medical practitioners classified as psychiatrists, it will assist in ensuring that adequate workforce arrangements are in place for the administration of the Act, particularly in rural and remote areas of the state.

Amendment of the *Queensland Mental Health Regulation 2002*

The Regulation was amended to update the schedule of corresponding laws, which was out of date and incomplete due to legislative changes in other jurisdictions. Since the commencement of the Regulation in 2002, there have been changes to the corresponding interstate laws, including the passage of new legislation in several states. Ministerial interstate agreements for planned transfers and apprehension and return of involuntary mental health patients require the declaration of corresponding laws in the Mental Health Regulation.

[17] The 2016 Act provides for the appointment of a Chief Psychiatrist. The Chief Psychiatrist is an independent statutory officer, with functions, powers and responsibilities under the 2016 Act. The position of Chief Psychiatrist replaces the Director of Mental Health position established in the *Mental Health Act 2000*

The Regulation was amended to provide for:

- the declaration of laws of another State as corresponding laws for the purposes of the Act. Under the Schedule to the Act, a corresponding law is defined as being ‘a law of another State that is declared under a regulation to be a corresponding law for this Act’

- records to be kept by the administrator of an AMHS for involuntary patients of the service, patients detained under a court order and patients who are secluded

- the change to an out-dated reference to the Act as a consequence of amendments to the Act by the *Forensic Disability Act 2011*.

These amendments commenced on 6 November 2015.

Supporting quality improvements in mental health service delivery

The Director of Mental Health has an ongoing commitment to ensuring the safety and quality of services provided under the Act as part of a continuous reform and quality improvement agenda.

Some key safety and quality improvement initiatives which were undertaken during 2015-2016 are set out below.

Memorandum of Understanding between Queensland Health and the Queensland Police Service—Mental Health Collaboration

The Memorandum of Understanding between Queensland Health and the Queensland Police Service for Mental Health Collaboration has been revised by the MHAODB in consultation with Queensland Health's Mental Health Intervention Coordinators, clinicians, administrators of AMHSs, clinical directors and executive directors of AMHSs, Health Service Chief Executives, the Queensland Fixated Threat Assessment Centre, the Queensland Ambulance Service and the Queensland Police Service.

The Memorandum of Understanding allows for disclosure and exchange of confidential information between Queensland Health and the Queensland Police Service for the purposes of proactively developing mental health intervention strategies and responding to mental health incidents and situations involving vulnerable persons.

In 2005, Queensland Health became party to the Memorandum of Understanding for Mental Health Collaboration between Queensland Health and the Queensland Police Service. The Memorandum of Understanding was revised in 2011 to provide increased clarity and consistency for the disclosure of information when responding to a mental health incident.

The 2016 revisions to the Memorandum of Understanding incorporate the legislative provisions in the HHB Act for sharing confidential information and expand the scope of the Memorandum of Understanding to include the proactive work undertaken to prevent mental health incidents by Queensland Health and the Queensland Police Service.

The Memorandum of Understanding was signed by Queensland Health and the Queensland Police Service on 16 June 2016, and has been prescribed in the HHB Regulation, commencing on 25 November 2016.

Memorandum of Understanding between Queensland Health and Queensland Corrective Services—Confidential Information Disclosure

The Memorandum of Understanding between Queensland Health and Queensland Corrective Services for Confidential Information Disclosure, established in 2011, has been updated to reflect the legislative provisions in the HHB Act for sharing confidential information and the current management practices across Queensland Health and Queensland Corrective Services.

The Memorandum of Understanding enables information sharing between Queensland Health and Queensland Corrective Services for the joint management of a person in circumstances where other legislative avenues of obtaining confidential information, particularly through obtaining consent of the prisoner, have been exhausted. Sharing information under this Memorandum of Understanding enables Queensland Health and Queensland Corrective Services to undertake their respective roles and responsibilities, and to facilitate and coordinate health services for prisoners.

The Memorandum of Understanding was signed by Queensland Health and Queensland Corrective Services on 16 May 2016, and has been prescribed in the HHB Regulation, commencing on 25 November 2016.

Interagency working group - young people in correctional facilities

Three quarters of children and young people in correctional facilities are known to have poor mental health, and/or an intellectual disability or a developmental difficulty that influences their propensity for offending. These complex issues are compounded for those who have impaired decision-making capacity and do not have the support and assistance of a parent or guardian.

An inter-agency working group has been established to improve information sharing between the agencies, with the aim of enabling better outcomes for the health and well-being of young people in detention and reducing the likelihood of recidivism. The working group will examine existing information sharing arrangements, identify barriers to collaborative service provision and develop strategies for improved service delivery.

Membership includes the MHAODB, Prison Mental Health Service; Queensland Corrective Services; Department of Justice and Attorney-General, Department of Communities, Child Safety and Disability Services, Office of the Public Guardian, the Department of Education and Training, and the Child and Youth Mental Health Service, Children's Health Queensland.

Suicide Risk Assessment and Management in Emergency Departments

In 2015-16, the Suicide Risk Assessment and Management in Emergency Department settings (SRAM-ED) training program was developed as a partnership between the Office of the Chief Psychiatrist, the Queensland Centre for Mental Health Learning and the Queensland Health Clinical Skills Development Service. The program was designed to help emergency department staff and other front-line acute mental health care staff to recognise, respond to and provide care for people presenting to health services with suicide risk. The package is a combination of online e-learning modules with a face-to-face workshop consisting of scenario-based simulation exercises. The program aims to enhance the capacity and capabilities of staff working in emergency departments to identify and respond appropriately to a suicidal person, including awareness of the impact their own personal beliefs and reactions can have.

By 30 June 2016, the SRAM-ED train-the-trainer program had been delivered 17 times across the state, training a total of 158 clinicians to become program facilitators. An additional 216 people have completed the e-learning modules (without attending a face-to-face workshop).

Feedback from participants indicates the program has greatly assisted them with their suicide risk assessment skills and provided the motivation to ensure a patient’s engagement with the health

system is a positive one. It has also fostered greater collaboration and communication between clinicians in emergency departments and those in mental health services.

