

Evaluation of the

# ***Mental Health Act 2016*** **implementation**

April 2019



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Published by the State of Queensland (Queensland Health), April 2019



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# An evaluation of the implementation of key initiatives and change management processes associated with the commencement of the *Mental Health Act 2016*

The *Mental Health Act 2016* (MHA 2016) commenced on 5 March 2017, replacing the *Mental Health Act 2000* (MHA 2000) which had been in operation for over 10 years. Due to the significant reforms introduced and implementation efforts required, a commitment was made to undertake an evaluation of the implementation of the MHA 2016 within two years of its commencement.

The evaluation sought to gain an understanding of:

- the extent to which key initiatives within the MHA 2016 have been successfully implemented; and
- stakeholder views of the change management processes associated with the implementation of the MHA 2016.

The evaluation found that, on balance, the MHA 2016 was effectively implemented. Available data and information indicates the MHA 2016 is supporting less restrictive ways and patient rights focused treatment and care. Despite this, a number of findings indicate that some work is still to be done to refine and embed the framework introduced by the MHA 2016.

	<p><b>Targeted training and education</b></p> <p>Training and education emerged as a key area requiring focus. It is expected the development of more practical education and training tools, including a review of the Chief Psychiatrist policies and practice guidelines will: improve the uptake of less restrictive ways and strengthen patient rights focused treatment and care; improve compliance with the MHA 2016; improve safeguards and help uphold the principles of the MHA 2016; and improve record-keeping and data quality.</p>
	<p><b>Improved data quality and analysis</b></p> <p>A common theme across a number of the new requirements of the MHA 2016 was the quality of available data. This may be attributed to the need for further education, and to limitations of existing data system specifications.</p>
	<p><b>Refined performance outcome monitoring</b></p> <p>Performance outcome monitoring will be considered and refined for some existing processes, including the independent patient rights adviser model, and the Court Liaison Service.</p>

A number of specific practical improvements were also identified, including targeted review of the Chief Psychiatrist policies and practice guidelines, updated forms which provide greater guidance to users, amendments to the consumer integrated mental health application (CIMHA), and the development of resources that support understanding for people with impaired capacity.

## Scope and limitations

A key focus of the evaluation was how the changes made by the MHA 2016 meet the objectives and principles of the Act, with particular regard to the use of less restrictive ways (including the use of advance health directives and substitute decision making processes), patient rights focused treatment, and recovery-oriented practices.

The evaluation was not intended to be a review of the provisions of the MHA 2016, the operation of the Act or compliance with the Act. The purpose of the evaluation was to consider how the policies, set by government with the commencement of the MHA 2016, had been implemented. The evaluation did not seek to review these policies, or to consider alternatives to the policies. This approach was taken with due regard to the extensive four year review which resulted in the introduction of the MHA 2016.

This report: describes MHA 2016 implementation activities; summarises the evidence of the extent to which key initiatives of the MHA 2016 were achieved in its first full year of operation (2017-18); reports performance across key areas of the MHA 2016; and makes findings to inform ongoing monitoring and/or enhancements to the operation of the mental health legislative scheme in Queensland.

## Implementation activities

A number of significant reforms were introduced which required major implementation efforts from the mental health sector, and the organisations that interact with the sector, to prepare for commencement.

### **Information, education and training**

Information and updates were distributed to staff using various mechanisms including internal Queensland Health email communications; and comprehensive competency-based education and training packages were delivered.



