Queensland Health

Office of the Chief Psychiatrist

Chief Psychiatrist annual report 2018–19

Communication objective

The aim of this annual report is to inform the Minister for Health and Minister for Ambulance Services, the Queensland Parliament, mental health consumers, carers, service providers and members of the public about the administration of the *Mental Health Act 2016* and associated activities and achievements for the 2018-19 financial year.

Annual report of the Chief Psychiatrist 2018-19

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An electronic version of this document is available at https://www.health.qld.gov.au/mental-health-act

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To:
The Honourable Steven Miles MP
Minister for Health and Minister
for Ambulance Services

Dear Minister

I present the 2018–19 Annual Report of the Chief Psychiatrist.
This report is provided in accordance with section 307 of the *Mental Health Act 2016*.

Yours sincerely

Dr John Reilly
Chief Psychiatrist

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Message from the Chief Psychiatrist

I am pleased to present the Chief Psychiatrist Annual Report for the 2018-19 financial year.

This year the Office of the Chief Psychiatrist (the Office) progressed several significant initiatives in collaboration with Hospital and Health Services (HHSs) and our other key stakeholders. A key activity was completing an evaluation of the *Mental Health Act 2016* implementation, which found that on balance the Act was effectively implemented and that new provisions in the Act are operating as intended to support the less restrictive way and patient rights focused treatment and care. While this is reassuring, the evaluation also identified opportunities to further improve the operation of the Act. This report outlines activities commenced in 2018-19 in response to the evaluation findings.

The Violence Risk Assessment and Management Framework for Mental Health Services was also completed during 2018-19. This Framework, developed in response to the report *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*, guides services to identify, assess and manage consumers who may pose a risk of violence towards others, improving care for consumers and safety for the community, including staff.

Other significant initiatives in which the Office works closely with stakeholders include the development of an enhanced statewide clinical documentation suite and the standardisation of comprehensive care in mental health and alcohol and other drug services.

The enhanced statewide clinical documentation suite is being developed in preparation for the integration of alcohol and other drugs services and mental health services clinical information systems, scheduled for July 2020. This work has sharpened the focus on integration of mental health alcohol and other drugs services and their processes, contributing to more cohesive, holistic treatment and care for consumers, while assisting services to meet elements of the National Safety and Quality Health Service Standards Comprehensive Care standard.

To complement this work, the Office hosted a statewide forum to initiate the development of standardised approaches to case review, care planning and formulation, led and attended by clinicians and consumers. This work will enhance the care provided to consumers with a focus on: case review that is clinically meaningful, practical, and aligns with consumer needs; approaches to care planning that are inclusive, enable continuity of care, and are individualised; and written formulations that are adaptable for clinician preferences, demonstrate why treatment decisions have been made, and contribute to appropriate case reviews and care plans. Ongoing work will be supported by various clinical networks, committees and forums coordinated by the Office. Further standardisation of these processes will support more consistent involvement of consumers in their development and use.

The Mental Health Alcohol and Other Drugs Quality Assurance Committee (QAC) is one of these committees. The QAC supports quality and safety in mental health alcohol and other drugs services with a focus on clinical incident management practices, strategies for learning from incident review and analysis, and supporting services to implement improvements. The work of the QAC overlaps with Chief Psychiatrist investigations whose recommendations are implemented and monitored as part of routine service delivery. I have learnt a great deal from the members of the QAC and the investigation teams. More information about the QAC and Chief Psychiatrist investigations during the year is included in the Report.

Continuous improvement in the safety and quality of mental health alcohol and other drug services is integral to all work of the Office of the Chief Psychiatrist and can only be achieved in partnership with our many stakeholders including consumers, carers, clinicians, statutory officers, government and non-government agencies. I am sincerely grateful for the work of the Office and the continued dedication and commitment of its staff and our stakeholders, and I look forward to ongoing support in 2019-20.

Dr John Reilly
Chief Psychiatrist

Administration of the *Mental Health Act 2016*

A range of systems and processes support the effective administration of the *Mental Health Act 2016* (the Act) to ensure safe, quality, recovery-oriented mental health care.

The Chief Psychiatrist has broad functions to facilitate the proper administration of the Act as well as decision making responsibilities for individual matters. Activity relating to some of the Chief Psychiatrist's key functions is discussed below.

Also addressed are the outcomes of the Evaluation of the *Mental Health Act 2016* implementation, and work that has commenced in the Office of the Chief Psychiatrist to address the findings and improve the administration of the Act.

Providing policies and resources

The Chief Psychiatrist's functions include making policies and practice guidelines relating to the administration of the Act. Decision makers under the Act, including authorised doctors, authorised mental health practitioners and authorised mental health service administrators, are required to comply with the requirements and procedures set out in the Chief Psychiatrist's policies and practice guidelines.

Promoting awareness and understanding of the Act is an important function of the Chief Psychiatrist. The day to day operation of the Act is supported by a suite of resources, including forms, education materials, and information resources, to help understanding of Act requirements and safeguards to protect individual rights.

The Chief Psychiatrist policies and practice guidelines and other information resources can be accessed at www.health.qld.gov.au/mental-health-act

While all policies and resources are the subject of ongoing review and amendment, a primary focus this year has been to promote understanding and application of the less restrictive way in treatment and care.

The **'less restrictive way'** requires clinicians to consider alternatives to involuntary treatment and care; in particular, when a person does not have capacity to make their own healthcare decisions, clinicians must consider whether the person is able to receive treatment and care for mental illness under an advance health directive, or with the consent of an appointed substitute decision maker.

The Chief Psychiatrist has issued Less Restrictive Way Guidelines to support clinicians in applying the less restrictive way in clinical practice. The guidelines provide direction and structure for assessing and documenting capacity, considering consent, and supporting substitute decision making. The guidelines are the outcome of a project hosted by the Gold Coast Hospital and Health Service and were informed by an expert reference group, in collaboration with the Office of the Chief Psychiatrist.

Significant progress has also been made with the development of an on-line training resource for clinicians which addresses specific requirements in assessing capacity and applying the less restrictive way for a minor. The training resource has been developed by the Queensland Centre for Mental Health Learning and was informed by a clinical advisory group.

The Less Restrictive Way Guidelines are available at www.health.qld.gov.au/mental-health-act by selecting 'Key Topics' and then 'Patient Rights and Support'

The training resource is available at www.qcmhl.qld.edu.au

In addition to policies and resources, the Office of the Chief Psychiatrist provides information and advice on the interpretation and application of the Act on a day to day basis. Enquiries largely come from clinicians and others directly involved in the administration of the Act, as well as patients and members of the general public.

Safeguarding patient rights

Protection of patient rights is central to the Act and its operation. A key function of the Chief Psychiatrist is ensuring the protection of patient rights under the Act and balancing these rights with the rights of others.

The Act upholds patient rights through a range of mechanisms including, for example: requirements for patients and their support persons to be provided with information about treatment and care and their rights; access to an Independent Patient Rights Adviser (IPRA) to assist patients in understanding and exercising their rights; access to a second opinion if there are unresolved concerns about treatment; processes for independent review by the Mental Health Review Tribunal; and access to legal representation before the tribunal in particular circumstances.

Information and resources are available at www.health.qld.gov.au/mental-health-act by selecting 'Key topics' and then 'Patient rights and support'

Independent Patient Rights Advisers

IPRAs have been engaged by HHSs since early 2017 with 28 positions funded across Queensland at that time. As at 30 June 2019, 27 of the 28 IPRA positions were filled.

The Chief Psychiatrist has a direct role in supporting and monitoring the functions of IPRAs. Ongoing development of the IPRA role is facilitated by a Statewide Coordinator who reports directly to the Chief Psychiatrist. In 2018-19, two IPRA forums were held to explore solutions for common patient rights issues with the aim of providing consistent service delivery across the state. In addition to the forums, the IPRA network meets monthly via teleconference to discuss day to day operational issues raised by HHSs.

Common activities undertaken by the IPRAs include:

» advising patients of their rights under the Act
» supporting patient engagement with their treating teams to participate and gain a better understanding of their treatment and care and better understand involuntary treatment
» explaining the purpose of the Mental Health Review Tribunal and associated processes such as Self Reports and Applications for Applicant Review.

In 2018-19 the IPRAs:

Engaged with
13,183 patients
(increase of 18% from the previous year)

Of the 13,183 patients,
81%
were seen at an
inpatient facility

Engaged with
1,958
family members, carers, or other supports
(increase of 27% from the previous year)

Supporting individual treatment and care

The Chief Psychiatrist's functions include decision-making about individuals who are subject to the Act's provisions. While these decision-making functions are wide-ranging, they largely relate to circumstances where an individual is also subject to criminal justice system processes or where interjurisdictional matters, such as interstate movement, arise.

Mental Health Court matters represent a significant part of this work. The Mental Health Court's role is to determine matters relating to individuals charged with a serious offence as well as appeals against decisions of the Mental Health Review Tribunal. As a party to Mental Health Court proceedings, the Chief Psychiatrist's primary interest is ensuring the treatment and care needs of individuals appearing before the court are met, and that the court has appropriate information to make these decisions. The Office of the Chief Psychiatrist provides the interface between the Mental Health Court and the service system, working closely with authorised mental health services as well as other stakeholders involved in the court process.

The Office of the **Chief Psychiatrist** was a party to **212 matters** heard by the Mental Health Court **in 2018-19**

Ensuring proper treatment and care is also supported through a Complex Case Panel system. The Office of the Chief Psychiatrist is responsible for conducting Complex Case Panels which may be required in preparation for Mental Health Court or where clinicians seek assistance from the Chief Psychiatrist for an individual with complex clinical needs. The composition of Complex Case Panels is dependent on individual circumstances and may involve representation from a number of authorised mental health services and a range of government agencies. While similar collaborative care planning approaches operate day to day at the local level, Complex Case Panels provide an avenue to engage stakeholders at a more senior level.

Supporting victim rights

The Act provides a number of processes to support victims of crime when an offender is assessed as having a mental illness or intellectual disability, including provisions for victims to receive information about the patient that is relevant to the victim's safety and wellbeing.