Evaluation of implementation of Safe Transport of People with a Mental Illness: a Queensland Interagency Agreement

An evaluation of the implementation of Safe transport of people with a mental illness: a Queensland interagency agreement, within HHSs was conducted in June 2015.

The agreement, released in August 2014, was developed collaboratively between Queensland Health, the Queensland Ambulance Service and the Queensland Police Service. The agreement outlines a statewide interagency approach between Queensland Health, the Queensland Ambulance Service and the Queensland Police Service for the safe transport of people with a known or suspected illness who require, or may require, mental health assessment, treatment or care. It clarifies the roles and responsibilities of each agency involved, and provides a framework for the development and review of local interagency agreements and protocols to support interagency collaboration in ensuring safe mental health patient transport.

The agreement also addresses one of the four key national safety priorities in mental health—safe transport of people experiencing mental disorders.

There are a number of significant challenges in ensuring the safe transport of people with a mental illness or suspected mental illness. Of particular importance is the need for consistent decision making pathways and communication processes between agencies. In rural and remote areas, transport issues are further complicated by large travel distances and limited resource availability across agencies.

The evaluation focused on the use of the framework for the development or review of local interagency agreements and protocols with police, ambulance and health services, and its effectiveness in ensuring timely and appropriate transport of people with mental illness.

The evaluation found that the majority of HHSs consider the agreement defines a statewide interagency approach and provides consistent decision making and communication processes to guide coordinated transport arrangements for people with a mental illness.

While most HHSs have clear local interagency processes and contacts in place for organising patient transport, less than half have an active interagency agreement or protocol completed. The priority for strengthening/continuing the implementation of the agreement is the development and/or the finalisation of local agreements. The goodwill developed through local communication networks and arrangements which incorporate consideration of conflicting demands on resources will continue to be major contributors to successful arrangements for transport of people with a mental illness.

The agreement is available on the Department of Health's internet site at: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/guidelines/default.asp

Review of sentinel events

On 8 May 2015, the Minister for Health and Minister for Ambulance Services announced the establishment of a statewide Sentinel Events Review (the Review) involving people with a known or suspected mental illness in receipt of Queensland public mental health services. The focus of the Review was on homicides or attempted homicides involving persons with a mental illness (either as a perpetrator or victim) and fatalities arising from police use-of-force intervention involving people with a known or suspected mental illness that occurred between January 2013 and April 2015.

The Review was conducted by an independent expert committee who were tasked to make findings and recommendations on systemic matters relating to the sentinel events which will inform strategic directions, policy and clinical practice, improve the care of people with a mental illness, and minimise or prevent the reoccurrence of such events.

The findings and recommendations of the Review report, *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*, and the Queensland Health response can be accessed at: www.publications.qld.gov.au/dataset/mental-health-sentinel-events-review-2016.

Guideline for information sharing between mental health workers, consumers, carers, family and significant others

The guideline, *Information sharing between mental health workers, consumers, carers, family and significant others*, was revised in consultation with mental health services and clinicians and reissued in May 2016. The revised guideline reflects current legislative provisions of the HHB Act and contemporary clinical practice.

For most people with a mental illness, the meaningful engagement of people who play a significant part in a person's life will contribute greatly to their recovery. In keeping with best practice, mental health clinicians should ensure that everyone identified as important to the mental health patient is appropriately engaged and involved in the patient's treatment and care. It is fundamental to a patient-centred approach that information is shared as often as possible between clinicians, patients and those involved in helping a person's recovery.

The guideline was developed to support mental health workers understand their obligations under the law when sharing confidential information. It provides information on the benefits of sharing information and the legislative framework within which patient information can and should be shared, and how it can be applied in clinical practice.

The guideline is available on the Department of Health's internet site at: www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/clinical-staff/mental-health/guidelines/info_sharing.pdf

Absence without permission reduction strategies

Reducing absence without permission and restrictive practices, particularly within inpatient AMHSs is a high priority for the MHAODB and HHSs.

Absence without permission occurs when an involuntary patient leaves a facility without authorisation, or fails to return from authorised leave when required. Absence without permission can involve risks to patients, their families and the community, and also organisational risks for the health service system.

Following significant concerns regarding rates of absence without permission in 2012-2013, a range of evidence-based, recovery oriented strategies have been implemented over recent years to ensure the safety and security of inpatient mental health facilities, while working towards a least restrictive model of care. Statewide and service level strategies include:

- clinical practice improvements e.g. changes to models of care
- program development e.g. meaningful leave, Safewards[18]
- structural improvements e.g. capital works, building modifications
- staff training and education
- peer support programs
- reporting and data analysis
- benchmarking across services.

Individual patient strategies include an assessment of each patient's risk of becoming absent without approval. Director of Mental Health policy requires this risk assessment to be conducted on the patient's initial contact with the service or facility and to be reviewed at regular intervals throughout the service episode. In addition, an absent without permission prevention and response plan must be developed for all inpatients and is recommended for community patients.

An absent without permission prevention and response plan 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 absent without approval.

While safety is a key concern, it is equally critical that patients' rights are protected, and restrictions are the minimum required in the circumstances. The Director of Mental Health has issued policies and guidelines to support safety and security in AMHSs, reducing absence without permission and upholding the rights of voluntary and involuntary patients.

A comprehensive report by the MHAODB in July 2014 on initial implementation of absence without permission reduction strategies identified:

[18] Safewards is a clinical model developed in the United Kingdom which aims to promote safer, less coercive practices in mental health care, and to reduce incidents of conflict involving patients or staff. The model attempts to identify and address the causes of behaviours in mental health settings that may result in harm – such as violence, self-harm or absconding – and to reduce the likelihood of these behaviours occurring

- the need for future priorities to have a greater focus on active inclusion of patients and carers in care planning and risk management,
- the use of evidence-based strategies and programs
- the need to work towards a least restrictive model of care in adult acute mental health inpatient units.

This approach is consistent with the December 2014 report by Queensland Mental Health Commission, *Options for reform: moving towards a more recovery-oriented, least restrictive approach in acute mental health wards including locked wards* (the 2014 Report).