### Competency-based iLearn training on the MHA 2016

was delivered to **1,076 authorised doctors and psychiatrists** and **4,058 authorised mental health practitioners** (as at 30 June 2018)



**Capacity assessment training** was delivered through **18 face-to-face workshops** and completed by **192 participants**. **1,939 capacity assessment eLearning modules** were completed (as at 30 June 2018)



**1,780** advance health directive eLearning modules were completed (as at 30 June 2018)

#### Extensive enhancements to CIMHA:

- improved monitoring and reporting capability
- interface between CIMHA and the Queensland Courts
- recording of advance health directives and appointed substitute decision makers

#### Working groups and committees established to support implementation:

- Inter-departmental Executive Committee
- Less Restrictive Ways Project expert reference group
- Court Liaison Service steering group
- Classified Patient Committee
- Tri-Agency Absent without Approval Committee

#### Queensland Health developed collaborative partnerships with:

- Office of the Public Guardian
- Queensland Police Service
- Queensland Ambulance Service
- Legal Aid Queensland
- Department of Communities, Disability Services and Seniors
- Queensland Corrective Services
- Queensland Parole Board



**38** Chief Psychiatrist policies and practice guidelines were developed and published online

## Key changes and outcomes

### Change management

A change management survey was developed to inform the evaluation, focusing on the key areas of: information and updates; readiness for commencement; and training and education.

Ninety-six per cent of survey respondents felt **information and updates** about the MHA 2016 were effectively communicated to mental health services and stakeholders. Fifty-one percent of survey respondents stated implementation activities assisted them to feel **moderately to well prepared** for commencement of the MHA 2016.

The evaluation found there was scope for improvements to the training and education available to support implementation of the MHA 2016. Queensland Health stakeholders consistently provided feedback about the useability, quality and strength of the iLearn modules, citing difficulties such as ambiguous wording, and a lack of practical examples which would allow staff the opportunity to work through scenarios as they apply to the everyday administration of the MHA 2016.



representing the majority of authorised mental health services, and a variety of professional streams, **responded to the survey.**

Two hundred and forty-five survey respondents nominated a number of key focus areas for future **education and training**. These include: MHA 2016 forms; advance health directives and capacity; absent without approval; attorneys and guardianship; Court Liaison Service; assessment and risk management committees; CIMHA; interagency liaison – Queensland Police Service and Queensland Ambulance Service; emergency examination authorities; treatment support orders; Mental Health Review Tribunal – role and requirements; and minors.

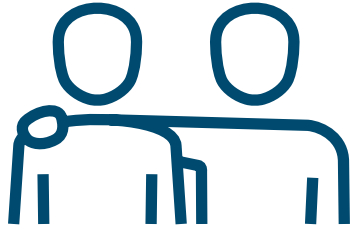


The 2017 Queensland Health *Your Experience of Service* survey found under the MHA 2016

**79 per cent of involuntary patients stated their experience of having their rights and responsibilities explained to them was either good, very good or excellent.**

### Improved patient rights and support

The protection of patient rights is a paramount consideration under the MHA 2016 and extensive safeguards were included to ensure the protection of patient rights at all stages of involuntary treatment and care. Additionally, the principles of the MHA 2016 established that support persons for a patient are to be involved in decisions about the patient's treatment and care to the greatest extent practicable (subject to the patient's right to privacy).



During 2017-18,  
**nominated  
support persons**  
attended  
**847 MHRT  
hearings**, which  
represents seven per cent  
of all MHRT hearings  
during the period.

### **New nominated support person provisions**

Replacing the allied person provisions of the MHA 2000, the MHA 2016 provides for a patient to nominate one or two nominated support persons to support them in their treatment and care if they are, or become, an involuntary patient under the Act. The patient's nominated support persons receive all notices required to be given to the patient under the MHA 2016, can discuss confidential information with the treating team, and support or represent the patient at Mental Health Review Tribunal (MHRT) hearings.

As at 30 June 2018, 13 per cent (n 720) of involuntary patients had one or more nominated support person. On 4 March 2017, prior to the commencement of the MHA 2016, 18 per cent (n 948) of involuntary patients had an allied person appointed. This reduction in the number of nominated support persons may be due to a variety of factors, including that the role of allied person did not automatically transfer to that of nominated support person under the new Act, the requirement for a patient to have capacity to appoint a nominated support person, and the removal of the ability of an administrator to appoint an allied person if one was not already appointed and the patient did not have capacity to appoint one.

The 2017 Queensland Health *Your Experience of Service* survey found that under the MHA 2016, 83 per cent of involuntary patients stated they usually or always had opportunities for their family and carers to be involved in their treatment and care if they wanted.

