Comparison of Key Provisions
Mental Health Act 2000 and *Mental Health Act 2016* (yet to commence)

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	**Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)**
Chapter 1 Preliminary	
The objects of the Act clearly distinguish between improving and maintaining the health and wellbeing of persons who do not have capacity to consent to treatment, and the 'forensic' purposes of the Act where persons are charged with committing an unlawful act. The meaning of 'involuntary patient' reflects the revised approaches in the Act, namely: • persons subject to an examination authority (replacing a justices examination order) • persons subject to a recommendation for assessment (or being detained while a recommendation for assessment is being prepared) • persons subject to a treatment authority (replacing an involuntary treatment order) • forensic patients • persons subject to a treatment support order (a new order) • persons subject to a judicial order (replacing various court orders), and	The principles in the Act for persons with a mental illness are comparable to the MHA, with the following additions: • the role of support persons being in treatment and care • the needs of Aboriginal people and Torres Strait Islander people • the needs of persons from culturally and linguistically diverse backgrounds • the needs of minors • the importance of recovery-oriented services The meaning of 'mental illness' is comparable to the MHA.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
• a person who has absconded from interstate and detained in an authorised mental health service. The Act includes principles relating to victims of unlawful acts.	
Chapter 2 Making of treatment authorities after examination and assessment	
'Justices examination orders' are replaced with the more tightly managed 'examination authorities', which are made by the Mental Health Review Tribunal. A person must seek clinical advice before applying for an examination authority. 'Emergency examination orders' are replaced by emergency examination authorities in the *Public Health Act 2005*. These powers apply in emergency situations to persons who appear to have a major disturbance in mental capacity due to illness, disability, injury, intoxication or another reason. The meaning of 'treatment criteria' has been updated to better support individual rights, including that the person does not have capacity to consent to treatment. The requirement to treat a person in a 'less restrictive way' is included in the Act. This requires a person to be treated under an advance health directive or with the consent of a personal guardian or attorney if the person's treatment needs can be met this way. Where this applies, a treatment authority cannot be made for the person. A comprehensive definition of 'capacity to consent to be treated' is included in the Act. There are no longer separate 'assessment criteria' and 'treatment criteria' outlined in the Act. The Act instead requires a prima facie case that the treatment criteria may apply for a recommendation for assessment to be made.	The powers that can be exercised under an examination authority are comparable to those that can be exercised under a justices examination order under the MHA. The powers that can be exercised under an emergency examination authority are comparable to those that can be exercised under an emergency examination order under the MHA, with the ability to extend detention in an authorised mental health service or a public sector health service facility for a further 6 hours if required (total of 12 hours). The powers that can be exercised in assessing a person, including the detention of the person, are comparable to the MHA. If a treatment authority is made by an authorised doctor who was not a psychiatrist, the requirement to review the making of the authority by a psychiatrist is comparable to that which applies for involuntary treatment orders under the MHA.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
A person may be detained in an authorised mental health service or a public sector health service facility while a recommendation for assessment is being prepared. Restrictions on the use of audio-visual technology no longer apply for assessments. The Act enables an authorised doctor in a designated 'rural and remote' area to do both a recommendation for assessment, and the assessment, if another authorised doctor is not reasonably available to do the assessment The Act enables the review of the making of a treatment authority by an authorised psychiatrist in a designated 'rural and remote' area to be extended from 3 days to 7 days if there is no other reasonably practicable way to do the review within 3 days Requirements are included in the Act to discuss an assessment with the person and support persons. A treatment authority may be an inpatient category or community category (comparable to the MHA), but the 'default' category is to be community (i.e. the category must be community unless the person's treatment and care cannot be met this way).	
Chapter 3 Persons in Custody	
The Chief Psychiatrist is to be notified if a person is not transferred to an authorised mental health service within 72 hours. This enables the Chief Psychiatrist to take action, as necessary, to ensure the person receives timely treatment.	The Act makes provision for when a person in custody (e.g. in a watch house or prison), may be transferred to an authorised mental health service for: • an assessment to decide if a treatment authority should be made for the person, or • for treatment and care for the person's mental illness.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
	These provisions are comparable with the MHA, but have been presented in a clearer and more transparent way. Provisions relating to the suspension of proceedings where a person becomes a classified patient are comparable to the MHA, but are presented more clearly as a single set of provisions in the Act.