The Queensland Health Victim Support Service is a free statewide service providing specialised counselling, support and information to victims of crime when the person charged has been assessed as having a mental illness or intellectual disability. More information is available at www.health.qld.gov.au/qhvss

Information notices

The Chief Psychiatrist may make an information notice in relation to a person who is subject to a Forensic Order or Treatment Support Order. The information notice allows specific information such as Mental Health Review Tribunal review dates and decisions to be provided to a victim, a close relative of the victim, or other person affected by an offence.

In 2018-19, the Chief Psychiatrist received and approved 17 applications for information notices. No applications were pending decision at 30 June 2019.

The provisions for information notices also apply to people with an intellectual disability under the *Forensic Disability Act 2011*. Decisions about release of information in relation to clients of the Forensic Disability Service are made by the Director of Forensic Disability. Once approved, notifications for all information notices are managed by the Office of the Chief Psychiatrist and are provided to victims via the Queensland Health Victim Support Service on the Chief Psychiatrist's or Director's behalf.

As at 30 June 2019, there were 147 information notices in place in relation to Forensic Order and Treatment Support Order patients. This includes two information notices for clients of the Forensic Disability Service.

Classified patient information

The Chief Psychiatrist may also provide particular information about a classified patient to a victim or other person affected by an offence. A classified patient is a person admitted to an authorised mental health service from a place of custody.

In 2018-19, one application was received and approved by the Chief Psychiatrist in relation to a classified patient. No applications were pending decision at 30 June 2019.

As at 30 June 2019, one applicant was registered to receive information about classified patients.

More information and resources relating to support for victims is available at www.health.qld.gov.au/mental-health-act by selecting 'Key topics' and then 'Victim support'.

Monitoring and investigating compliance

The Chief Psychiatrist's functions under the Act also include monitoring and auditing authorised mental health service compliance with the legislation. A related function is the Chief Psychiatrist's power to investigate a matter such as an incident or legislative non-compliance.

The Chief Psychiatrist Policy *Notifications to Chief Psychiatrist of Critical Incidents and Non-Compliance with the Act* outlines the matters that must be notified to the Chief Psychiatrist. The primary focus of the policy for non-compliance matters is legislative and policy requirements that have significant impact on individual rights and liberties including involuntary detention and restrictive practices, such as seclusion and restraint.

The policy is available at www.health.qld.gov.au/mental-health-act by selecting 'Chief Psychiatrist Policies and Practice Guidelines' under 'Administration of the Act'

Where legislative non-compliance is reported, authorised mental health service administrators are required to ensure appropriate remedial action at the local level to minimise potential for recurrence including, for example, additional training or changes to local procedures. Non-compliance may also be identified through reports generated from the Consumer Integrated Mental Health Application (CIMHA), the statewide mental health database which is the designated patient record for the purposes of the Act.

At the statewide level, non-compliance with documentation and processes relating to seclusion and restraint remains an area of focus. The Office of the Chief Psychiatrist provides feedback on a case by case basis and has developed seclusion flowcharts to support clinician compliance with the strict requirements of the Act.

Investigations

Investigations under the Act may be undertaken by the Chief Psychiatrist or by inspectors appointed by the Chief Psychiatrist. These investigations are one of a range of mechanisms that operate in the health system to review an incident which has resulted in an adverse patient outcome or a matter relating to patient care. Other mechanisms include clinical reviews, root cause analyses and investigations under the *Hospital and Health Boards Act 2011*, and investigations conducted by the Health Ombudsman.

Investigations and incident reviews more broadly are critical to understanding what occurred with a view to identifying potential system improvements. The Chief Psychiatrist's decision to undertake an investigation under the *Mental Health Act 2016* takes account of other review processes that are occurring or proposed to occur and, where appropriate, liaison occurs with the relevant entity to understand the resulting findings, recommendations and remedial actions.

Where the Chief Psychiatrist determines that an investigation is to be made under the Act, a written report of the investigation must be prepared and may include recommendations for service improvement. Recommendations resulting from an investigation may be referred to the relevant authorised mental health service administrator for action. The Office of the Chief Psychiatrist is responsible for monitoring the implementation of recommendations at the authorised mental health service and actioning recommendations that have statewide relevance.

In 2018–19, the Chief Psychiatrist commissioned three investigations under the Act; one of which was finalised and two that are to be completed in 2019-20. The finalised investigation examined the admission, assessment and management of a classified patient, that is, a person transferred to an authorised mental health service from Queensland Corrective Services custody.

The resulting recommendations were directed to two authorised mental health services; one that was engaged with the patient in prison and the other following the patient's transfer to an authorised mental health service. The recommendations relate to clinical processes and documentation, information sharing, education and training, and consideration of specialist clinical resources. The recommendations have been referred to relevant authorised mental health service administrators and implementation will continue to be monitored by the Office of the Chief Psychiatrist. The Office will also oversight implementation of statewide recommendations which relate to engagement with correctional centre managers regarding security at mental health service facilities, development of an education package relating to classified patient admissions, and information sharing to inform referrals to an authorised mental health service.

Evaluation of the *Mental Health Act 2016* implementation

In recognition of the changes brought about by the Act, the Department of Health committed to an evaluation of the implementation of the Act within two years of its commencement.

The evaluation, undertaken by the Mental Health Alcohol and Other Drugs Branch, commenced in July 2017 and considered:

- the extent to which key new initiatives of the Act have been successfully implemented
- stakeholder views of the change management processes associated with the implementation of the Act.

The evaluation considered how the changes made by the Act met the objectives and principles of the Act, with particular regard to the use of the less restrictive way (the consideration of advance health directives and substitute decision making when a person does not have the capacity to make health care decisions), patient rights focused treatment, and recovery-oriented practices.

Consultation was undertaken through a range of approaches including stakeholder reference groups comprised of service providers, statutory authorities, and patient and carer representatives. Two forums were held, in Brisbane and Townsville, to enable active participation and engagement of patients, carers and support networks.

The evaluation was finalised in April 2019. It found, on balance, that the Act was effectively implemented and is supporting the less restrictive way and patient rights focused treatment and care. Opportunities for improvement were identified across three key themes: targeted training and education; enhanced data quality and analysis; and refined performance outcome monitoring.

Targeted training and education

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 the less restrictive way and strengthen patient rights focused treatment and care; improve compliance with the Act; improve safeguards and help uphold the principles of the Act; and improve record-keeping and data quality.

Improved data quality and analysis

A common theme across a number of the new requirements of the Act was the quality of available data. This may be attributed to the need for further education, and to limitations of existing data system specifications.

Refined performance outcome monitoring

Performance outcome monitoring will be considered and refined for some existing processes, including the independent patient rights adviser model, and the Court Liaison Service.

More information including the full evaluation report and findings is available at www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/evaluation

Responding to findings of the evaluation

The Office of the Chief Psychiatrist has commenced a number of activities to address the findings of the evaluation. Relevant initiatives currently being progressed include the:

- review of Chief Psychiatrist policies and practice guidelines to consider opportunities for improvement such as streamlining this documentation and including practical tools for clinicians
- review of the Mental Health Act website to improve usability and access to information on the Act
- development of a handbook to support consistent information system data entry and associated administrative processes including practical scenarios and links to relevant forms, system requirements and other associated information and resources.

Improving data quality has been a key focus to date. Availability of complete and reliable information is critical to clinical care as well as effective monitoring and analysis at the local and statewide level. The Office has been working with key stakeholders during the 2018-19 reporting period to improve the quality and completeness of data with achievements including:

- establishment of a shared consumer data validation process with the Mental Health Review Tribunal and Mental Health Court Registry. Work is also underway to automate the transfer of information between CIMHA (statewide mental health patient database) and the Mental Health Review Tribunal information system which will further ensure data quality
- establishment of an information exchange process between HHSs, the Office of Public Guardian and the Office of Advance Care Planning for notification of guardianship decisions for patients. This process provides clinicians with timely notification of matters where the Public Guardian is appointed as decision maker and supports engagement with the Office of the Public Guardian in matters relating to treatment and care
- development of additional reports to improve identification of persons charged with an offence and eligible for a psychiatrist report. This ensures better protection of patient's entitlement to request a psychiatrist report, at no cost, should the person wish to pursue a mental health defence.

Work has also progressed to facilitate more effective use of data to inform practice and support oversight of the operation of the Act. Consultation has commenced with authorised mental health services to identify priority areas to inform the development of data dashboards using information recorded in CIMHA. The dashboards will provide authorised mental health service administrators with a visual snapshot of Act-related activity to enhance local oversight of performance and compliance and inform targeted practice improvement activities.

Reporting functionality is also being enhanced through the Mental Health and Addiction Portal (MHAP); a business intelligence solution that is being iteratively developed to collate and integrate data from different sources to improve access and use of data by mental health and alcohol and other drug services. Integration of Act-related data into MHAP commenced in 2018-19. As foundational data and functionality continues to be built within MHAP, the benefits of and opportunities for benchmarking and evaluation continue to grow.

The evaluation provided a comprehensive analysis of the early implementation of the Act. The Office of the Chief Psychiatrist will continue to monitor its operation and work with stakeholders to identify opportunities for further improvement.

Safety and quality initiatives

The Office of the Chief Psychiatrist undertakes many and varied activities in its role to provide leadership and support continuous improvement in the safety and quality of mental health alcohol and other drug services.

The Office facilitates and participates in advisory and governance committees and leads key statewide safety and quality reforms such as implementation of recommendations from '*When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*' and the Suicide Prevention in Health Services Initiative. Achievements and developments in this reporting period are outlined below.

Mental Health Alcohol and Other Drugs Statewide Clinical Network

Established in 2013, the Mental Health Alcohol and Other Drugs Statewide Clinical Network brings together senior leaders, clinicians, and consumer and carer representatives to promote better consumer outcomes in public sector mental health alcohol and other drug services. Its activities focus on improvement to service quality, safety, equity and accessibility. As one of a number of Queensland Health clinical specialty networks, the Mental Health Alcohol and Other Drugs Statewide Clinical Network, led by Ms Linda Hipper, Director Addiction and Mental Health Service, Metro South Hospital and Health Service, provides an opportunity for clinicians and other key stakeholders to engage in planning, priority setting, information sharing and system improvement.