The 2017 Queensland Health pilot *Carer Experience Survey* found carers rated their experience of being given the opportunity to discuss the care, treatment and recovery of their family member, partner, or friend as 4.5 out of 5 (even, if for reasons of confidentiality, they could not be told specific information).

It is expected the number of patients with nominated support persons will grow during the life of the MHA 2016 as patients regain capacity to make an appointment, and the provisions continue to be highlighted by treating teams and independent patient rights advisers (IPRAs).

## Independent patient rights advisers

In line with the intent to strengthen patient rights, the MHA 2016 introduced IPRA to assist public authorised mental health services (AMHSs) across the State to support patients to understand and exercise their rights under the MHA 2016. Twenty-eight IPRA positions and a statewide coordinator were created and funded.

**In 2017-18, IPRA provided advice to 6,987 patients through 12,356 interactions and 18,859 service delivery activities with patients and/or support persons.**



The top five common themes identified by IPRA during their day to day work with patients and support persons were:

- explanation of treatment and discharge plans
- leave conditions
- medication issues
- linking patients with treating team
- MHRT issues.

Seventy-six per cent of interactions occurred within an inpatient unit and 39 per cent of initial interactions occurred within the first five days of a patient's service episode. The average amount of time spent with a patient and/or support person was 31 minutes.

IPRA line managers and purchasers of IPRA services consistently stated the establishment of the IPRA role within hospital and health services was working well and that the role was very important for mental health patients and mental health staff to better understand patient rights under the MHA 2016. Other stakeholders provided feedback that IPRA were invaluable because they: provide positive outcomes for collaboration across the treating team in identifying less restrictive ways; help build capacity of others to understand patient rights; and provide a valuable referral option where a patient has questions or concerns about their treatment which would benefit from an IPRA supported conversation with the patient's treating team.

Hospital and health services have successfully implemented the IPRA model, and no significant changes to the model were identified. While hospital and health services are continuing to develop capacity to support the IPRA role and embed a patient rights focus, some work needs to be done to explore service delivery outcomes and performance reporting for the model to determine the impact of IPRA in hospital and health services.