Chapter 4 Psychiatrist reports for serious offences	
A person subject to a treatment authority, forensic order or treatment support order may request a psychiatrist report be prepared if they are charged with a 'serious offence'. A serious offence is an indictable offence, other than an offence that must be heard by a Magistrate (as set out in the Criminal Code). This request may also be made by a representative of the person, for example, a legal representative or a nominated support person (see below). A referral to the Mental Health Court may then be made by the person or the person's lawyer. The Chief Psychiatrist may also direct that a psychiatrist report be prepared in relation to person who has committed a serious offence (regardless of whether the person is also currently subject to an authority or order) if it is in the public interest. Where a psychiatrist report is prepared, the Chief Psychiatrist may refer the matter to the Mental Health Court if it is in the public interest. This approach replaces the current model whereby a psychiatrist report is mandatorily prepared for an involuntary patient for any offence. Currently, references are made to the Mental Health Court by the Chief Psychiatrist as a result of these reports whether or not the relevant person wishes this to occur.	Provisions relating to the suspension of proceedings where a psychiatrist report is being prepared are comparable to the MHA, but are presented more clearly as a single set of provisions in the Act. The purpose of preparing a psychiatrist report – to provide an opinion on whether the person was of unsound mind at the time of alleged offence, or is unfit for trial – is comparable to the MHA.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
Chapter 5 Mental Health Court references	
The Act amends the jurisdiction of the Mental Health Court to 'serious offences'. A serious offence is an indictable offence, other than an offence that must be heard by a Magistrate (as set out in the Criminal Code). The Act includes a revised definition of 'unsound mind', reflecting its use under the Criminal Code. Under the Act, the Mental Health Court may make a less intensive order - a treatment support order. Treatment support orders will not have the stringent oversight that applies to persons on forensic orders. Unlike forensic orders, the Court (and the Mental Health Review Tribunal) does not set limits on the extent of community treatment under treatment support orders. As with treatment authorities, this will be the responsibility of authorised doctors in accordance with the criteria established under the Act. As with treatment authorities, these persons will be placed on a community category, unless it is necessary for the person to be an inpatient. However, like forensic orders, only the tribunal may revoke a treatment support order. The criteria for the Mental Health Court to make decisions under the Act have been updated and made consistent with equivalent decisions made by the Mental Health Review Tribunal. This mainly applies to the making of orders and the extent of treatment in the community. Persons placed on a forensic order may be placed on an: • an inpatient category with no limited community treatment • an inpatient category with limited community treatment (up to 7 days), or • a community category.	Mental Health Court decisions in relation to a person being of unsound mind, of diminished responsibility or unfit for trial are comparable to the MHA. The power for the Mental Health Court to make forensic orders is comparable to the MHA. A forensic order may be a forensic order (mental health) or a forensic order (disability). The authority to treat a person under a forensic order (mental health) and provide care under a forensic order (disability) is comparable to the MHA. Detention is also authorised for inpatient category patients under forensic orders. The Court may impose a condition on a forensic order that the person wear a GPS tracking device. Provisions related to the 'right to trial' are comparable to the MHA. This applies where the person is found of unsound mind but still wishes to have the matter considered before a jury. Procedural provisions for the Mental Health Court are comparable to the MHA.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
This approach replaces the model under the MHA, which did not have a community category. Under the MHA, 'limited community treatment' extended to treatment in the community on an ongoing basis. For serious violent offences, such as murder, manslaughter and rape (a 'prescribed offence'), the Court can impose a non-revocation period for a forensic order of up to 10 years. For persons placed on a forensic order, the Court may recommend an intervention program, such as a drug and alcohol rehabilitation program. The person's willingness to participate in the program, if offered to the person, is considered by the Tribunal when the order is reviewed.	