In 2018-19, a range of review and planning activities were undertaken to identify a more structured approach to quality improvement, with the aim of supporting mental health alcohol and other drug services to achieve measurable and sustainable positive change in specific areas of care. Work is underway to trial a 'brief breakthrough collaborative' quality improvement model, which combines improvement science with team-based collaborative learning and support. With a focus on the care planning process, the initial brief breakthrough collaborative will aim to produce clinical practice improvements within participating sites and identify key lessons to enable uptake in other sites.

The network maintained an interest in the reduction and where possible elimination of seclusion and restraint. Key activities have included examining data on the use of seclusion and restraint; monitoring the progress of work occurring at a statewide level to prevent and better manage occupational violence in healthcare; and exploring options to enhance identification and risk management for involuntary consumers at risk of absence without approval. Commissioned by the network, a checklist was developed to enhance the assessment of risk of absence without approval for individual consumers in acute mental health inpatient settings[1]. Further information on statewide activity focused on the reduction of seclusion and restraint is included in the following section.

Monitoring and reducing the use of seclusion and restraint

There is a strong commitment nationally and internationally to the reduction and elimination of seclusion and restraint in mental health services. In the past seven years, Queensland Health has significantly reduced overall rates of seclusion for mental health patients. The Office of the Chief Psychiatrist works in partnership with HHSs to ensure continuing reform that promotes a least-restrictive, therapeutic environment in mental health inpatient units, while maintaining the safety and dignity of all patients and staff.

[1] Meehan, T., Mansfield, Y., Stedman, T. (2019). Development of a checklist to aid in the assessment of 'failure to return' from approved leave by acute inpatients. Int. J Ment Health Nurs, 2019 May 25 doi: 10.1111/inm.12604.

In November 2018, selected delegates from the Office of the Chief Psychiatrist and the Mental Health Alcohol and Other Drugs Statewide Clinical Network attended the *12th National Towards Elimination of Restrictive Practices Forum* in Tasmania. Through connections made at the forum, representatives contributed to the *Safe in Care, Safe at Work* toolkit developed by the Australian College of Mental Health Nurses. The toolkit is designed to assist mental health services in implementing systematic and structured activities to support the reduction of seclusion and restraint in inpatient settings, and to enhance the safety of both consumers and staff.

Reducing the use of seclusion and restraint in high secure and forensic extended treatment settings has remained an area of focus in 2018-19. A project funded by the Office of the Chief Psychiatrist and undertaken by the West Moreton Hospital and Health Service explored innovative approaches to preventing and reducing the use of long-term seclusion in forensic mental health facilities. Work has now commenced on implementing a comprehensive set of evidence-based strategies supported by the *Safe in Care, Safe at Work* toolkit.

Working with clinicians, lived experience representatives and other stakeholders from across the state, the Office of the Chief Psychiatrist has also commenced the development of a statewide framework to guide collaborative work in reducing the use of seclusion and restraint in Queensland Health mental health, alcohol and other drug services. The framework will draw from contemporary Australian and international literature and guidelines, including *Safe in Care, Safe at Work*.

Mental Health Alcohol and Other Drugs Quality Assurance Committee

The Mental Health Alcohol and Other Drugs Quality Assurance Committee (QAC) was established by the Director-General in September 2017 under the auspices of the Office of the Chief Psychiatrist. Established under Part 6 of the *Hospital and Health Boards Act 2011*, its purpose is to improve the safety and quality of public mental health alcohol and other drugs services by:

» reviewing and analysing information and investigation findings to inform continuous improvement and reform

» assessing and evaluating the quality of care provided by services

» reporting and making recommendations for service improvement.

In 2018-19, the QAC refined its approach and developed an agreed plan of activities up to 2022 under four priority areas.

» **learning from incidents:** the QAC aims to examine clinical incident management practices to inform the development of guiding resources to improve the quality of clinical incident reviews (and resulting recommendations) undertaken by mental health alcohol and other drugs services

» **culture:** the QAC will explore its application of Restorative Just Culture principles and consider potential actions to support use of this approach by HHSs. The QAC aims to explore in detail: the concepts; how the approach contrasts with more traditional Just Culture concepts; and the relationship between Restorative Just Culture and Safety Culture. The QAC has also engaged with a HHS undertaking work in Restorative Just Culture to share lessons for consideration of the QAC

» **data:** the QAC aims to establish a methodology and framework for reviewing treatment and care of designated patient cohorts

» **communication and collaboration:** the QAC has established a process for communicating lessons and good practice identified through reviews, investigations and coronial findings. Communiques will be distributed

to mental health alcohol and other drug services for consideration of implications and improvement opportunities. The first communique will be issued to HHSs in the next reporting period and will focus on the importance of sharing lessons broadly across services, teams and individual clinicians and considerations for an effective learning culture.

In 2018-19, the Office of the Chief Psychiatrist, in collaboration with the Patient Safety and Quality Improvement Service, led a review of the implementation of the Queensland Health suite of environmental safety guidelines for mental health alcohol and other drugs services, a recommendation of the Northern Coroner. The QAC provided guidance in the development of the methodology for the review. Findings from this review will be disseminated by the QAC following completion of the review.

The QAC's activities will inform a triennial report to the Director-General of Queensland Health, due in 2020.

The report will be available on the Mental Health Alcohol and Other Drugs Quality Assurance website at www.clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/quality-assurance-committees/mhaod-quality-assurance-committee

Queensland Electroconvulsive Therapy Committee

The Queensland Electroconvulsive Therapy Committee, chaired by Dr Shanthi Sarma, Staff Specialist, Gold Coast Hospital and Health Service, is comprised principally of clinicians and supports the Chief Psychiatrist by providing expert advice and leadership in the delivery of electroconvulsive therapy (ECT) in Queensland. Its focus is the improvement of safety, quality, equity and efficiency of ECT treatment through consideration of practice standards and training requirements.

In 2018-19, the Committee completed a focused review of the Queensland Health Administration of Electroconvulsive Therapy Guideline to ensure alignment with the *Mental Health Act 2016* and the *Royal Australian and New Zealand College of Psychiatrists Professional Practice Guideline - Administration of Electroconvulsive Therapy 2018*.

During the reporting period, the Committee also collaborated with the Chief Psychiatrist in developing a discussion paper for consideration by the National Safety and Quality Partnership Standing Committee on clinical variation in the use of ECT.

ECT resources including a consumer and carer information brochure and guide is available on the Act website www.health.qld.gov.au/mental-health-act. Select 'Treatment and care' from under 'Key topics'.

National Safety and Quality Partnership Standing Committee

The Chief Psychiatrist represents Queensland as a member of the national Safety and Quality Partnership Standing Committee (SQPSC). The SQPSC was established by the Mental Health Principal Committee (MHPC), a principal committee of the Australian Health Ministers' Advisory Council (AHMAC). It provides expert technical advice and recommendations to the MHPC on the development of national policy and strategic directions for patient safety and quality in mental health services and mainstream health initiatives.

Participation in the SQPSC enables the Chief Psychiatrist to contribute to national policy reform which is directly related to the delivery of mental health services in Queensland.

The SQPSC also advises the MHPC on the implementation of *The Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan). The Chief Psychiatrist has responsibility for Action 26 of the

Fifth Plan which has tasked state and territory governments with improving consistency in mental health legislation across jurisdictions, with a view to ensuring seamless and safe care for consumers who move between jurisdictions. In 2018-19, the Chief Psychiatrist worked with the Tasmanian Chief Psychiatrist to investigate reform options to achieve mutual recognition of mental health orders and develop an options paper for consideration by SQPSC, MHPC and AHMAC.

The Chief Psychiatrist is also responsible for leading and progressing the development of clinical indicators relating to ECT. In June 2019, the Chief Psychiatrist led cross-jurisdictional discussion on ECT treatment harmonisation to reduce clinical variation in the use of ECT, informed by recommendations presented in the discussion paper prepared by the Queensland Electroconvulsive Therapy Committee. An update on the progress of this work will be provided in the 2019-20 report.

Queensland Health response to 'When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services (2016)'

The Office of the Chief Psychiatrist is leading the implementation of the Queensland Health response to the report '*When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*' which is aimed at improving the mental health service system for all patients, and particularly those who pose a risk of violence to others, with a view to minimising or preventing the occurrence of adverse events.

Activities within the response have focused on early intervention and prevention, excellence in clinical practice and service provision, and a culture of safety and quality assurance that encourages ongoing monitoring and review of a patient's risk profile and management plan.

The *Violence Risk Assessment and Management Framework – Mental Health Services* (the Framework) was released in March 2019 and is a key initiative of the response.

The Framework is a guiding document for the identification, assessment and management of patients who may pose a risk of violence towards others. It provides a structured three-tiered approach to risk assessment and management, with each tier providing a more comprehensive and specialised service response. Each tier of the Framework is supported by clinical documentation and training modules to build clinical competencies and capabilities.

Developed in consultation with mental health clinicians and patient and carer representatives, the Framework was piloted across five HHSs between June 2018 and January 2019.

Evaluation of the pilot found that application of the Framework:

- improved the capability of clinicians and services to identify, assess, and develop risk management plans
- improved senior clinician involvement in the identification, assessment and management of patients who pose a risk of violence, particularly when levels of risk increased
- improved liaison with, and referrals to, specialist forensic mental health services to provide assessment and management support for patients with complex needs and a significantly elevated risk of violence.

Following the pilot, statewide implementation of the Framework was successfully completed in June 2019. Performance measures relating to the clinical processes will enable ongoing monitoring of the effectiveness of the Framework.

The three-year project to implement the Queensland Health response is scheduled for completion by December 2019 with a final implementation report to be published in late 2019.