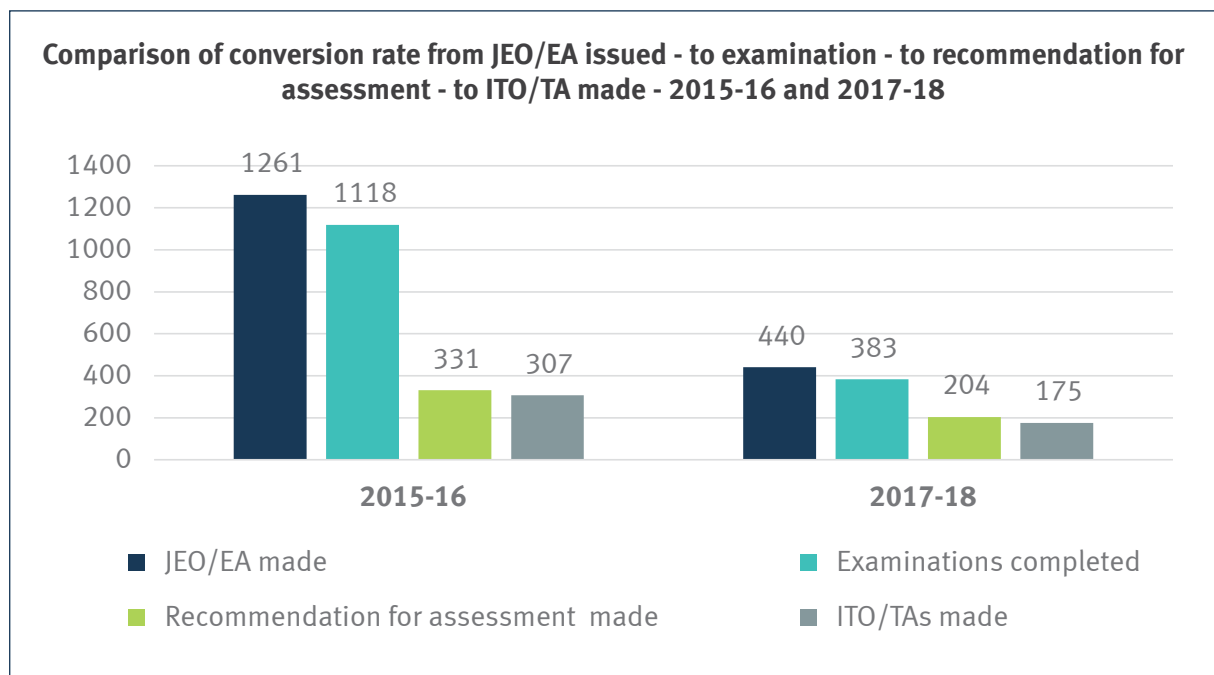


## Simplified examination and assessment processes

### Examination authorities

The MHA 2016 introduced simplified and more clearly defined steps to commence involuntary examination and assessment of a person. The justice examination order (JEO) (previously made by a Justice of the Peace or Magistrate) was replaced with the examination authority (EA) which must be made by the MHRT. In 2017-18 (under the MHA 2016), the MHRT made 440 EAs, compared with 1,261 JEOs made in 2015-16 (under the MHA 2000), representing a 65 per cent reduction in the number of JEOs/EAs made. Roughly the same proportion of JEOs/EAs resulted in a completed examination (89 per cent in 2015-16 and 87 per cent in 2017-18) and an increase in the proportion of JEOs/EAs that resulted in a recommendation for assessment: 26 per cent of JEOs in 2015-16 and 46 per cent of EAs in 2017-18. There was also a significant increase in the proportion of JEOs/EAs that resulted in an involuntary treatment order (ITO) or treatment authority (TA) being made: 24 per cent in 2015-16 (under the MHA 2000) and 40 per cent in 2017-18 (under the MHA 2016).

The below figure provides a comparison between 2015-16 and 2017-18 of the number of JEOs/EAs issued, the number of recommendations for assessment made, and the number of recommendations for assessments that converted to ITOs/TAs.



These results suggest that the more robust examination and assessment process is resulting in a more targeted application of EAs.

## Emergency examination authorities

Emergency examination orders were replaced by emergency examination authorities and relocated to the *Public Health Act 2005* to ensure mental health legislation is confined to only those matters that are within its intended scope. The evaluation found that while the number of emergency examination authorities made in 2017-18 has increased over the previous year, the number which resulted in a mental health assessment has remained consistent, indicating patients continue to receive mental health care and treatment where it is required.

## Strengthened safeguards for treatment and care

The MHA 2016 requires clinicians to consider if there is a less restrictive way for a person to receive treatment and care for their mental illness. The Act provides that treatment and care can be provided in the following less restrictive ways: under a person's advance health directive; with the consent of a person's personal guardian, attorney or statutory health attorney; and if the person is a minor, with the consent of the minor's parent. The MHA 2016 also highlights that where a person's treatment and care needs can be met in a less restrictive way, a treatment authority must not be made.

### Less restrictive ways

In 2017-18, of the 8,016 treatment authorities made, 185 treatment authorities were made for patients who had an existing advance health directive or substitute decision maker. Information about how and whether treating teams were relying upon less restrictive ways was not readily available.

The evaluation found the uptake of less restrictive ways could be improved and that existing data systems could be enhanced to improve reporting about the use of less restrictive ways. Targeted training and education about less restrictive ways is expected to assist to improve uptake. There is also scope for existing forms to provide more guidance about the less restrictive ways which must be considered by health practitioners under the MHA 2016.



The number of **advance health directives / substitute decision makers** recorded for involuntary patients **increased by 47 per cent** during the 2017-18 period.