A follow up survey of on strategies being used to curtail inpatient absence without permission and support reductions in restrictive practices, such as the use of seclusion and restraint AMHSs was conducted by the MHAODB in June 2015. Both the findings from the survey and the Queensland Mental Health Commission's Options for Reform report informed the development of the program for a Least Restrictive Practices Roundtable hosted by the Mental Health Alcohol and Other Drugs Statewide Clinical Network in June 2015. The Roundtable enabled sharing of learnings from evidence-based models and strategies being implemented in acute adult mental health units across the state.

A second comprehensive report by the MHAODB was released in September 2015, *Reducing restrictive practices and absence without permission in authorised mental health services within Queensland's Hospital and Health Services* (the 2015 Report). The 2015 Report found significant progress had been made in implementing the actions recommended by the 2014 Report. All services are implementing a range of best practice, recovery-oriented approaches to reduce absence without permission, and are working towards a less restrictive model of care in adult acute mental health inpatient units. There has been a shift in focus since 2013-14, with a greater emphasis on the inclusion of patients and carers in care planning and absence without permission risk reduction. The report noted improvement in absence without permission rates, particularly from mental health inpatient settings, had been sustained over an 18 month period to June 2015.

During 2015-2016, the MHAODB has continued to monitor statewide absence without permission trends. AMHSs are provided with their aggregated quarterly absence without permission data (based on monthly data reported by AMHSs) to assist with monitoring local issues and trends. The rate of absence without permission from an adult acute mental health inpatient unit per 1000 involuntary inpatient days is used for the purpose of benchmarking across AMHSs, and is routinely available to HHSs.

In addition, the MHAODB has maintained a continued focus on strategies and actions to promote improvements in absence without permission activity:

- Reducing absence without permission rates is a standing agenda item for Clinical and Executive Directors' meetings.

- The Chief Psychiatrist follows up individual AMHSs with absence without permission activity above the average statewide rate of absence without permission per 1000 involuntary inpatient days at any point across the quarter, or with a significant increase in their absence without permission events during the quarter.

- Director of Mental Health policy has been amended to require uniformity of practices for complex case reviews of repeat absence without permission patients and planning and review processes for patients accessing limited community treatment for the first time.

The MHAODB continues to work collaboratively with the Mental Health Alcohol and Other Drugs Statewide Clinical Network and services to ensure:

- a strong focus is maintained on implementing and sustaining recovery-oriented, evidence-based strategies and models to reduce absence without permission and work towards a least restrictive model of care in adult acute mental health inpatient units

- mechanisms are identified to assist auditing, evaluation and research at service or unit level to monitor implementation and inform quality improvements in care

- Queensland Health contributes to national work currently in progress to inform defining, measuring and reporting on the use of restraint and other restrictive practices in mental health services.

A second Least Restrictive Practices Roundtable is planned for late 2016, with a focus on the development of a therapeutic environment in adult acute mental health inpatient services.

While there are fluctuations in absence without permission data, absence without permission reduction strategies have led to an overall 44 per cent decrease in inpatient absence without permission activity from 1 September 2013 to 30 June 2016.

Mental Health Act 2000 Resource Guide

The *Mental Health Act 2000* Resource Guide is issued by the Director of Mental Health under sections 309A and 493A of the Act. It provides explanatory information about the Act and related legislation, and sets out the Director of Mental Health policies and guidelines.

The Resource Guide was substantially revised in October 2015 to incorporate policy developments and changes to relevant legislation. Key changes included:

- clarifying that an emergency department is part of the inpatient facility of an authorised mental health service for the purposes of seclusion and return of patients absent without permission

- clarifying policy requirements for observation of patients while being secluded

- considerations to be taken into account in decisions about transfers of involuntary patients between authorised mental health services and classified patient admissions.

In June 2016, the Resource Guide was further revised to make minor policy amendments, particularly in relation to prevention of and response to patient absence without permission events, and to update website links and contact details.

The Resource Guide is available on the Department of Health's internet site at:
www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/act-2000/

Fact sheet: Prescribed public nuisance offences and associated offences—supporting mental health consumers

The fact sheet, *Prescribed public nuisance offences and associated offences—supporting mental health consumers,* was revised and re-issued in July 2015. The fact sheet sets out information about prescribed public nuisance offences and how clinicians may assist mental health patients who are charged with such offences.

A prescribed public nuisance offence is a simple offence which disrupts or is likely to disrupt the peaceful passage through, or enjoyment of, a public place. A public nuisance offence involves the following:

- behaving in a disorderly, offensive, threatening or violent way
- the use of offensive, obscene, abusive and threatening language.

Police officers may issue an infringement notice for a public nuisance offence instead of commencing court proceedings for the offence. An infringement notice is a ticket with a payable fine.

An associated offence is one committed at the time the police officer is dealing with a public nuisance offence. There are two types of associated offences:

- obstructing police during the issuing of the ticket
- not stating correct name and address.

An offence of this nature may result in an additional ticket being issued or a charge.

Before issuing a ticket, a police officer is required to attempt to engage in de-escalation, informal resolution and referral to an appropriate agency. In deciding whether to issue a ticket, police officers are required to identify, to the best of their abilities, whether the person has special needs or circumstances affecting their judgement and/or capacity to act in a socially appropriate way. This includes having a mental illness, impaired capacity or a substance use problem.

There are a range of options available to people who have been charged with a public nuisance offence. A clinician may assist a mental health patient who has been charged with such an offence with decision making about these options and completing the relevant processes.

Local partnerships between Queensland Health mental health services and the Queensland Police Service through the Mental Health Intervention Project are critical to ensuring mental health patients are not unnecessarily involved in the criminal justice system and their rights, as well as those of the community, are protected.

The fact sheet is available on the Queensland Health internet site at:
http://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/clinical-staff/mental-health/resources/factsheets/SPER_public_nuisance_offence.pdf

Fact sheet—Conditions of bail

Often when a person is released on bail, a condition of their bail may require the services of a specified clinician and/or mental health service. While every attempt is made to assist people in need of mental health services, situations may arise where a clinician and/or a mental health service may not be able to support the person to comply with their bail conditions.