Chapter 6 Powers of courts during criminal proceedings and related processes	
The Act provides that a Magistrate may discharge a person charged with an offence if the court is reasonably satisfied, on the balance of probabilities, that the person was, or appears to have been, of unsound mind when the offence was allegedly committed or is unfit for trial. Magistrates may also order that a person before the court be examined by an authorised doctor to decide if a treatment authority should be made for the person or to make recommendations about the person's treatment and care.	The power for a Supreme Court or District Court to refer a person to the Mental Health Court is comparable to the MHA. The provisions in relation to forensic orders (Criminal Code) are comparable to the MHA. The power for a court to detain a person in an authorised mental health service during an adjournment in a trial is comparable to the MHA.
Chapter 7 Treatment and care of patients	
The provisions related to the treatment and care of patients replace the disparate and limited provisions in the MHA. Key changes from the MHA include: • stating the responsibility of administrators and authorised doctors for providing treatment and care	The arrangements for authorised doctors to decide the extent of community treatment for persons on forensic orders or treatment authorities (replacing involuntary treatment orders) are broadly comparable to the MHA. However, the criteria for making these decisions are clearly stated for each type of order or authority, and are consistent throughout the Act.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
• replacing the use of 'treatment plans' under the MHA by a statutory obligation to record planned and actual treatment • requiring authorised doctors to have regard to the views of the patient and support persons • requiring authorised doctors to document the patient's treatment and care while being treated in the community, and • stating the relationship between community treatment and a person's custodial status under another Act An authorised doctor is not required to revoke a treatment authority if the person regains capacity, but the capacity is not stable. The ability for the Chief Psychiatrist to impose a condition for a patient to wear a GPS tracking device is removed. Limited community treatment for classified patients and patients subject to judicial orders is limited to on-ground escorted leave. For the performance of electroconvulsive therapy, the approval of the Tribunal is required if the person is a minor, while maintaining the emergency treatment provisions for all patients. The Act distinguishes between psychosurgery (where brain tissue is intentionally damaged or removed to treat a mental illness) and non-ablative neurosurgery, such as deep brain stimulation techniques. Under the Act, psychosurgery is prohibited. Non-ablative neurosurgery can only be performed with the consent of the person and the approval of the Tribunal. A person may appoint one or two 'nominated support persons' to support the person if they become an involuntary patient.	The provisions related to the approval of temporary absences are comparable to the MHA. The provisions related to electroconvulsive therapy are otherwise comparable to the MHA.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
Chapter 8 Use of mechanical restraint, seclusion, physical restraint and other practices	
The offence of using mechanical restraint, other than in accordance with the Act, applies for all patients in an authorised mental health service. All uses of mechanical restraint must be approved by the Chief Psychiatrist. This is a change from the current MHA whereby an authorised doctor may approve the use of restraint, provided the device used in the restraint is approved by the Chief Psychiatrist. The criteria for applying mechanical restraint have been strengthened, including by requiring that there is no other reasonably practicable way to protect the patient or others from physical harm. Patients under mechanical restraint must be continuously observed. The Chief Psychiatrist may require an approval to apply mechanical restraint to be sought be way of a reduction and elimination plan, the purpose of which is to eliminate the use of restraint for the patient. Mechanical restraint may only be used for a total period of 9 hours in a 24-hour period, unless it is approved under a reduction and elimination plan. Mechanical restraint must be removed if it is no longer required. The offence of using seclusion, other than in accordance with the Act, applies for all patients in an authorised mental health service. The Chief Psychiatrist may give an authorised mental health service written directions about the use of seclusion. This may include that seclusion only be used under an approved reduction and elimination plan.	

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
Seclusion may only be used for a total period of 9 hours in a 24-hour period, unless it is approved under a reduction and elimination plan. Provisions also allow seclusion to be extended beyond 9 hours if a reduction and elimination plan is being prepared. Seclusion for a patient must be ended if it is no longer required.	
An offence is established for using physical restraint on a patient unless authorised by an authorised doctor or the person in charge of the unit. An exception applies in urgent circumstances or if authorised under another law. An offence is established stating that medication may only be used if it is clinically necessary for the patient's treatment and care.	