Further information about the Queensland Health response including implementation reports, is available at https://publications.qld.gov.au/dataset/mental-health-sentinel-events-review-2016

Suicide Prevention in Health Services Initiative

The Suicide Prevention in Health Services Initiative, a component of *Connecting Care to Recovery 2016 - 2021: a plan for Queensland's State-funded mental health, alcohol and other drug services*, is a key initiative led by the Office of the Chief Psychiatrist to reduce suicide and its effect on Queenslanders. The Initiative consists of three main components:

- the operation of the Suicide Prevention Health Taskforce as a partnership between the Department of Health, HHSs, Primary Health Networks and people with a lived experience of suicide
- multi-incident analysis of suspected suicide deaths of individuals who had a recent contact with a health service
- continued implementation of suicide risk assessment and management within the health service delivery context.

The *Suicide Prevention Health Taskforce Phase 2 Action Plan*, released in November 2018 sets out priority areas for investment, building on the strategies, programs and services implemented since 2016. Following recommendations from a series of roundtables held in 2018, there is a significant focus on Aboriginal and Torres Strait Islander suicide prevention.

The Zero Suicide in Healthcare Multi-Site Collaborative continues to be the lead investment with 11 HHSs implementing the *Zero Suicide in Healthcare* framework using collaborative methodology.

- 1200 respondents across nine HHSs completed a workforce survey in 2018 enabling sites to identify improvement opportunities for staff training and consumer services. The workforce survey will be administered again late 2019
- ten sites have been extended for a further six months, supporting the development of a sustainable practice improvement strategy and rigorous evaluation to contribute to the emerging evidence of suicide prevention efforts and the mental health and alcohol and other drugs services system in Queensland
- three learning forums have been held for all participating sites, including international and national engagement from the United States of America, England, New Zealand and Victoria, Australia. The learning forums remain a critical factor for the success of the collaborative, enabling participants to share, learn and seek support from peers.

Significant progress was also made on the multi-incident analysis of suspected suicides, including statistical analysis of linked coronial and health services data. Draft findings and recommendations relating to four at-risk demographic and clinical cohorts (children and young people, Aboriginal and Torres Strait Islander people, older people, and the acute mental healthcare pathway) were refined to inform and advance existing service reform activities. Queensland Health's response to the recommendations and implementation actions will be available in the next reporting period.

Suicide risk assessment and management training for health service staff continues to be an ongoing focus for the Initiative with an emphasis on emergency department clinicians. However, in this reporting period, other health professions have been included to illustrate the expansion of suicide prevention workforce training.

As at 30 June 2019:

» 5,648 individuals have participated in some aspect of the Suicide Risk Assessment and Management in Emergency Departments (SRAM-ED) settings training since commencement in April 2016; 1,680 in 2018-19

» 267 clinicians have been trained as facilitators to deliver the SRAM-ED training locally within their hospital and health service since commencement in April 2016; 43 in 2018-19

» 107 School Based Youth Health Nurses have attended Supporting Suicidal Young People training between March – June 2019

» 135 individuals from the sites engaged in the Zero Suicide in Healthcare Multi-Site Collaborative participated in the Engage, Assess, Respond to, and Support Suicidal People (EARS) training.

Information and updates are available at www.clinicalexcellence.qld.gov.au by searching 'Suicide Prevention in Health Services Initiative'.

Reporting on the *Mental Health Act 2016*

This section sets out information about how legislative processes are applied in authorised mental health services, including those matters that are required to be reported in the Annual Report of the Chief Psychiatrist under section 307 of the Act.

The primary data source for the annual report is the Consumer Integrated Mental Health Application (CIMHA).

Authorised mental health service abbreviations are set out in Appendix 1.

Authorised mental health services

Authorised mental health services are declared by the Chief Psychiatrist and include both public and private sector health services. While authorised mental health services provide treatment and care to both voluntary and involuntary patients, additional regulation applies for persons subject to involuntary treatment and care.

A declaration by the Chief Psychiatrist may include conditions that facilitate the provision of treatment and care to persons in rural and remote areas, for example, by allowing a more limited range of services to be provided at a small rural hospital.

The Chief Psychiatrist may also declare a public sector mental health service to be a high security unit. The Act provides additional safeguards for treatment and care in a high security unit.

A small number of private sector health services have been declared as an authorised mental health service for the specific purpose of administering electroconvulsive therapy to patients who have given informed consent. This declaration ensures that private sector patients continue to have appropriate access to this treatment. 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.

St Andrew's War Memorial Hospital is currently the only authorised mental health service declared for the purpose of performing non-ablative neurosurgery on a person who has given informed consent, and the tribunal has given approval to the treatment.

The schedule of authorised mental health services is available on the Act website at www.health.qld.gov.au/mental-health-act under 'Queensland mental health services'

Overview of patients subject to involuntary assessment, treatment, care or detention under the *Mental Health Act 2016*

Each year in Queensland more than 100,000 people are seen in the public mental health system with over two million clinical encounters. Around 50,000 people receive ongoing treatment and care through more than 60,000 community episodes, almost 1,000 residential stays and 24,000 admissions to specialist mental health inpatient units. Of those receiving ongoing care, only a small proportion of people, less than one-third, who have very serious mental illness require involuntary treatment and care in an authorised mental health service to ensure their own or others safety.

Table 1 provides a summary of patients subject to involuntary assessment, treatment, care or detention in Queensland as at 30 June 2019.

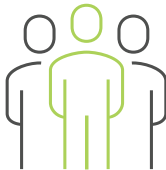
A small number of patients were subject to more than one involuntary status category at that time; for example, a patient receiving treatment and care under a Treatment Authority who is transferred to an authorised mental health service from custody as a classified patient. The total number of patients reported per service provides a unique count of patients for each authorised mental health service. The statewide total provides a unique count of patients subject to involuntary assessment, treatment, care or detention in Queensland as at 30 June 2019. There are therefore small differences in row and column counts in Table 1. Each apparent discrepancy has been checked and confirmed as a duplication resulting from an individual across multiple services and/or streams.

Each year in Queensland

50,000 people

receive ongoing treatment for mental illness.

One third involuntary.



60,000
community episodes

24,000
admissions to inpatient units

1,000
residential stays

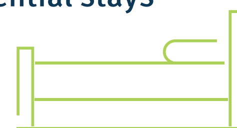


Table 1: Patients subject to involuntary assessment, treatment, care or detention as at 30 June 2019

Authorised Mental Health Service	Involuntary assessment	Treatment Authorities	Treatment Support Order	Forensic Order	Classified	Total patients
Bayside	1	145	7	21	1	175
Belmont Private	0	14	0	0	0	14
Cairns	4	374	10	53	0	439
Central Queensland	1	342	7	24	0	374
Children's Health Queensland	0	8	0	0	0	8
Darling Downs	1	301	13	67	1	382
Gold Coast	2	593	22	40	1	657
Greenslopes Private	0	1	0	0	0	1
Logan Beaudesert	1	398	13	50	0	461
Mackay	1	145	10	16	1	172
New Farm Clinic	0	11	0	0	0	11
Princess Alexandra Hospital	5	550	25	79	2	658
Princess Alexandra Hospital High Security	0	0	0	0	0	0
Redcliffe Caboolture	1	269	7	43	2	320
RBWH	2	666	17	54	0	739
Sunshine Coast	1	355	7	39	1	401
The Park	0	14	0	41	0	55
The Park High Security	0	44	0	45	24	89
The Prince Charles Hospital	2	362	10	62	1	435
Toowong Private	0	5	0	0	0	5
Townsville	0	328	8	75	0	410
West Moreton	1	257	22	55	2	334
Wide Bay	3	151	9	31	0	194
Statewide	**26**	**5333**	**187**	**795**	**36**	**6333**

Involuntary assessment

The Act promotes the voluntary engagement of people in mental health assessment, treatment and care wherever possible. When it is not possible to provide the required assessment or treatment with consent (i.e. consent given by the person or another person authorised to consent on their behalf) the involuntary processes in the Act may be applied.

The involuntary process usually commences with a Recommendation for Assessment however, in some circumstances, the Recommendation for Assessment is preceded by an examination authorised under another legislative process such as an Examination Authority or an Emergency Examination Authority[1].

A Recommendation for Assessment may be made by a doctor or authorised mental health practitioner. The purpose of the assessment is to decide whether a Treatment Authority should be made. In some instances, the assessment may reveal that the person has an existing involuntary order or authority in which case a new Treatment Authority is not required.

Table 2 provides a summary of occasions when a Recommendation for Assessment was made which resulted in assessment in the 2018-19 reporting period.

[1] An Emergency Examination Authority is issued under the *Public Health Act 2005* to allow police and ambulance officers to detain and transport a person to a Public Sector Health Service Facility in emergency circumstances without their consent so that the person may receive appropriate assessment, treatment and care.

Table 2: Involuntary assessment: entry pathway and outcome (1 July 2018 - 30 June 2019)

Authorised Mental Health Service	Involuntary assessment entry pathway				Total assessments	Assessment outcome			
	Recommendation alone	Recommendation preceded by Examination Authority	Recommendation preceded by Emergency Examination Authority	Other (e.g. assessment of person from interstate)		Treatment Authority made	Treatment Authority not made	Pre-existing involuntary status	Assessment incomplete at 30 June 2019
Bayside	473	11	6	0	490	266	224	0	0
Belmont Private	68	0	0	0	68	48	20	0	0
Cairns	768	2	225	0	995	542	442	11	0
Central Queensland	280	5	87	0	372	219	153	0	0
Children's Health Queensland	109	0	13	0	122	74	47	1	0
Darling Downs	592	15	141	1	749	488	261	0	0
Gold Coast	1508	21	359	2	1890	1224	634	32	0
Greenslopes Private	0	0	0	0	0	0	0	0	0
Logan Beaudesert	881	20	118	0	1019	588	429	2	0
Mackay	271	2	166	0	439	243	192	4	0
New Farm Clinic	27	0	0	0	27	25	2	0	0
Princess Alexandra Hospital	1158	38	45	0	1241	810	429	2	0
Princess Alexandra Hospital High Security	0	0	0	0	0	0	0	0	0
Redcliffe Caboolture	773	8	77	0	858	579	276	2	1
RBWH	963	17	400	0	1380	1013	346	21	0
Sunshine Coast	419	4	243	0	666	439	227	0	0
The Park	0	0	0	0	0	0	0	0	0
The Park High Security	6	0	0	0	6	6	0	0	0
The Prince Charles Hospital	1007	21	156	1	1185	900	283	2	0
Toowong Private	19	0	0	0	19	14	5	0	0
Townsville	868	8	59	2	937	361	571	5	0
West Moreton	321	16	223	0	560	376	179	5	0
Wide Bay	419	12	63	0	494	308	180	6	0
Statewide	**10930**	**200**	**2381**	**6**	**13517**	**8523**	**4900**	**93**	**1**

Examination Authorities

In circumstances where it is not possible to engage a person in assessment voluntarily, an application may be made to the Mental Health Review Tribunal for an Examination Authority. Examination Authorities can be made in circumstances where there is, or may be, serious risk of harm or worsening health and all reasonable efforts have been made to engage the person in a voluntary examination.