The fact sheet for conditions of bail has been developed to assist mental health services understand their legal obligations if implicated in a person's condition of bail.

The factsheet is available on the Queensland Health internet site at:
www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/clinical-staff/mental-health/resources/factsheets/bail_fact_sheet.pdf

Appendices

Appendix 1: Director of Mental Health delegations

As at 30 June 2016

Power delegated	Delegate
Full DMH powers with the exclusion of any powers under Chapter 13, Pt 2	Dr Cassandra Griffin Dr Edward Heffernan Dr Darren Neillie Dr Jacinta Powell Dr Terry Stedman Dr John Reilly Dr Vinit Sawnhey Dr Vikas Moudgil Dr William Kingswell
Chapters 2, 3, 4, 4A, 5, 6 ,7 (except section 309A), 7A, 8, 12, sections 493B and 499 of Chapter 13 and section 526 of Chapter 14	Associate Professor David Crompton
Chapters 2, 3, 4, 4A, 5, 6, 7, 7A, 8, 9, 12,13 (except sections 493AD, 493AE, 493AF, 493AG, 500 and 503 and those powers which cannot be delegated under Chapter 13, Part 2)	Associate Professor William Brett Emmerson
Chapter 13, Part 1, Division 1A and Chapter 14, Part 5, section 526	Executive Director, Mental Health Alcohol and Other Drugs Branch
Sections 166, 167, 184, 185, 186(2)(a) and 186(2)(b) (for patients detained at The Park—Centre for Mental Health AMHS and The Park High Security Program AMHS)	Director of Clinical Services, West Moreton Division of Mental Health and Specialist Services, The Park—Centre for Mental Health Clinical Director, Forensic and Secure Services, West Moreton Division of Mental Health and Specialist Services, The Park—Centre for Mental Health
Sections 184, 165, 186(2)(a) (for patients at The Park - Centre for Mental Health AMHS and The Park High Security Program AMHS	Psychiatrist On Call, The Park—Centre for Mental Health
Chapter 14, Part 5, section 526	Chief Executives, Hospital and Health Services
Sections 70(4), 237, 245, 264(1A), 3180(1) (excluding subsection (l) and 3180(1A)	Director, Legislation Unit, MHAODB Manager, Mental Health Act Administration Team, MHAODB

Appendix 2: Schedule of Administrators of authorised mental health services

As at 30 June 2016

Authorised mental health service	Administrator
Bayside	Executive Director Mental Health
Belmont Private Hospital	Director, Belmont Private Hospital
Cairns Network	Clinical Director of Mental Health
Central Queensland Network	Director of Clinical Services, Central Queensland Mental Health Alcohol and Other Drugs Service
Children's Health Queensland	Divisional Director, Child and Youth Mental Health Services
Darling Downs Network	Executive Director of Mental Health Services
Gold Coast	Clinical Director of Mental Health and Integrated Care
Greenslopes Private Hospital	Director of Psychiatry
Logan-Beaudesert	Executive Director Mental Health
Mackay	Clinical Director
New Farm Clinic	Director of Clinical Services
The Park – Centre for Mental Health	Executive Director Mental Health and Specialised Services
The Park High Security Program	Executive Director Mental Health and Specialised Services
The Prince Charles Hospital	Clinical Director, Metro North Mental Health Service
Princess Alexandra Hospital	Executive Director Mental Health
Princess Alexandra Hospital High Security Program	Executive Director Mental Health
Redcliffe Caboolture	Clinical Director Mental Health Services
Royal Brisbane and Women's Hospital	Clinical Director, Metro North Mental Health – Royal Brisbane and Women's Hospital
Sunshine Coast Network	Executive Director, Mental Health Service
Toowong Private Hospital	Chief Executive Officer
Townsville Network	Medical Director Mental Health Services Group
West Moreton	Executive Director Mental Health and Specialised Services, West Moreton Hospital and Health Service
Wide Bay	Executive Director Wide Bay Fraser Coast

Appendix 3 Number of authorised doctors (including authorised psychiatrists)

Please note this table represents the number of authorised doctors (including authorised psychiatrists) at each authorised mental health service. An authorised doctor may be appointed at more than one authorised mental health service.

As at 30 June 2016

Authorised Mental Health Service**	Authorised Psychiatrist	Other Authorised Doctor	Total^
Bayside	131	174	305
Belmont Private	45	13	58
Cairns	77	55	132
Central Queensland	28	58	86
Children's Health Queensland	34	33	67
Darling Downs	65	47	112
Fraser Coast	3	2	5
Gold Coast	50	63	113
Greenslopes Private	10	0	10
Logan Beaudesert	132	158	290
Mackay	16	33	49
New Farm Clinic	52	38	90
Princess Alexandra	130	151	281
Redcliffe Caboolture	34	92	126
RBWH	61	148	209
Sunshine Coast	22	26	48
The Park	28	18	46
The Park - High Security			
The Prince Charles	40	58	98
Toowong Private	61	1	62
Townsville	66	85	151
West Moreton	20	21	41
Wide Bay	22	26	48

**** See appendix 5 for full AMHS title**

Appendix 4 Number of authorised mental health practitioners

As at 30 June 2016

Authorised Mental Health Service**	Total^
Bayside	359
Belmont Private	32
Cairns	132
Central Queensland	78
Children's Health Queensland	99
Darling Downs	129
Gold Coast	163
Greenslopes Private	7
Logan Beaudesert	356
Mackay	57
New Farm Clinic	24
Princess Alexandra	369
Princess Alexandra High Security Program	1
Redcliffe Caboolture	110
RBWH	192
Sunshine Coast	160
The Park	35
The Park - High Security	
The Prince Charles	116
Toowong Private	34
Townsville	164
West Moreton	89
Wide Bay	104
Total	**2,006**