59 per cent of advocates, legal representative and other service providers agreed the MHA 2016 has promoted less restrictive alternatives to involuntary treatment (54 respondents). 58 per cent of patients, carers and support persons did not agree that the MHA 2016 has promoted less restrictive ways (38 respondents).



In 2017-18,

**659 reduction and elimination plans were approved**

across the majority of AMHSs.

## Strengthened safeguards for regulated practices

The MHA 2016 built on existing safeguards for restrictive practices to support the reduction, and where possible, elimination of these practices. In addition to increased regulatory oversight for seclusion and mechanical restraint, the MHA 2016 introduced safeguards and reporting measures for physical restraint and the use of medication. The Chief Psychiatrist will continue to work closely with AMHSs to support the reduction, and where possible, elimination of restrictive practices.

### Reduction and elimination plans

Upon commencement of the MHA 2016, the Chief Psychiatrist policy and practice guidelines required all AMHSs to implement reduction and elimination plans. Reduction and elimination plans are aimed at reducing, and where possible, eliminating the use and duration of seclusion and restraint.

### Physical restraint

The MHA 2016 introduced the regulation of physical restraint for patients in AMHSs. During 2017-18, there were 2,067 physical restraint events (including emergency restraint events). The evaluation found that while the regulation of physical restraint has been well embedded across the State, there are opportunities for hospital and health services to improve data entry for physical restraint events to improve data quality.

### Increased safeguards and oversight of electroconvulsive therapy

The MHA 2016 provided an opportunity to increase safeguards and oversight of electroconvulsive therapy (ECT), including requiring the approval of the MHRT in all cases where the person is a minor, and the appointment of legal representation (at no cost for patients) at hearings where an application for ECT treatment is being considered.

Since the MHA 2016 took effect, less applications to the MHRT are being made for ECT treatment, and when they are determined by the MHRT less applications are resulting in an approval.

Between 2015-16 and 2017-18 the number of ECT approvals dropped by 27 per cent and the proportion of not approved ECT applications has risen slightly from five per cent in 2015-16 to six per cent in 2017-18.

### Expanded considerations for minors

The MHA 2016 included provisions intended to support clinical best practice and statutory processes where the needs of minors should be given additional consideration, particularly in circumstances where a minor's rights may be infringed.

## Legal representation at MHRT hearings

Under the MHA 2016 the MHRT must appoint a lawyer for any hearing involving a minor. In 2017-18, legal representation was provided at 157 MHRT hearings involving minors: four ECT application hearings; seven forensic order review hearings; and 146 treatment authority review hearings.

## Requirement for administrators to notify the Public Guardian regarding minors

The MHA 2016 includes two new requirements for administrators of AMHSs to notify the Public Guardian of:

- admission of a minor to a high security unit or an inpatient mental health unit of an AMHS other than a child and adolescent inpatient unit within 72 hours of admission; and
- use of mechanical restraint, seclusion or physical restraint of a minor.

The Office of the Chief Psychiatrist and the Office of the Public Guardian continue to work together to monitor the application of the notification provisions.

In 2017-18, the Office of the Public Guardian received 79 notifications of an admission of a minor to a high security unit or an inpatient mental health unit of an AMHS other than a child and adolescent inpatient unit. Seventy-three of the 79 notifications were received by the Office of the Public Guardian within 72 hours of the minor's admission.

## Improvements to the operation of the courts

In recognition of the importance of balancing the rights of a person with a mental illness or intellectual disability with the protection of the community, the MHA 2016 introduced reforms to how people with a mental illness or intellectual disability interface with the justice system and sought to improve the operation of the Magistrates Court and the Mental Health Court.

### Magistrates Court

#### New powers to dismiss or adjourn due to unsoundness or unfitness

The MHA 2016 introduced explicit powers for a Magistrate to dismiss or adjourn a simple offence where the person charged was, or appears to have been, of unsound mind at the time of the alleged offence, or is not fit for trial. Changes to the jurisdiction of the Magistrates Court to allow the Magistrates Court to deal with simple offences where a person is of unsound mind or unfit for trial are designed to ensure forensic orders are only made in appropriate circumstances and when necessary. These provisions have been operating well and are being used by Magistrates.