An application to the tribunal may be made by an authorised person at an authorised mental health service or a family member, friend, colleague or other member of the community who has concerns about the person. If made by a concerned person, a written statement by a doctor (e.g. general practitioner) or authorised mental health practitioner must be provided with the application.

The Examination Authority is in force for seven days and authorises a doctor or authorised mental health practitioner to examine the person to determine whether a Recommendation for Assessment should be made.

Table 3: Examination Authorities issued and outcomes (1 July 2018 - 30 June 2019)

Authorised Mental Health Service	Examination Authorities issued	Outcome			
		Recommendation made	Recommendation not made		
			Examination Authority ended before examination	Examination did not result in Recommendation	Pre-existing involuntary status
Bayside	22	12	1	9	0
Belmont Private	0	0	0	0	0
Cairns	12	2	5	5	0
Central Queensland	11	5	1	5	0
Children's Health Queensland	0	0	0	0	0
Darling Downs	37	15	4	16	2
Gold Coast	54	22	13	19	0
Greenslopes Private	0	0	0	0	0
Logan Beaudesert	52	20	17	14	1
Mackay	3	2	0	1	0
New Farm Clinic	0	0	0	0	0
Princess Alexandra Hospital	65	35	6	24	0
Princess Alexandra Hospital High Security	0	0	0	0	0
Redcliffe Caboolture	18	8	0	10	0
RBWH	27	15	6	5	1
Sunshine Coast	17	5	3	8	1
The Park	0	0	0	0	0
The Park High Security	0	0	0	0	0
The Prince Charles Hospital	38	24	1	13	0
Toowong Private	0	0	0	0	0
Townsville	19	8	3	8	0
West Moreton	33	15	1	17	0
Wide Bay	35	12	1	22	0
Statewide	**443**	**200**	**62**	**176**	**5**

Persons transferred from a place of custody (classified patients)

The Act makes provision for a person to be transferred from a place of custody (e.g. prison or watch house) to an authorised mental health service for assessment or treatment of mental illness. The person is admitted as a classified patient. The Act also makes provisions for the person's return to custody when they no longer require inpatient treatment and care.

A classified patient admission can only occur on the recommendation of an authorised doctor or authorised mental health practitioner. Different documents apply depending on the circumstances.

- a Transfer Recommendation is made when a person in custody:
  - is consenting to treatment and care in an authorised mental health service (i.e. the transfer is for voluntary treatment) or
  - is already subject to an order or authority under the Act (i.e. the transfer is for involuntary treatment)
- a Recommendation for Assessment is made when the person is not able to consent to the transfer and is not subject to an order or authority under the Act (i.e. the transfer is for assessment).

In all circumstances, the person's transfer to an authorised mental health service requires the consent of both the authorised mental health service administrator at the receiving service and the person's custodian:

- the administrator's consent confirms they are satisfied that the service has capacity to provide treatment and care, and that providing the treatment and care would not pose an unreasonable risk to the safety of the person or others
- the custodian (i.e. at the correctional facility, watch-house, detention centre) cannot give consent if the custodian considers the transfer to the authorised mental health service for assessment or treatment would pose an unreasonable risk to the person or others having regard to security requirements.

The Act also requires that, following admission to an authorised mental health service, an authorised doctor must consider the clinical appropriateness of the patient receiving treatment and care as an inpatient. If the doctor decides it is not clinically appropriate, the Act sets out a process for the person's return to custody.

Table 4: Classified patient referrals and admissions (1 July 2018 – 30 June 2019)

Authorised Mental Health Service	Total referrals	Referrals not resulting in classified patient admission		Entry pathway			Total classified admissions
		Ended in reporting period	Open as at 30 June 2019	Recommendation for Assessment	Transfer Recommendation		
				Involuntary assessment	Involuntary treatment	Voluntary treatment	
Bayside	10	7	1	0	2	0	2
Belmont Private	0	0	0	0	0	0	0
Cairns	8	0	0	2	5	1	8
Central Queensland	22	10	1	3	6	2	11
Children's Health Queensland	3	1	0	0	2	0	2
Darling Downs	27	6	2	16	3	0	19
Gold Coast	70	51	0	11	8	0	19
Greenslopes Private	0	0	0	0	0	0	0
Logan Beaudesert	60	36	3	11	10	0	21
Mackay	7	0	0	4	2	1	7
New Farm Clinic	0	0	0	0	0	0	0
Princess Alexandra Hospital	47	29	2	8	5	3	16
Princess Alexandra Hospital High Security	0	0	0	0	0	0	0
Redcliffe Caboolture	26	16	0	9	1	0	10
RBWH	33	9	0	6	17	1	24
Sunshine Coast	25	15	1	7	1	1	9
The Park	0	0	0	0	0	0	0
The Park High Security	62	14	4	24	18	2	44
The Prince Charles Hospital	21	10	3	3	5	0	8
Toowong Private	0	0	0	0	0	0	0
Townsville	28	1	0	13	12	2	27
West Moreton	30	14	0	6	9	1	16
Wide Bay	11	4	0	5	2	0	7
Statewide	**490**	**223**	**17**	**128**	**108**	**14**	**250**

Treatment Authorities

If a person is not able to consent to treatment of their mental illness, an authorised doctor may make a Treatment Authority to authorise involuntary treatment for the person. The doctor must be satisfied that the treatment criteria apply and that there is no less restrictive way of providing treatment and care for the person. The person's views, wishes and preferences are considered.

If the authorised doctor who made the Treatment Authority is not a psychiatrist, an authorised psychiatrist must complete a second examination and decide whether to confirm or revoke the Treatment Authority. The second examination must be completed within three days. The Treatment Authority ends after three days if it is not confirmed or revoked.

When a Treatment Authority is made, the authorised doctor must determine whether the patient is to receive treatment as an inpatient or in the community. An authorised doctor may change the category of the Treatment Authority at any time during the person's treatment.

As a key safeguard patients subject to a Treatment Authority are regularly reviewed by the Mental Health Review Tribunal. The tribunal must confirm or revoke the Treatment Authority and may change the category of the Authority, limited community treatment arrangements or any other conditions of the Authority.

The tribunal is also responsible for reviewing patients on a Forensic Order or Treatment Support Order. Subject to the Act's requirements, the tribunal may revoke the Order and make a Treatment Authority for the person.

Treatment Authorities open as at 30 June 2019

Total Treatment Authorities	Community	Inpatient
5333	4392	941

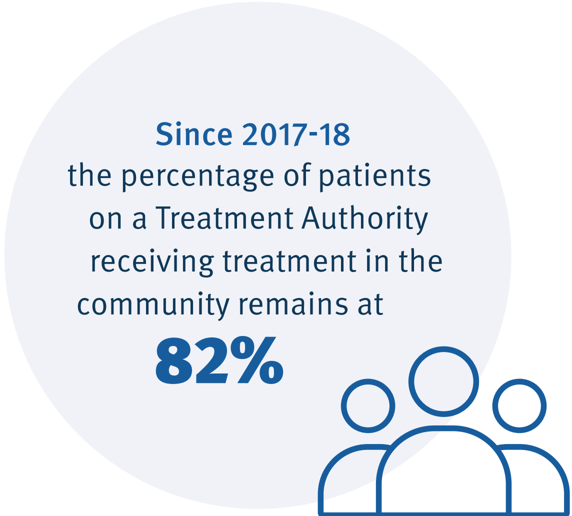


Table 5: Treatment Authorities made (1 July 2018 – 30 June 2019)

Authorised Mental Health Service	Treatment Authority made by		Category of initial order			Treatment Authority made by authorised doctor			
							Outcome of second examination		
	Authorised doctor	Mental Health Review Tribunal	Community	Inpatient	Total Treatment Authorities made	Second examination required	Treatment Authority confirmed	Treatment Authority not confirmed	Treatment Authority ended or revoked prior to second examination
Bayside	265	0	3	262	265	187	147	16	24
Belmont Private	53	0	1	52	53	2	2	0	0
Cairns	546	0	10	536	546	296	250	28	18
Central Queensland	224	0	7	217	224	158	128	23	7
Children's Health Queensland	75	0	2	73	75	57	26	9	22
Darling Downs	509	1	8	502	510	362	252	82	28
Gold Coast	1234	1	13	1222	1235	989	759	153	77
Greenslopes Private	0	0	0	0	0	0	0	0	0
Logan Beaudesert	601	0	38	563	601	421	325	44	52
Mackay	246	0	4	242	246	205	153	12	40
New Farm Clinic	23	0	0	23	23	14	14	0	0
Princess Alexandra Hospital	834	0	14	820	834	609	514	54	41
Princess Alexandra Hospital High Security	0	0	0	0	0	0	0	0	0
Redcliffe Caboolture	578	0	8	570	578	430	325	60	45
RBWH	1038	0	6	1032	1038	908	737	22	149
Sunshine Coast	510	0	33	477	510	251	204	40	7
The Park	0	0	0	0	0	0	0	0	0
The Park High Security	29	0	0	29	29	13	13	0	0
The Prince Charles Hospital	919	0	11	908	919	732	470	108	154
Toowong Private	14	0	0	14	14	0	0	0	0
Townsville	371	0	11	360	371	198	162	11	25
West Moreton	380	0	4	376	380	271	191	48	32
Wide Bay	313	0	8	305	313	237	171	37	29
Statewide	**8762**	**2**	**181**	**8583**	**8764**	**6340**	**4843**	**747**	**750**

A Treatment Authority is required to be revoked if the person no longer meets the treatment criteria or if there is a less restrictive way for the patient to receive treatment for their mental illness. A Treatment Authority may be revoked at any time by an authorised doctor or the Mental Health Review Tribunal.