**** See appendix 5 for full AMHS title**

^ An AMHP may be appointed at more than one AMHS

Appendix 5 Authorised mental health service abbreviations

As at 30 June 2016

Authorised mental health service (abbreviated)	Authorised mental health service (full title)
Bayside	Bayside Authorised Mental Health Service
Belmont Private	Belmont Private Hospital Authorised Mental Health Service
Cairns	Cairns Network Authorised Mental Health Service
Central Queensland	Central Queensland Network Authorised Mental Health Service
Children's Health Queensland	Children's Health Queensland Authorised Mental Health Service
Darling Downs	Darling Downs Network Authorised Mental Health Service
Fraser Coast	Fraser Coast Authorised Mental Health Service
Gold Coast	Gold Coast Authorised Mental Health Service
Greenslopes Private	Greenslopes Private Hospital Authorised Mental Health Service
Logan Beaudesert	Logan Beaudesert Authorised Mental Health Service
Mackay	Mackay Authorised Mental Health Service
New Farm Clinic	New Farm Clinic Authorised Mental Health Service
Princess Alexandra	Princess Alexandra Hospital Authorised Mental Health Service
Princess Alexandra High Security	Princess Alexandra Hospital High Security Program Authorised Mental Health Service
Redcliffe Caboolture	Redcliffe Caboolture Authorised Mental Health Service
RBWH	Royal Brisbane & Women's Hospital Authorised Mental Health Service
Sunshine Coast	Sunshine Coast Network Authorised Mental Health Service
The Park	The Park – Centre for Mental Health Authorised Mental Health Service
The Park High Security	The Park High Security Program Authorised Mental Health Service
The Prince Charles	The Prince Charles Hospital Authorised Mental Health Service
Toowong Private	Toowong Private Hospital Authorised Mental Health Service
Townsville	Townsville Network Authorised Mental Health Service
West Moreton	West Moreton Authorised Mental Health Service
Wide Bay	Wide Bay Authorised Mental Health Service

Appendix 6 Schedule of authorised mental health services

as at 30 June 2016

<table>
<tr><th colspan="2">Cairns and Hinterland, Cape York and Torres Strait – Northern Peninsula Hospital and Health Services</th></tr>
<tr><th colspan="2">Cairns Network Authorised Mental Health Service</th></tr>
<tr><th>Inpatient facilities</th><th>Community components</th></tr>
<tr><td rowspan="8">Cairns Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): The Esplanade, Cairns QLD 4870</td><td>Cairns Community Mental Health Service:
165 Sheridan Street, Cairns Qld 4870
16 Danbulah Street, Smithfield Qld 4870
130 McLeod Street, Cairns Qld 4870
10-12 Robert Road, Edmonton Qld 4869</td></tr>
<tr><td>Innisfail Community Mental Health Service:
Innisfail Hospital, Innisfail Qld 4860
Tully Community Health Centre, Tully Qld 4854</td></tr>
<tr><td>Tablelands Community Mental Health Service:
Atherton Health Centre, Louise Street, Atherton Qld 4883
Lloyd Street, Mareeba Qld 4880</td></tr>
<tr><td>Cape York Community Mental Health Service, Weipa Hospital Lot 407, John Evans Drive, Weipa Qld 4874</td></tr>
<tr><td>Cooktown Community Mental Health Service, Hope Street, Cooktown Qld 4871</td></tr>
<tr><td>Thursday Island Community Mental Health Service, Thursday Island Community Health Centre, Thursday Island Qld 4875</td></tr>
<tr><td>Bamaga Community Mental Health Service, Bamaga Health Centre, Bamaga Qld 4876</td></tr>
<tr><td>Mossman Community Mental Health Service, Mossman Hospital, 9 Hospital Street, Mossman Qld 4873</td></tr>
</table>

Central Queensland and Central West Hospital and Health Services	
Central Queensland Network Authorised Mental Health Service	
Inpatient facilities	**Community components**
Rockhampton Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Canning Street, Rockhampton QLD 4700 Eventide Psychogeriatric inpatient unit, Corner North and Campbell Streets, Rockhampton QLD 4700	Rockhampton Community Mental Health Service: • Rockhampton Hospital, Quarry Street, Rockhampton Qld 4700 • Sterling Place, 156 Bolsover Street, Rockhampton Qld 4700
	Capricorn Coast Community Mental Health Service, Capricorn Coast Hospital, 8 Hoskyn Drive, Yeppoon Qld 4703
	Gladstone Community Mental Health Service, Gladstone Hospital, Flinders Street, Gladstone Qld 4680
	Biloela Community Mental Health Service, Outpatients Department, Biloela Hospital, 2 Hospital Road, Biloela Qld 4715
	Central Highlands Community Mental Health Service, Emerald Hospital, Hospital Road, Emerald Qld 4720

Children's Health Queensland Hospital and Health Service	
Children's Health Queensland Authorised Mental Health Service	
Inpatient facilities	**Community components**
Lady Cilento Children's Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Vulture Street, South Brisbane QLD 4101	Greenslopes Child and Youth Mental Health Service, 34 Curd Street, Greenslopes QLD 4120
	Inala Child and Youth Mental Health Service, 7 Kittyhawk Avenue, Inala QLD 4077
	Yeronga Child and Youth Mental Health Service, 51 Park Road, Yeronga QLD 4104
	Mt Gravatt Child and Youth Mental Health Service, Garden Square, 643 Kessels Road, Mount Gravatt QLD 4122
	Evolve Therapeutic Services South, Garden Square, 643 Kessels Road, Mount Gravatt QLD 4122
	Brisbane North Adolescent Day Program, Building C23 Bramston Terrace, Herston 4029
	Evolve Therapeutic Services North, 289 Wardell Street, Enoggera QLD 4051
	Nundah Child and Youth Mental Health Service, Nundah Community Health Centre, 10 Nellie Street, Nundah QLD 4012
	North West Child and Youth Mental Health Service, North West Community Health Centre, 49 Corrigan Street, Keperra QLD 4054
	Pine Rivers Child and Youth Mental Health Service, Pine Rivers Community Health Centre, 568 Gympie Road, Strathpine QLD 4500
	Zero to Four Child and Youth Mental Health Service, Nundah Cottages, 31-33 Robinson Road, Nundah QLD 4012