**413 simple offence matters were dealt with in the Magistrates Court:**

**128 matters were dismissed** because a Magistrate was satisfied the person was either of unsound mind when the offence was allegedly committed, or unfit for trial, and **285 matters were adjourned** due to a person's temporary unfitness for trial.

**Referral to an appropriate agency**

A Magistrate may refer to Queensland Health or an agency responsible for disability services the mental condition of a person who has had their matter dismissed or adjourned. As at 30 June 2018, the Magistrates Court had not made any referrals to either Queensland Health or the Department of Communities, Disability Services and Seniors under the MHA 2016.

However, the Court Liaison Service facilitates informal referrals without the need for a formal court referral process for people who need a mental health assessment or treatment, or disability supports, through informal linkages with other government agencies. The Court Liaison Service also provides information and assistance for consumers and guardians requiring disability support to self-refer to the National Disability Insurance Agency.

**References to the Mental Health Court**

The MHA 2016 allows a Magistrate to refer an indictable offence (other than an offence against a law of the Commonwealth) to the Mental Health Court if the person appears to have been of unsound mind or is unfit for trial. Twenty-four references (plus one amended reference) were received by the Mental Health Court from Magistrates in 2017-18.



In 2017-18,  
**95 examination orders**

were made by Magistrates.



In 2017-18, the Court Liaison Service conducted over  
**3,500 intake assessments**  
and provided over  
**800 medico-legal reports to Magistrates**  
(for adults) about fitness for trial and unsoundness of mind.

**Examination orders**

When a person charged with a simple offence has, or may have, a mental illness or intellectual disability, Magistrates now have the power to make an examination order. A Magistrate may direct the person to attend an AMHS for an examination which may result in a treatment authority being made for the person, the development of a treatment plan for the voluntary treatment of the person, or, if the person is already on an authority or order under the MHA 2016, a change to the person’s treatment.

**Expansion of the Court Liaison Service**

The expanded Court Liaison Service is operating effectively and plays a critical role in supporting Magistrates to make decisions through the provision of medico-legal reports on unsoundness of mind and unfitness for trial, informal referrals to health or disability services, and advice regarding the appropriateness of examination orders. The expanded Court Liaison Service has strong support from Magistrates and a range of other stakeholders, including legal sector stakeholders, advocates, legal representatives and other service providers. While the Court Liaison Service is effectively supporting Magistrates to discharge new powers under the MHA 2016, there is limited evidence to determine whether changes are required to support the operation of the Court Liaison Service. It would be beneficial for performance indicators and service delivery outcomes to be developed to measure whether there are opportunities for the operation of the Court Liaison Service to be improved.

## Mental Health Court

Under the MHA 2016, the Mental Health Court continues to provide a specialist function within the Supreme Court for deciding issues of unsoundness of mind and fitness for trial and, where relevant, determining whether a forensic order or treatment support order is made for a person charged with a serious offence or indictable offence referred by a Magistrate. Amendment to the jurisdiction of the Mental Health Court to hear matters primarily related to serious offences, and the removal of the requirement for mandatory psychiatrist reports for involuntary patients charged with a simple or indictable offence intended to: reduce the number of matters referred to the Mental Health Court and subsequently provide for more targeted forensic orders; improve the timeliness of matters brought before the Mental Health Court; and increase public confidence regarding the management of risk to the community through providing greater certainty about the revocation of forensic orders.

### Psychiatrist reports and references to the Mental Health Court

In 2017-18, there were 197 occasions where the psychiatrist report provisions of the MHA 2016 potentially applied for patients charged with a serious offence. By comparison, in 2015-16 there were 2,172 reported occasions where the psychiatrist report provisions of the MHA 2000 applied, or potentially applied, for patients charged with any offence.

In 2017-18, 106 psychiatrist reports were received under the new provisions for patients charged with a serious offence. In 2015-16, 1,745 mandatory psychiatrist reports were received for patients charged with any offence. This represents a 94 per cent reduction in the total number of psychiatrist reports developed.