As identified above, a Treatment Authority also ends if a second examination by an authorised psychiatrist is required, and the Treatment Authority is not confirmed or revoked by the psychiatrist within the three-day period.

In a very small number of circumstances, a Treatment Authority is made for a person who is already subject to an order or authority under the Act, and therefore the Treatment Authority is ended. This usually occurs in emergency situations where the Treatment Authority is made to ensure the person receives necessary treatment and care.

A Treatment Authority also ends if the Mental Health Court makes a Forensic Order (mental health) or Treatment Support Order for the patient or if the patient is transferred interstate or is deceased.

Table 6: Treatment Authorities ended (1 July 2018 – 30 June 2019)

Authorised Mental Health Service	Pre-existing involuntary status	Treatment Authority not revoked or confirmed within the timeframe	Treatment Authority revoked		Forensic Order made	Treatment Support Order made	Transfer interstate	Patient deceased	Total Treatment Authorities ended
			Authorised doctor	Mental Health Review Tribunal					
Bayside	0	7	242	5	1	0	0	0	255
Belmont Private	1	1	70	0	0	0	0	0	72
Cairns	2	6	460	11	7	0	0	3	489
Central Queensland	0	3	182	9	0	1	0	1	196
Children's Health Queensland	0	6	72	0	0	0	1	0	79
Darling Downs	1	10	510	4	3	0	1	2	531
Gold Coast	0	21	1064	17	2	1	2	8	1115
Greenslopes Private	0	0	0	0	0	0	0	0	0
Logan Beaudesert	0	27	567	6	3	0	0	7	610
Mackay	0	3	234	9	2	1	0	5	254
New Farm Clinic	0	1	35	0	0	0	0	0	36
Princess Alexandra Hospital	0	22	625	10	3	1	0	7	668
Princess Alexandra Hospital High Security	0	0	0	0	0	0	0	0	0
Redcliffe Caboolture	0	14	491	2	2	0	0	4	513
RBWH	3	35	805	10	4	0	0	8	865
Sunshine Coast	0	2	439	7	0	1	0	3	452
The Park	0	0	0	0	0	0	0	0	0
The Park High Security	0	0	16	1	12	0	0	1	30
The Prince Charles Hospital	0	55	873	4	1	0	0	1	934
Toowong Private	0	0	22	0	0	0	0	0	22
Townsville	0	4	342	0	2	0	0	4	352
West Moreton	0	7	388	4	4	3	0	3	409
Wide Bay	0	11	290	3	1	0	0	0	305
Statewide	**7**	**235**	**7727**	**102**	**47**	**8**	**4**	**57**	**8187**

Psychiatrist reports

The Chief Psychiatrist can direct that a psychiatrist report be prepared for a person charged with a serious offence[2]. The psychiatrist report provides an opinion on whether a person was of unsound mind at the time of the alleged offence and whether the person is fit for trial. A report may be used to inform a decision about referring a matter to the Mental Health Court and, if the matter is referred, to assist the court in its deliberations.

An involuntary patient charged with a serious offence (or someone on their behalf) is entitled to request a psychiatrist report at no cost. The Chief Psychiatrist will direct the report be prepared on confirming that legislative requirements are met.

The Chief Psychiatrist may also direct a psychiatrist report for a person if the Chief Psychiatrist believes it is in the public interest.

When a direction for a psychiatrist report has been given by the Chief Psychiatrist, criminal proceedings against the person in relation to the offence are suspended.

The Chief Psychiatrist may request a second psychiatrist report; for example, due to the complexity of the matters in the report. No second psychiatrist reports were directed in the reporting period.

An authorised psychiatrist has 60 days to complete the report. The Chief Psychiatrist may extend this timeframe for a further 30 days if required.

On receiving the psychiatrist report, the person or the person's lawyer may refer the matter to the Mental Health Court. The Chief Psychiatrist may also make a reference to the Mental Health Court if the report indicates the person may have been of unsound mind or is unfit for trial and there is a compelling reason in the public interest to refer the matter.

If no reference is made to the Mental Health Court within the timeframes specified in the Act, the criminal proceedings cease to be suspended.

Below is a summary of Chief Psychiatrist references to Mental Health Court for psychiatrist reports received in 2018-19, including reports directed in 2017-18. Table 7 reports on the application of psychiatrist report provisions however this data is limited to reports directed in 2018-19 only. Therefore a small variance is noted between these data sets for total reports received in the reporting period.

Psychiatrist reports received and Chief Psychiatrist references to Mental Health Court (1 July 2018 – 30 June 2019)

Total reports received in 2018/19	Referred to MHC		Not referred in MHC	
	From reports directed within 2018-19	From reports directed within 2017-18 but received 2018-19	From reports directed within 2018-19	From reports directed within 2017-18 but received 2018-19
275	71	20	150	34

[2] Serious offence includes offences such as arson, grievous bodily harm, indecent treatment, robbery, rape, serious assault and manslaughter but does not include offences such as common assault and most forms of wilful damage.

Table 7: Application of psychiatrist report provisions (1 July 2018 - 30 June 2019)

Authorised Mental Health Service	Occasions when person was eligible to request report	Direction for psychiatrist report		Direction for psychiatrist report revoked	Number of reports received in the reporting period
		On Chief Psychiatrist own initiative (public interest)	On request by patient or other		
Bayside	20	1	9	0	6
Belmont Private	0	0	0	0	0
Cairns	76	0	32	0	21
Central Queensland	60	0	25	4	12
Children's Health Queensland	1	0	0	0	0
Darling Downs	50	1	17	0	15
Gold Coast	91	0	23	1	17
Greenslopes Private	0	0	0	0	0
Logan Beaudesert	54	2	19	1	13
Mackay	40	0	25	1	23
New Farm Clinic	0	0	0	0	0
Princess Alexandra Hospital	60	0	12	0	5
Princess Alexandra Hospital High Security	0	0	0	0	0
Redcliffe Caboolture	31	0	15	0	12
RBWH	83	1	39	2	27
Sunshine Coast	47	1	22	3	15
The Park	3	0	2	0	0
The Park High Security	36	2	22	1	9
The Prince Charles Hospital	52	3	15	0	12
Toowong Private	0	0	0	0	0
Townsville	78	0	24	0	15
West Moreton	54	0	21	1	11
Wide Bay	12	1	8	0	8
Statewide	**848**	**12**	**330**	**14**	**221**

Forensic Orders

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

The court also determines the Order type:

» a Forensic Order (Mental Health) is made if the person's unsoundness of mind or unfitness for trial is due to a mental condition other than an intellectual disability, or if the person has a dual disability (a mental illness and an intellectual disability) and needs involuntary treatment and care for mental illness as well as care for the person's intellectual disability

» a Forensic Order (Disability) is made if the person's unsoundness of mind or unfitness for trial is due to an intellectual disability and the person needs care for the person's intellectual disability but does not need treatment and care for mental illness.

In addition, the court must decide if the patient requires treatment as an inpatient of an authorised mental health service or if the person can reside in the community. The court may decide the category is community only if there is not an unacceptable risk to the safety of the community because of the person's mental condition[3].

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

Table 8 shows total Forensic Orders made in 2018-19 including the initial category of the Order at the time it was made. Forensic Order data included in this report does not include Orders made for clients of the Forensic Disability Service. Information relating to the forensic disability service is provided in the Annual Report of the Director of Forensic Disability.

Forensic Orders open as at 30 June 2019

Total Forensic Orders	Forensic Order (Disability)		Forensic Order (Mental Health)	
	Community	Inpatient	Community	Inpatient
798	90	19	451	238

[3] A number of matters before the Mental Health Court in the reporting period were referred and therefore determined under the *Mental Health Act 2000*. Community category was not available under that Act however limited community treatment approval applied to authorise a person's residence in the community.

Table 8: Forensic Orders made (1 July 2018 – 30 June 2019)

Authorised Mental Health Service	Forensic Order (Disability)		Forensic Order (Mental Health)		Total Forensic Orders made
	Community	Inpatient	Community	Inpatient	
Bayside	0	0	2	0	2
Belmont Private	0	0	0	0	0
Cairns	0	0	6	6	12
Central Queensland	2	0	1	0	3
Children's Health Queensland	0	0	0	0	0
Darling Downs	0	0	3	1	4
Gold Coast	2	0	3	1	6
Greenslopes Private	0	0	0	0	0
Logan Beaudesert	1	0	2	4	7
Mackay	0	1	2	0	3
New Farm Clinic	0	0	0	0	0
Princess Alexandra Hospital High Security	0	0	0	0	0
Princess Alexandra Hospital	0	0	6	1	7
Redcliffe Caboolture	0	0	3	0	3
RBWH	1	0	1	3	5
Sunshine Coast	0	2	1	0	3
The Park	0	0	0	0	0
The Park High Security	0	1	1	12	14
The Prince Charles Hospital	0	0	3	2	5
Toowong Private	0	0	0	0	0
Townsville	0	0	5	3	8
West Moreton	2	0	4	1	7
Wide Bay	1	0	0	3	4
Statewide	**9**	**4**	**43**	**37**	**93**

The Mental Health Review Tribunal must review a person's Forensic Order every six months to decide whether to confirm or revoke the order.

If the tribunal revokes the Forensic Order, it may make a Treatment Support Order, a Treatment Authority or no further order.

If a Forensic Order results from a finding of temporary unfitness for trial and the tribunal subsequently finds that the person is fit for trial, the criminal proceedings against the person are recommenced. In this circumstance, the Forensic Order ends when the person appears before the court.