Darling Downs and South West Hospital and Health Services	
Darling Downs Network Authorised Mental Health Service	
Inpatient facilities	**Community components**
Toowoomba Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Pechey Street, Toowoomba QLD 4350 Baillie Henderson Hospital inpatient and specialist health units (excluding the intellectual disability beds, the grounds of the hospital and non-treatment facilities on the hospital campus): Hogg Street, Toowoomba QLD 4350	Toowoomba Community Mental Health Services: • Fountain House, Toowoomba Hospital, (access via) 220 James Street, Toowoomba Qld 4350 • Toowoomba Hospital, Pechey Street, Toowoomba Qld 4350
	Dalby Community Mental Health Service, Dalby Hospital, Hospital Road, Dalby Qld 4405
	Chinchilla Community Mental Health Service, Cnr Heeney and Hypatia Street, Chinchilla Qld 4413
	Inglewood Community Mental Health Service, Inglewood Hospital, Cunningham Highway, Inglewood Qld 4387
	Goondiwindi Community Mental Health Service, 122 Marshall Street, Goondiwindi Qld 4390
	Stanthorpe Community Mental Health Service, “The Boulders” Stanthorpe Hospital, McGregor Terrace, Stanthorpe Qld 4380
	Warwick Community Mental Health Service, Locke Street Specialist Clinic, 56 Locke Street, Warwick Qld 4370
	Roma Community Mental Health Service, 59-61 Arthur Street, Roma Qld 4455
	St George Community Mental Health Service, St George Hospital, 1 Victoria Street, St George Qld 4487
	Charleville Community Mental Health Service, 2 Eyre Street, Charleville Qld 4470
	Kingaroy Community Mental Health Service, Kingaroy Hospital, 166 Youngman Street, Kingaroy Qld 4610
	Cherbourg Community Mental Health Service, 2 Baranbah Avenue, Cherbourg Qld 4605

Gold Coast Hospital and Health Service	
Gold Coast Authorised Mental Health Service	
Inpatient facilities	**Community components**
Gold Coast University Hospital, inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): 1 Hospital Boulevard, Southport QLD 4215 Robina Hospital, inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): 2 Bayberry Lane, Robina QLD 4226	Southport Child and Youth Community Mental Health Service, 60 High Street, Southport Qld 4215
	Evolve Therapeutic Services, Level 1, 67 Davenport Street, Southport Qld 4215
	Robina Community Mental Health Service, Robina Health Precinct, Level 3, 2 Campus Drive, Robina Qld 4226
	Palm Beach Community Mental Health Service, 9 Fifth Avenue, Palm Beach Qld 4221
	Ashmore Community Mental Health Service, Suite 10, Ashmore Commercial Centre, 207 Currumburra Road, Ashmore Qld 4214

Mackay Hospital and Health Service	
Mackay Authorised Mental Health Service	
Inpatient facilities	**Community components**
Mackay Base Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Bridge Road, Mackay QLD 4740	Mackay Community Mental Health Service, 12-14 Nelson Street, Mackay Qld 4870
	Whitsunday Community Mental Health Service, 12 Altmann Avenue, Cannonvale Qld 4802
	Moranbah Community Mental Health Service, 142 Mills Avenue, Moranbah Qld 4744
	Bowen Community Mental Health Service, Gregory Street, Bowen Qld 4805
	Whitsunday Community Mental Health Service, 26-32 Taylor Street, Proserpine Qld 4800

Metro North Hospital and Health Service	
The Prince Charles Hospital Authorised Mental Health Service	
Inpatient facilities	**Community components**
The Prince Charles Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Rode Road, Chermside QLD 4032	Nundah Community Mental Health Service, Corner Nellie Street and Melton Road, Nundah Qld 4012
	Pine Rivers Community Mental Health Service, 568 Gympie Road, Strathpine QLD 4500
	Chermside Community Mental Health Service, The Prince Charles Hospital, Rode Road, Chermside QLD 4032
Redcliffe Caboolture Authorised Mental Health Service	
Inpatient facilities	**Community components**
Caboolture Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): 9 McKean Street, Caboolture QLD 4510 Redcliffe Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Anzac Avenue, Redcliffe QLD 4020 Cooinda House, Psychogeriatric inpatient unit, 60 George Street, Kippa-Ring QLD 4021 Jacana Acquired Brain Injury inpatient unit, 19th Avenue, Brighton QLD 4017	Redcliffe-Caboolture Child and Youth Mental Health Service, 12 King Street, Caboolture Qld 4510
	Caboolture Adult Mental Health Service, Caboolture Hospital, 9 McKean Street, Caboolture Qld 4510
	Redcliffe Adult Mental Health Service, Redcliffe Health Campus, 181 Anzac Avenue, Kippa Ring Qld 4021
Royal Brisbane & Women's Hospital Authorised Mental Health Service	
Inpatient facilities	**Community components**
Royal Brisbane and Women's Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Herston Road, Herston QLD 4029	Inner North Brisbane Mental Health Service, 162 Alfred Street, Fortitude Valley Qld 4006

Metro South Hospital and Health Service	
Bayside Authorised Mental Health Service	
Inpatient facilities	**Community components**
Redland Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Weippin Street, Cleveland QLD 4163 Daintree Psychogeriatric inpatient unit, 3 Weippin Street, Cleveland QLD 4163 Casuarina Lodge, 48 New Lindum Road, Wynnum West QLD 4178	Bayside Community Mental Health Service, 2 Weippin Street, Cleveland Qld 4163
Logan Beaudesert Authorised Mental Health Service	
Inpatient facilities	**Community components**
Logan Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Corner Armstrong and Loganlea Roads, Meadowbrook QLD 4131	Beenleigh Community Mental Health Service, 10-18 Mount Warren Boulevard, Mount Warren Park Qld 4207
	Logan Central Community Mental Health Service, 51 Wembley Road, Logan Central Qld 4114
	Logan Acute Care Community Mental Health Service, Logan Hospital, Corner Armstrong and Loganlea Roads, Meadowbrook Qld 4131
	Evolve Therapeutic Services, Unit 12, 3-19 University Drive, Meadowbrook Qld 4131
	Beaudesert Community Mental Health Service, Beaudesert Hospital, Tina Street, Beaudesert Qld 4285
	Browns Plains Community Mental Health Service, Corner Middle Road and Wineglass Drive, Hillcrest Qld 4118