Chapter 9 Rights of patients and others	
The Act establishes a stand-alone chapter dealing with the rights of patients and support persons. The Act includes the right to communicate with other persons by phone or electronic device unless the administrator prohibits or restricts this, on a case-by-case basis, where it may be detrimental to the patient or others. Extended requirements are placed on authorised doctors and others to take reasonable steps to ensure patients understand oral information provided to the patient. The Act also requires explanations to be given to the patient's nominated support person and other support persons. The provisions in relation to the giving of written notices replace the disparate and inconsistent provisions in the MHA. The Act requires notices to be given to the patient's nominated support person, personal guardian or attorney.	The Act continues a requirement for a statement of rights. The Act continues the right to be visited by family, carers and other support persons unless it may be detrimental to a patient's health and wellbeing. The Act continues the ability for a patient to be visited by a health practitioner, legal or other adviser.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
The Act states that a patient, or someone on behalf of the patient, may request a second opinion about the patient's treatment and care. The Act outlines the roles and responsibilities of family, carers and other support persons. The Act requires public sector mental health services to appoint or engage independent patient rights advisers to advise patients and support persons of their rights and responsibilities under the Act.	
Chapter 10 Chief psychiatrist	
The Act mandates that policies must be made on a range of matters, such as the application of the treatment criteria, the way in which records are to be kept, the management of complaints, and the treatment and care of forensic patients. The Act also lists matters for which policies and practice guidelines may be made, and requires all policies and practice guidelines to be made publicly available. The provisions in relation to 'forensic information orders' for victims of unlawful acts are replaced by 'information notices', and are approved by the Chief Psychiatrist rather than the Tribunal. Timeframes for making decisions in relation to information notices have been included in the Act to ensure information is provided to victims in a timely manner.	The Act continues the role of Chief Psychiatrist (renamed from the Director of Mental Health under the MHA). The functions, powers and independence of the Chief Psychiatrist are comparable to the MHA. The requirement to produce an annual report continues under the Act, but its content is detailed in the Act. The ability for the Chief Psychiatrist to undertake investigations is comparable to the MHA. The ability for the Chief Psychiatrist to take action where there is a serious risk to persons or public safety, including suspending community treatment for a 'class' of patients, is comparable to the MHA. The information that can be provided under an information notice is comparable to 'forensic information orders' under the MHA, with Schedule 1 of the Act stating more clearly this information and including the new requirement that brief reasons for an increase in the person's treatment in the community be provided.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
Chapter 11 Authorised mental health services	
The Chief Psychiatrist may include conditions when declaring an authorised mental health service. This supports service delivery options in smaller rural or remote areas by allowing a small rural hospital to provide a more limited range of services under the Act. The Chief Psychiatrist may declare an authorised mental health service (rural and remote) in which specific provisions of the Act apply (see above). The appointment of authorised mental health practitioners is to be made by administrators of authorised mental health services rather than the Chief Psychiatrist (Director of Mental Health under the MHA). The Act enables other categories of health practitioners to be prescribed to perform some or all functions of authorised doctors if they have the required competencies. The provisions in the Act related to the transfer of patients replace the disparate provisions in the MHA. The requirement for Ministerial Interstate Agreements to be in place for patients to be transferred interstate has been removed. The Act consistently deals with the transport of persons, including the administration of medication for the purpose of transporting a patient. Chief Psychiatrist approval is required for the use of mechanical restraint while a person is being transported. The provisions related to the security of authorised mental health services, including searches in high security units, have been updated.	The declaration of authorised mental health services and high security units is comparable to the MHA. The appointment of authorised doctors is comparable to the MHA.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
Chapter 12 Mental Health Review Tribunal proceedings	
Additional functions for the Tribunal under the Act are: • the review of treatment support orders • the hearing of applications for examination authorities (which replace justices examination orders) • the hearing of applications for the transfer of forensic order and treatment support order patients out of Queensland, and the equivalent of forensic patients into Queensland On a review of a forensic order, the Tribunal may make a treatment support order as a 'step down' from a forensic order. The Tribunal must review a forensic order (Criminal Code) to decide whether the order should become a forensic order (mental health) or a forensic order (disability). For clarity and transparency, the Act provides clear and consistent criteria for decisions made by the Tribunal. This applies to the continuing or revocation of orders and authorities, and the extent of treatment in the community. The initial review of the making of a treatment authority is to occur within 28 days (currently 6 weeks for involuntary treatment orders). For a person on a treatment authority for 12 months, the Tribunal is to consider whether the person's treatment needs may be met in a less restrictive way with the consent of a personal guardian.	The role of the Tribunal in deciding whether to continue or revoke a forensic order or treatment authority (involuntary treatment order under the MHA) and the extent of treatment in the community under the order or authority are comparable to the MHA. The role of the Tribunal in deciding fitness for trial, and the actions taken after a review, are comparable to the MHA. The role of the Tribunal in hearing applications for regulated treatments (ECT and neurosurgery) is comparable to the MHA (noting that psychosurgery is prohibited under the Act).