Table 9: Forensic Orders ended (1 July 2018 – 30 June 2019)

Authorised Mental Health Service	Forensic Order revoked		Patient found fit for trial	Patient transferred interstate	Patient deceased	Total Forensic Orders ended
	Treatment Support Order made	No other order made				
Bayside	3	0	0	0	0	3
Belmont Private	0	0	0	0	0	0
Cairns	2	1	0	1	1	5
Central Queensland	3	1	0	0	0	4
Children's Health Queensland	0	0	0	0	0	0
Darling Downs	2	0	0	0	0	2
Gold Coast	10	2	1	0	0	13
Greenslopes Private	0	0	0	0	0	0
Logan Beaudesert	8	0	0	1	1	10
Mackay	6	0	0	0	0	6
New Farm Clinic	0	0	0	0	0	0
Princess Alexandra Hospital High Security	0	0	0	0	0	0
Princess Alexandra Hospital	8	1	0	0	2	11
Redcliffe Caboolture	3	0	0	0	2	5
RBWH	1	0	0	0	0	1
Sunshine Coast	5	1	0	0	0	6
The Park	0	0	0	0	0	0
The Park High Security	0	1	1	0	0	2
The Prince Charles Hospital	5	1	0	0	0	6
Toowong Private	0	0	0	0	0	0
Townsville	3	1	0	1	1	6
West Moreton	8	0	1	1	0	10
Wide Bay	3	1	1	0	0	5
Statewide	**70**	**10**	**4**	**4**	**7**	**95**

Treatment Support Orders

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

A Treatment Support Order may also be made by the Mental Health Review Tribunal however this only applies in circumstances where the tribunal has revoked a Forensic Order for the person.

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

Treatment Support Orders open as at 30 June 2019

Total Treatment Support Orders	Community	Inpatient
187	177	10

Table 10: Treatment Support Orders made 1 July 2018 – 30 June 2019

Authorised Mental Health Service	Mental Health Court		Mental Health Review Tribunal		Total Treatment Support Orders made
	Community	Inpatient	Community	Inpatient	
Bayside	1	0	3	0	4
Belmont Private	0	0	0	0	0
Cairns	0	0	2	0	2
Central Queensland	2	0	3	0	5
Children's Health Queensland	0	0	0	0	0
Darling Downs	0	0	2	0	2
Gold Coast	1	1	10	0	12
Greenslopes Private	0	0	0	0	0
Logan Beaudesert	0	0	8	0	8
Mackay	1	0	6	0	7
New Farm Clinic	0	0	0	0	0
Princess Alexandra Hospital	2	0	8	0	10
Princess Alexandra Hospital High Security	0	0	0	0	0
Redcliffe Caboolture	1	0	1	0	2
RBWH	1	0	3	0	4
Sunshine Coast	1	0	5	0	6
The Park	0	0	0	0	0
The Park High Security	0	0	0	0	0
The Prince Charles Hospital	0	0	5	0	5
Toowong Private	0	0	0	0	0
Townsville	0	0	3	0	3
West Moreton	3	1	8	0	12
Wide Bay	1	0	3	0	4
Statewide	**14**	**2**	**70**	**0**	**86**

The tribunal must review a person's Treatment Support Order every six months to decide whether to confirm or revoke the Order. If the tribunal revokes the Treatment Support Order, it may make a Treatment Authority or no further order.

Similar to the provisions for Forensic Orders, if the Treatment Support Order was made due to a finding of temporary unfitness for trial and the tribunal subsequently finds that the person is fit for trial, the criminal proceedings against the person are recommenced and the Treatment Support Order ends when the person appears before the court.

Table 11: Treatment Support Orders ended 1 July 2018 – 30 June 2019

Authorised Mental Health Service	Order revoked - Treatment Authority made	Patient found fit for trial	Order revoked – no other order made	Patient deceased	Total Treatment Support Orders ended
Bayside	0	0	0	0	0
Belmont Private	0	0	0	0	0
Cairns	0	0	2	0	2
Central Queensland	0	0	0	0	0
Children's Health Queensland	0	0	0	0	0
Darling Downs	1	0	1	0	2
Gold Coast	1	1	4	0	6
Greenslopes Private	0	0	0	0	0
Logan Beaudesert	0	0	1	0	1
Mackay	0	0	0	0	0
New Farm Clinic	0	0	0	0	0
Princess Alexandra Hospital	0	0	1	0	1
Princess Alexandra Hospital High Security	0	0	0	0	0
Redcliffe Caboolture	0	0	0	0	0
RBWH	0	0	0	0	0
Sunshine Coast	0	0	4	0	4
The Park	0	0	0	0	0
The Park High Security	0	0	0	0	0
The Prince Charles Hospital	0	0	3	0	3
Toowong Private	0	0	0	0	0
Townsville	0	0	2	1	3
West Moreton	0	0	2	0	2
Wide Bay	0	0	1	0	1
Statewide	**2**	**1**	**21**	**1**	**25**

Seclusion

Seclusion is the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented. Seclusion significantly affects patient rights and liberty and therefore can only be authorised when it is the least restrictive option available to protect the patient and others from physical harm and all other reasonably practicable ways to prevent harm have been considered and/or attempted.

Under the Act, seclusion may only be used on an involuntary patient in an authorised mental health service who is subject to a Treatment Authority, Forensic Order or Treatment Support Order, or a person absent without permission from another state who is detained in an authorised mental health service.

The Office of the Chief Psychiatrist plays a key role in a proactive monitoring process introduced in 2018-19 for service and statewide data on key performance indicators, including seclusion. This process enhances the early identification of both high and low performance to inform statewide and local quality improvement efforts.

Table 12 represents the statewide clinical indicators for monitoring seclusion rates in Queensland including the number of seclusion events per 1,000 accrued admitted patient days in authorised mental health services, reported by acute and extended treatment settings.

Acute settings include authorised mental health services delivering mental health care to admitted patients, usually on a short to medium-term and intermittent basis.

Extended treatment settings include authorised mental health services delivering mental health care to admitted patients over a long-term period and involve a specialist rehabilitation component to care. This includes high secure mental health services providing specialised treatment for high risk mental health patients. At times, seclusion rates may see an upward trend in high secure settings due to the complex needs of particular patients receiving treatment and care within these services.

Table 12: Seclusion statewide clinical indicators – five-year trend[4]

Setting	Indicator	2014-15	2015-16	2016-17	2017-18	2018-19
Acute	Seclusion events per 1,000 bed days	11.1	9.0	7.6	6.0	7.1
	Proportion of episodes with one or more seclusion events	4.8%	3.8%	3.1%	2.5%	2.8%
	Average (mean) duration of seclusion events (hours)	6.4	3.8	2.7	4.9	3.2
Extended	Seclusion events per 1,000 bed days	17.6	19.2	28.5	33.1	29.1
	Proportion of episodes with one or more seclusion events	7.1%	5.7%	7.0%	10.2%	9.4%
	Average (mean) duration of seclusion events (hours)	9.0	11.5	9.0	10.0	11.8

[4] From July 2018, a new methodology was applied to clinical indicators to improve alignment with system wide reporting and enable more accurate reporting across different service types (for example, identification of secure mental health rehabilitation units). All indicators across the five-year period have been updated using the new methodology to ensure 'like' comparison of data and therefore some variance may be noted from previous reports.

Seclusion may be authorised by an authorised doctor for up to three hours and for no more than nine hours in a 24-hour period. If required to be extended beyond this time, continued seclusion may be approved under a reduction and elimination plan.

If required, a 12-hour extension of seclusion may be authorised to allow a reduction and elimination plan to be prepared for the patient. This must be approved by a clinical director in the authorised mental health service. An extension of seclusion may only be granted once for each period of the admission in which the patient requires acute management.

The data provided in Table 13 includes all authorisations made for seclusion, including those made under a reduction and elimination plan. High security authorised mental health services reported a higher rate of seclusion authorisations in 2018-19 due to the complex needs of particular patients. The Chief Psychiatrist monitors seclusion rates across the state and is working closely with authorised mental health services to identify strategies for reducing the use of seclusion as a therapeutic intervention.

Table 13: Seclusion Authorisations (1 July 2018 – 30 June 2019)

Authorised Mental Health Service	Seclusion Authorisations				Extension of seclusion	
	Doctor	Emergency	Total Authorisations	Total patients	Total Extension Authorisations	Total patients
Bayside	30	24	54	21	0	0
Belmont Private	2	1	3	2	0	0
Cairns	42	63	105	46	0	0
Central Queensland	26	32	58	31	2	2
Children's Health Queensland	40	8	48	17	0	0
Darling Downs	82	140	222	93	1	1
Gold Coast	295	31	326	61	1	1
Greenslopes Private	0	0	0	0	0	0
Logan Beaudesert	258	147	405	93	1	1
Mackay	30	103	133	42	1	1
New Farm Clinic	0	0	0	0	0	0
Princess Alexandra Hospital	109	186	295	80	0	0
Princess Alexandra Hospital High Security	0	0	0	0	0	0
Redcliffe Caboolture	180	167	347	73	0	0
RBWH	162	173	335	118	0	0
Sunshine Coast	27	41	68	32	0	0
The Park	611	39	650	27	0	0
The Park High Security	13965	112	14077	51	1	1
The Prince Charles Hospital	267	90	357	68	2	2
Toowong Private	0	0	0	0	0	0
Townsville	134	60	194	40	0	0
West Moreton	134	48	182	34	0	0
Wide Bay	13	29	42	23	0	0
Statewide	**16407**	**1494**	**17901**	**952**	**9**	**9**

Mechanical Restraint

Mechanical restraint is the restraint of a person by the application of a device to the person's body, or a limb of the person to restrict the person's movement. Mechanical restraint does not include the appropriate use of a medical or surgical appliance in the treatment of physical illness or injury, or restraint that is authorised or permitted under another law.

The decision to use mechanical restraint is a last resort to prevent imminent and serious harm to the patient or another person, and only after alternative strategies have been trialled or appropriately considered and excluded. Mechanical restraint can only be used if there is no other reasonably practicable way to protect the patient or others from physical harm.

Mechanical restraint is closely monitored by the Chief Psychiatrist. All applications for approval to use mechanical restraint must be sent to the Chief Psychiatrist as soon as mechanical restraint is proposed. In urgent circumstances verbal approval from the Chief Psychiatrist may be given and the application is sent as soon as possible after the verbal approval is received.