Metro South Hospital and Health Service	
Princess Alexandra Hospital Authorised Mental Health Service	
Inpatient facilities	**Community components**
Princess Alexandra Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Ipswich Road, Woolloongabba QLD 4102Mater Misericordiae Hospital (Adult and Mothers) inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Raymond Terrace, South Brisbane QLD 4101Queen Elizabeth II Jubilee Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Kessels Road, Coopers Plains QLD 4108	Woolloongabba Community Mental Health Service, 2 Burke Street, Woolloongabba Qld 4102
	Inala Community Mental Health Service, 64 Wirraway Parade, Inala Qld 4077
	Mount Gravatt Community Mental Health Service, 519 Kessels Road, Macgregor Qld 4109
Princess Alexandra Hospital High Security Program Authorised Mental Health Service	
Inpatient facilities	**Community components**
Princess Alexandra Hospital Secure Unit, Rooms 19 and 20, the courtyards and surrounding corridors, treatment areas including GSU 20, GSU 26, GSU 30, GSU 32, GSU 34, GSU 40: Ipswich Road, Woolloongabba QLD 4102	

Sunshine Coast Hospital and Health Service	
Sunshine Coast Network Authorised Mental Health Service	
Inpatient facilities	**Community components**
Nambour Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Hospital Road, Nambour QLD 4650	Gympie Community Mental Health Service, 20 Alfred Street, Gympie Qld 4570
	Glenbrook Community Mental Health Service, 4 Jack Street, Nambour Qld 4560
	Nambour Community Mental Health Service, Ground Floor, Centenary Square, Nambour Qld 4560
	Maroochydore Community Mental Health Service, 100 Sixth Avenue, Maroochydore Qld 4558
	Maroochydore Child and Youth Community Mental Health Service, 15 Beach Road, Maroochydore Qld 4558
	Evolve Therapeutic Services, 108 Brisbane Road, Mooloolaba Qld 4557

Townsville and North West Hospital and Health Services	
Townsville Network Authorised Mental Health Service	
Inpatient facilities	**Community components**
Townsville Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): 100 Angus Smith Drive, Douglas QLD 4814 Kirwan Rehabilitation Unit and Acquired Brain Injury Unit, 138 Thuringowa Drive, Kirwan QLD 4817 Josephine Sailor Adolescent Inpatient Unit, 138 Thuringowa Drive, Kirwan QLD 4817 Pandanus Special Care Unit , Eventide, 54-78 Dalrymple Road, Charters Towers QLD 4820 Charters Towers Rehabilitation Unit, 35 Gladstone Road, Charters Towers QLD 4820 Mount Isa Base Hospital Department of Emergency Medicine, 30 Camooweal Street, Mount Isa Qld 4825[19]	Burdekin Community Mental Health Service, Ayr Hospital, 2 Chippendale Street, Ayr Qld 4807
	Palm Island Community Mental Health Service, Joyce Palmer Hospital, Palm Island Qld 4816
	Ingham Community Mental Health Service, 2-16 McIlwraith Street, Ingham Qld 4850
	Charters Towers Community Mental Health Service, Charters Towers Hospital, 137-139 Gill Street, Charters Towers Qld 4820
	North Ward Community Mental Health Service, 35 Gregory Street, North Ward Qld 4810
	Kirwan Community Mental Health Service, 138 Thuringowa Drive, Kirwan Qld 4817
	Josephine Sailor Adolescent Day Service, 138 Thuringowa Drive, Kirwan Qld 4817
	Mount Isa Community Mental Health Service, 30 Camooweal Street, Mount Isa Qld 4825

[19] Mental health treatment services at this facility are subject to the terms set out in the Director of Mental Health *Policy for declaration of an authorised mental health service facility with limited functions*.

West Moreton Hospital and Health Service	
The Park – Centre for Mental Health Authorised Mental Health Service	
Inpatient facilities	**Community components**
The Park—Centre for Mental Health inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Corner Ellerton Drive and Wolston Park Road, Wacol QLD 4076	
The Park High Security Program Authorised Mental Health Service	
Inpatient facilities	**Community components**
The Park—High Security Program (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Corner Ellerton Drive and Wolston Park Road, Wacol QLD 4076	
West Moreton Authorised Mental Health Service	
Inpatient facilities	**Community components**
Ipswich Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Chelmsford Street, Ipswich QLD 4305	West Moreton Community Mental Health Service, Ipswich Health Plaza, 12 Bell Street, Ipswich Qld 4305 • West Moreton Integrated Mental Health Service • Evolve Therapeutic Services
	Goodna Community Mental Health Service, 81 Queens Street, Goodna Qld 4300

Wide Bay Hospital and Health Service	
Wide Bay Authorised Mental Health Service	
Inpatient facilities	**Community components**
Bundaberg Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Bourbong Street, Bundaberg QLD 4670 Hervey Bay Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): Corner Nissan and Urraween Roads, Pialba QLD 4655 Maryborough Hospital inpatient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus): 185 Walker Street, Maryborough QLD 4650	Bundaberg Community Mental Health Service, Bundaberg Hospital, Bourbong Street, Bundaberg QLD 4670 Gayndah Hospital, 69 Warton Street, Gayndah QLD 4625 Monto Hospital, Flinders Street, Monto QLD 4630 Childers Hospital, 44 Broadhurst Street, Childers QLD 4660 Gin Gin Hospital, 5 King Street, Gin Gin QLD 4671 Village Community Mental Health Service, 28 Torquay Road, Pialba Hervey Bay QLD 4655 Bauer Wiles Community Mental Health Service, 167 Neptune Street, Maryborough QLD 4650