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
Chapter 13 Appeals	
-	The appeal provisions are comparable to the MHA.
Chapter 14 Monitoring and enforcement	
The Act significantly enhances the monitoring provisions from the MHA by enabling inspectors to be appointed to monitor and enforce compliance with the Act.	-
Chapter 15 Suspension of criminal proceedings, offences and other legal matters	
	The purpose of the provisions relating to the suspension of proceedings where a person becomes a classified patient, where a psychiatrist report is prepared or where a reference is made to the Mental Health Court, is comparable to the MHA. However, for clarity and consistency, the provisions have been placed in one area of the Act. The major offence and 'other legal matter' provisions are comparable to the MHA.
Chapter 16 Establishment and administration of court and tribunal	
<u>Mental Health Review Tribunal</u> The Act provides for the appointment of a deputy president. The Act requires the president to develop competencies for Tribunal members. The Act requires a treating practitioner to give a report about a patient for specified reviews at least 7 days before a hearing (currently in the Mental Health Review Tribunal Rules).	The provisions relating to the establishment and administration of the Tribunal and the Mental Health Court are otherwise comparable to the MHA. The 'Review of Detention' provisions by the Mental Health Court are comparable to the MHA. Many of the procedural provisions for the Court and Tribunal are comparable to the MHA.

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
The Act states that the person the subject of a proceeding may be represented by a nominated support person, a lawyer or other person. The Act states that the person the subject of a proceeding may be accompanied by a nominated support person, family member, carer or other support person. The Act requires the Tribunal to appoint, at no cost to the person, a lawyer for the following hearings: • if the person is a minor • for a fitness for trial review • for an electroconvulsive therapy treatment application • at a hearing where the Attorney-General is to appear • another hearing prescribed by regulation For proceedings for a review of a treatment authority where the person does not wish to attend or be represented by another person, the matter may be heard 'on the papers'. The Tribunal may refer a question of law to the Mental Health Court. <u>Mental Health Court</u> The Court may be assisted by one assisting clinician if appropriate. The Mental Health Court may be assisted by a person with expertise in the care of persons who have an intellectual disability.	

Key provisions in the *Mental Health Act 2016* that are <u>different</u> from the *Mental Health Act 2000* (MHA)	Key provisions in the *Mental Health Act 2016* that are <u>comparable</u> to the *Mental Health Act 2000* (MHA)
Chapter 17 Confidentiality	
The Act enables information to be disclosed for specific purposes, namely: • to assist in identifying persons who may have a mental health defence • to assist in identifying and offering support to victims • to assist in the preparation of a private psychiatrist report • to provide relevant information to an independent patient rights adviser • to provide limited information to the victim of a person who is a classified patient (this replaces classified patient information orders under the MHA) • to enable information to be disclosed to a lawyer preparing for a proceeding of the Mental Health Court or the Tribunal • the disclosure of photographs of a person required to return.	The other confidentiality provisions are otherwise comparable to the MHA. The confidentiality duty in relation to patient information is under the *Hospital and Health Boards Act 2011.*
Chapter 18 General provisions	
The Act enables information to be disclosed by Queensland Civil and Administrative Tribunal about whether a personal guardian has been appointed for a person.	