In 2017-18, 63 references were made by the Chief Psychiatrist following receipt of a psychiatrist report. In 2015-16 (under the provisions of the MHA 2000), the former Director of Mental Health made 188 references to the Mental Health Court. This represents a marked reduction in the number of references to the Mental Health Court by the Chief Psychiatrist.

### Forensic orders and treatment support orders

Forensic orders are made by the Mental Health Court to allow for the involuntary treatment and care of a person charged with a serious offence who has a mental condition or intellectual disability and is found to be of unsound mind at the time of committing an alleged offence or is unfit for trial.

In 2017-18, the number of forensic orders made (n 105), was similar to the number in 2015-16 (n 118). The Mental Health Court is still considering a number of remaining references which must be determined under the MHA 2000. As the Mental Health Court considers new MHA 2016 references, it is anticipated the uptake of treatment support orders will increase, potentially resulting in a reduction in the number of forensic orders made by the Mental Health Court.

The MHA 2016 allows the Mental Health Court to make a treatment support order, when a forensic order (mental health) is not appropriate in the circumstances. This change recognises that placing a person on a forensic order is not always warranted due to their risk to the community, for example in circumstances where a person's role in an offence was relatively minor.

In 2017-18, 104 treatment support orders were made, nine of which were made by the Mental Health Court. All nine were made under a community category and no treatment support orders were made for people who had committed a prescribed offence. This shows that in circumstances where it is not necessary for a person to be placed on a forensic order, the Mental Health Court is relying on treatment support orders as an alternative option.

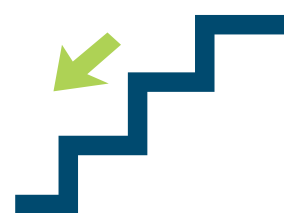
## Mental Health Review Tribunal changes

Under the MHA 2016, the MHRT maintained its primary function of reviewing the involuntary status of persons with a mental illness and/or intellectual disability.

### Forensic order step-down to treatment support order

The introduction of treatment support orders gives the MHRT the ability, when reviewing a forensic order (mental health), to revoke the forensic order (mental health) and make a treatment support order as a part of a patient's recovery when it is appropriate to do so. This recognises that continuing some patients on a forensic order for an extended period is not warranted by their risk to the community.

The evaluation found that the new treatment support orders are operating as intended and allow for patients to step-down from a forensic order onto a more appropriate form of order, particularly in circumstances where the patient has been on a forensic order for an extended period.



In 2017-18,  
the MHRT converted  
(stepped down)

**95 forensic orders**  
to **treatment**  
**support orders.**

74 per cent of advocates, legal representatives and other service providers agreed that access to legal representation has improved support for patients (42 respondents); 60 per cent of patients, carers and support persons disagreed (15 respondents).



### Legal representation at particular MHRT hearings

Regardless of a patient's ability to pay for representation, the MHA 2016 requires the MHRT to appoint a lawyer to provide legal representation (at no cost to the patient) where the MHRT is hearing a matter relating to a minor, an application to perform ECT, a fitness for trial hearing, or a forensic patient review where the Attorney-General is legally represented. A patient may elect not to be represented if the patient is an adult and has capacity to make the decision.

In 2017-18, for those patients who were eligible under the MHA 2016 for legal representation, representation was provided at 2,541 MHRT hearings, including at 157 hearings involving minors.

### Amended timeframes for the provision of reports to the MHRT

The MHA 2016 introduced a requirement for treating practitioners to provide a clinical report to the patient seven clear days before their MHRT hearing. While the MHRT may adjourn hearings at its discretion, it was identified that this new requirement may be one of the factors contributing to a higher rate of adjournments.