Private Sector Services	
Belmont Private Hospital Authorised Mental Health Service	
Inpatient facility	**Community components**
Belmont Private Hospital inpatient and specialist health units: 1220 Creek Road, Carina QLD 4152*	
Greenslopes Private Hospital Authorised Mental Health Service	
Inpatient facility	**Community components**
Greenslopes Private Hospital inpatient and specialist health units: Newdegate Street, Greenslopes QLD 4120*	
New Farm Clinic Authorised Mental Health Service	
Inpatient facility	**Community components**
New Farm Clinic inpatient and specialist health units: 22 Sargent Street, New Farm QLD 4005*	
Toowong Private Hospital Authorised Mental Health Service	
Inpatient facility	**Community components**
Toowong Private Hospital inpatient and specialist health units: 496 Milton Road, Toowong QLD 4066*	

*Refer to map of hospital boundaries available at: https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/clinical-staff/mental-health/private-facility-maps.pdf

Appendix 7 High Security Units

As at 30 June 2016

The Park High Security Program

Authorised Mental Health Service

Address

The Park—Centre for Mental Health Treatment, Education and Research

Cnr Ellerton Drive and Wolston Park Road, Wacol Qld 4076

Administrator

Executive Director Mental Health and Specialised Services

Princess Alexandra Hospital High Security Program

Authorised Mental Health Service

Address

Ipswich Road, Woolloongabba Qld 4102

Administrator

Executive Director Mental Health

Appendix 8 Facilities established as a authorised mental health service

For the purpose of administering electroconvulsive therapy to patients who have given informed consent as at 30 June 2016

Archerview Clinic, Hillcrest Rockhampton Private Hospital

Authorised Mental Health Service

Address

Hillcrest Rockhampton Private Hospital

4 Talford Street, Rockhampton Qld 4700

Administrator

Chief Executive Officer

Archerview Clinic Hillcrest Rockhampton Private Hospital

The Cairns Clinic

Authorised Mental Health Service

Address

The Cairns Clinic

253 Sheridan Street, Cairns Qld 4870

Administrator

Chief Executive Officer

Ramsay Cairns

1 Upward Street, Cairns Qld 4870

Caloundra Private Clinic

Authorised Mental Health Service

Address

Caloundra Private Clinic

96 Beerburrum Street, Caloundra Qld 4551

Administrator

Chief Executive Officer

Caloundra Private Clinic

Pine Rivers Private Hospital

Authorised Mental Health Service

Address

Pine Rivers Private Hospital Dixon

Street,Strathpine Qld 4500

Administrator

Director of Nursing

Pine Rivers Private Hospital

St Andrew's Toowoomba Hospital

Authorised Mental Health Service

Address

St Andrew's Toowoomba Hospital

280–288 North Street, Toowoomba Qld 4350

Administrator

Chief Executive Officer

St Andrew's Toowoomba Hospital

Sunshine Coast Private Hospital

Authorised Mental Health Service

Address

Sunshine Coast Private Hospital

Syd Lingard Drive, Buderim Qld 4556

Administrator

General Manager

Sunshine Coast Private Hospital

Appendix 9 Facilities established as authorised mental health services

For the purpose of administering psychosurgery to patients who have given informed consent as at 30 June 2016

St Andrew's War Memorial Hospital

Authorised Mental Health Service

Address

St Andrew's War Memorial Hospital

457 Wickham Terrace, Spring Hill Qld 4000

Administrator

General Manager

St Andrew's War Memorial Hospital

Appendix 10 List of tables

Appendix 11 List of figures

Appendix 12 Abbreviations and acronyms

Acronym	Full title
AMHP	authorised mental health practitioner
AMHS	authorised mental health service
CIMHA	Consumer Integrated Mental Health Application
CPIO	classified patient information order
DPP	Director of Public Prosecutions
ECT	electroconvulsive therapy
EEO	emergency examination order
FIO	forensic information order
FO	forensic order
HSCE	Health Service Chief Executive
HHS	Hospital and Health Service
HHB Act	Hospital and Health Boards Act 2011
ITO	involuntary treatment order
JEO	justices examination order
LCT	limited community treatment
MHAODB	Mental Health Alcohol and Other Drugs Branch, Queensland Health
SNFP	special notification forensic patient
the Act	Mental Health Act 2000
The 2016 Act	Mental Health Act 2016
the Tribunal	Mental Health Review Tribunal

Feedback form

Please fill out this form and return it via:

Fax: 07 3328 9619

Email: mha2016@health.qld.gov.au

Post: Office of the Chief Psychiatrist
Mental Health Alcohol and Other Drugs Branch
Department of Health
GPO Box 2368
Fortitude Valley BC QLD 4006

1. Overall how effectively do you think our annual report communicates our activities?
   - ☐ Very effectively
   - ☐ Effectively
   - ☐ Average
   - ☐ Poor
   - ☐ Very poor

2. Please rate the following elements of the annual report according to the rating scale below:

   1=Very poor 2=Poor 3=Average 4=Good 5=Excellent
   - ☐ Information content
   - ☐ Layout of information
   - ☐ Ease of comprehension
   - ☐ Readability
   - ☐ Ease of finding information

3. Do you have any comments you would like to make about the annual report?

_____

_____

_____

_____

4. In your opinion, how could our next annual report be improved?

_____

_____

_____

_____

_____

_____

5. Please indicate the group that best describes you.
   - ☐ Consumer or carer
   - ☐ Non-government organisation
   - ☐ Private sector
   - ☐ Private individual
   - ☐ Professional association
   - ☐ Queensland Health staff member
   - ☐ Queensland Government employee
   - ☐ Other government employee
   - ☐ Other (please specify)

Please note: Personal details will not be added to a mailing list or stored, nor will Queensland Health disclose these details to third parties without your consent or unless it is required by law.

Your feedback is welcome

We welcome your feedback on this annual report.

We have included a feedback form on the previous page for you to complete and return to us.

How you can contact us

Contact us to obtain further information about the *Mental Health Act 2000* or information in this report:

Phone: 1800 989 541

Email: mha2016@health.qld.gov.au

Post: Office of the Chief Psychiatrist

Mental Health Alcohol and Other Drugs Branch

Department of Health

GPO Box 2368

Fortitude Valley BC QLD 4006