Once approved by the Chief Psychiatrist, mechanical restraint may be authorised by an authorised doctor for up to three hours. Mechanical restraint may occur for no more than nine hours in a 24-hour period but may be continued beyond this time if approved under a reduction and elimination plan.

A Chief Psychiatrist approval for the use of mechanical restraint may be in place for up to seven days. Multiple events may be authorised under a single approval or alternately, no events may occur under the approval if determined that mechanical restraint is no longer required.

Table 14: Mechanical restraint approvals and events (1 July 2018 – 30 June 2019)

Authorised Mental Health Service	Number of approvals	Number of patients	Number of events
Bayside	0	0	0
Belmont Private	0	0	0
Cairns	0	0	0
Central Queensland	0	0	0
Children's Health Queensland	0	0	0
Darling Downs	0	0	0
Gold Coast	0	0	0
Greenslopes Private	0	0	0
Logan Beaudesert	0	0	0
Mackay	5	2	10
New Farm Clinic	0	0	0
Princess Alexandra Hospital	3	2	3
Princess Alexandra Hospital High Security	0	0	0
Redcliffe Caboolture	0	0	0
RBWH	0	0	0
Sunshine Coast	0	0	0
The Park	0	0	0
The Park High Security	21	6	39
The Prince Charles Hospital	4	3	6
Toowong Private	0	0	0
Townsville	1	1	1
West Moreton	0	0	0
Wide Bay	0	0	0
Statewide	**34**	**14**	**59**

Reduction and elimination plans

A reduction and elimination plan outlines measures to be taken to proactively reduce use of seclusion or mechanical restraint on a patient by ensuring clinical leadership, monitoring, accountability and a focus on safe alternative interventions.

A reduction and elimination plan must be in place for any patient that is secluded or mechanically restrained for more than nine hours in a 24-hour period and is recommended practice in all other instances where a patient is secluded or mechanically restrained.

A single reduction and elimination plan may apply to either mechanical restraint or seclusion or both, however seclusion and restraint are not permitted to be used simultaneously.

An individual patient may have multiple plans approved during the reporting period. Reduction and elimination plans are valid for no longer than seven days at which time clinical review of the patient occurs if a further plan is required.

Table 15: Reduction and elimination plans approved (1 July 2018 – 30 June 2019)

Authorised Mental Health Service	Mechanical restraint		Seclusion		Seclusion and mechanical restraint		Total Plans approved	
	Plans	Patients	Plans	Patients	Plans	Patients	Plans	Patients
Bayside	0	0	2	2	0	0	2	2
Belmont Private	0	0	0	0	0	0	0	0
Cairns	0	0	6	5	0	0	6	5
Central Queensland	0	0	6	6	0	0	6	6
Children's Health Queensland	0	0	0	0	0	0	0	0
Darling Downs	2	2	4	4	0	0	6	6
Gold Coast	0	0	24	19	0	0	24	19
Greenslopes Private	0	0	0	0	0	0	0	0
Logan Beaudesert	0	0	43	31	0	0	43	31
Mackay	6	2	17	12	0	0	23	14
New Farm Clinic	0	0	0	0	0	0	0	0
Princess Alexandra Hospital	2	2	26	23	0	0	28	25
Princess Alexandra Hospital High Security	0	0	0	0	0	0	0	0
Redcliffe Caboolture	0	0	16	10	0	0	16	10
RBWH	0	0	5	5	0	0	5	5
Sunshine Coast	0	0	8	8	0	0	8	8
The Park	0	0	49	15	0	0	49	15
The Park High Security	0	0	451	46	34	5	485	46
The Prince Charles Hospital	4	3	30	16	0	0	34	19
Toowong Private	0	0	0	0	0	0	0	0
Townsville	3	2	11	9	0	0	14	10
West Moreton	0	0	10	6	0	0	10	6
Wide Bay	0	0	0	0	0	0	0	0
Statewide	**17**	**11**	**708**	**217**	**34**	**5**	**759**	**227**

Electroconvulsive Therapy

Electroconvulsive Therapy (ECT) is a treatment for mental illness which involves the application of an electric current to specific areas of the head to produce a generalised seizure, which is modified by general anaesthesia and the administration of a muscle relaxing agent. ECT is a highly effective treatment with a strong evidence base, particularly for the treatment of severe depressive disorders, mania, schizophrenia and catatonia. ECT may be recommended for treatment of a person's mental illness in some acute situations when other treatments have been ineffective or when ECT has worked well previously.

In Queensland, ECT is performed at a range of facilities and settings. These include public and private hospitals in metropolitan and regional centres. A significant proportion of patients receive day procedure ECT as outpatients. However, ECT may only be performed in an authorised mental health service, declared under the Act.

ECT is a regulated treatment under the Act and may only be given:

- with informed consent – if the person is an adult, or
- with the approval of the Mental Health Review Tribunal – if the person is a minor or if the person is an adult who is unable to give informed consent.

An application for ECT must include any views, wishes and preferences the person has expressed about the therapy in an Advance Health Directive or at other times or in other documents.

In some circumstances, emergency ECT may be necessary to save the person’s life or to prevent the person from suffering irreparable harm. In these circumstances, a Certificate to Perform Emergency ECT may be made for an involuntary patient which enables ECT to be administered prior to the matter being determined by the Mental Health Review Tribunal.

Table 16: Applications to perform ECT made to the Mental Health Review Tribunal (1 July 2018 – 30 June 2019)

Authorised Mental Health Service	Treatment Application only	Emergency Certificates issued	Total Treatment Applications
Bayside	9	5	14
Belmont Private	17	4	21
Cairns	13	2	15
Central Queensland	14	1	15
Children's Health Queensland	1	0	1
Darling Downs	17	1	18
Gold Coast	70	7	77
Greenslopes Private	0	0	0
Logan Beaudesert	20	6	26
Mackay	6	0	6
New Farm Clinic	2	1	3
Princess Alexandra Hospital	47	16	63
Princess Alexandra Hospital High Security	0	0	0
Redcliffe Caboolture	10	5	15
RBWH	81	13	94
Sunshine Coast	38	7	45
The Park	3	0	3
The Park High Security	10	1	11
The Prince Charles Hospital	24	12	36
Toowong Private	4	2	6
Townsville	5	0	5
West Moreton	9	3	12
Wide Bay	12	2	14
Statewide	**412**	**88**	**500**

Patient absence without approval

Arrangements may be made under the Act for a patient who is absent without approval to be returned to an authorised mental health service or a public-sector health service facility. Unless risks in doing so are identified, reasonable efforts must be made to contact and encourage the patient to attend or return to an authorised mental health service or public-sector health service facility voluntarily. If the patient is not willing or able to return to the service voluntarily, an Authority to Transport Absent Person (ATAP) may be issued. An ATAP authorises the patient to be returned by a health practitioner, ambulance officer or, if necessary to ensure the safe transportation and return of the patient, a police officer.

Of the 2,630 ATAPs issued in the reporting period, 1,589 were in relation to patients residing in the community who were required to return to an authorised mental health service (e.g. a patient has become unwell or has failed to attend a scheduled appointment).

The remaining 1,041 ATAPs issued include the following categories and are represented in Table 17:

- failed/required to return from Limited Community Treatment (LCT): A patient failed to return or was required to return from approved LCT (i.e. leave) or temporary absence
- absconded from mental health unit: a patient absconded from an inpatient mental health unit
- absconded – other: a patient absconded from another unit (e.g. emergency department, community mental health facility) or while being transported between authorised mental health services.

Table 17 includes ATAPs issued for six Treatment Authority patients who were also classified patients at the time of the absence. Notification processes are in place to ensure timely and appropriate management of patients absent without approval, including immediate notification of classified patient absences to the Clinical Director of the relevant service and the Chief Psychiatrist. In 2018-19, the Chief Psychiatrist reviewed recommendations made from investigations and HHS reviews relating to classified patient absence. The Office of the Chief Psychiatrist continues working closely with authorised mental health services to support implementation of recommendations aimed at reducing patient absence without approval and management of classified patients and is considering options for statewide application of recommendations where appropriate.

Table 17: Authorities to Transport Absent Patients (ATAPs) issued (1 July 2018 – 30 June 2019)

Authorised Mental Health Service	Involuntary Assessment	Treatment Authority	Treatment Support Order	Forensic Order	Other*	Total ATAPs
Bayside	10	33	0	2	0	45
Belmont Private	0	1	0	0	1	2
Cairns	8	71	0	22	9	110
Central Queensland	14	47	0	4	0	65
Children's Health Queensland	1	4	0	0	0	5
Darling Downs	7	27	0	7	0	41
Gold Coast	7	114	1	8	1	131
Greenslopes Private	0	0	0	0	0	0
Logan Beaudesert	25	77	0	14	3	119
Mackay	3	20	1	5	1	30
New Farm Clinic	0	0	0	0	0	0
Princess Alexandra Hospital	3	49	1	6	1	60
Princess Alexandra Hospital High Security	0	0	0	0	0	0
Redcliffe Caboolture	5	44	0	4	1	54
RBWH	1	45	0	6	0	52
Sunshine Coast	8	44	0	20	1	73
The Park	0	7	0	8	0	15
The Park High Security	0	0	0	1	0	1
The Prince Charles Hospital	8	51	0	5	1	65
Toowong Private	0	0	0	0	0	0
Townsville	6	59	0	27	2	94
West Moreton	9	39	1	11	0	60
Wide Bay	3	10	0	5	1	19
Statewide	**118**	**742**	**4**	**155**	**22**	**1041**

*'Other' includes patients on another type of order such as a Judicial Order and persons detained for the purpose of making a Recommendation for Assessment.

Appendix 1. Abbreviations

Abbreviations – Authorised Mental Health Services

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
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 Hospital	Princess Alexandra Hospital Authorised Mental Health Service
Princess Alexandra Hospital High Security	Princess Alexandra Hospital High Security Program Authorised Mental Health Service
Redcliffe Caboolture	Redcliffe Caboolture Authorised Mental Health Service
RBWH	Royal Brisbane and 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 Hospital	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

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