In 2016-17, the percentage of adjournments for hearings under the MHA 2000 (1 July 2016 to 4 March 2017) was 19 per cent, while the percentage under the MHA 2016 (5 March 2017 to 30 June 2017) was 46 per cent. In response to this issue, the Office of the Chief Psychiatrist and the MHRT worked together to develop communication materials for AMHSs regarding the new timeframes involved in the provision of clinical reports. Due to this targeted action, the overall adjournment rate decreased from 38 per cent (as at 1 July 2017) to 24 per cent (as at 30 June 2018).

## **Risk assessment and management**

To coincide with the commencement of the MHA 2016, an assessment and risk management committee (ARMC) was established within each AMHS. The ARMC functions as a clinical peer review of the treatment and care of patients subject to a forensic order, treatment support order and other patients (whether subject to a treatment authority or voluntary) whose risk profile is assessed as high by their treating team.

The evaluation found ARMCs are meeting the expected policy outcomes and are considered by AMHSs to be a valuable forum for improved local oversight, visibility and management of high risk patients.

## **Improved access to treatment and care for classified patients**

The classified patient provisions of the MHA 2000 were expanded under the MHA 2016 through the introduction of a requirement for the Chief Psychiatrist to be notified by a doctor or authorised mental health practitioner if a person in custody is not transported to an AMHS within 72 hours of when an assessment or transfer recommendation has been made.

An automatic monitoring system was implemented to support this change, however, due to data entry issues, the automatic monitoring is not achieving its intended purpose. To address this, the classified patient statewide coordinator plays an active role monitoring people requiring transfer to an AMHS, and works with relevant agencies to identify individual pathways within 72 hours for people requiring transfer.

Despite the above data entry issues, the evaluation found that the classified patient provisions have been effectively implemented and the role of statewide coordinator is integral to ensuring mentally ill persons in custody are able to access beds in a timely manner.



## Improved victim support

The MHA 2016: requires persons performing functions under the Act to have regard to principles that apply to victims; aims to improve processes whereby victims receive information relating to forensic order and treatment support order patients, via an information notice or classified patient information notice; includes new confidentiality arrangements that apply to victims; and eliminates the requirement for victims to repeatedly submit a victim impact statement at each MHRT hearing. The MHA 2016 also allows for the identification of a person who is, or may be, a victim for the purpose of referring the person to victim support services.

67 per cent of survey respondents who commented on the principles for victims in the MHA 2016 being taken into account by decision-makers agreed they are taken into account (12 respondents).

77 per cent of survey respondents who commented on the amount of patient information they receive under the information notice provisions of the MHA 2016, agreed it meets their expectations (13 respondents).

### Information notice timeframes

Under the MHA 2016, the responsibility for deciding an information notice application within a set time frame sits with the Chief Psychiatrist. In 2017-18, 18 of the 20 information notice applications received were decided within the set timeframe. Classified patient information notice application approval continues to be provided by the Chief Psychiatrist under the MHA 2016 and must be decided as soon as possible after receipt by the Chief Psychiatrist.

The average duration between when an outcome was decided at an MHRT review and when the Chief Psychiatrist advised the Queensland Health Victim Support Service was nine days. Information relating to a classified patient information notice is provided to notice holders as soon as practicable.

## Confidentiality and victim impact statements

The MHA 2016 provides new confidentiality arrangements that apply for victims. In particular, a patient is not informed of a Chief Psychiatrist's decision to provide information to the victim, and does not receive a copy of a victim impact statement submitted to the Mental Health Court or the MHRT.

In 2017-18, the MHRT received 21 victim impact statements from the Mental Health Court, and an additional 20 were made directly to the MHRT. As at 30 June 2018, all 41 of these victim impact statements were still currently before the MHRT.

Nine of the 12 survey respondents who commented on the confidentiality provisions relating to victim impact statements agreed the provisions support victims and their relatives to share their views on the impact of an unlawful act with the MHRT.

## Next steps

To support improvements across these areas, the Chief Psychiatrist will work with hospital and health services and other stakeholders to consider the best way to address areas of concern. In addition to the actions identified by the evaluation, the operation of the MHA 2016 will continue to be monitored and policies and practice guidelines will continue to be reviewed and refined to ensure practice issues are addressed as they arise.





