Evaluation of the

Mental Health Act 2016 implementation

Evaluation report | April 2019

Queensland Government

Evaluation of the *Mental Health Act 2016* implementation | Evaluation Report
April 2019

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

For more information contact:
Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch, Department of Health, GPO Box 48, Brisbane, QLD 4001, email mha2016@health.qld.gov.au, phone 3328 9899.

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

Table of contents

1. Executive summary

The *Mental Health Act 2016* (MHA 2016) commenced on 5 March 2017, replacing the *Mental Health Act 2000* (MHA 2000) which had been in operation for over 10 years.

Although the MHA 2016 maintained the key structures established by the MHA 2000 (including the Mental Health Court (MHC), authorised mental health services (AMHSs), and the Mental Health Review Tribunal (MHRT)), a number of significant reforms were introduced which required major implementation efforts from the mental health sector, and the organisations that interact with the sector, to prepare for commencement. Due to these significant implementation efforts, a commitment was made to undertake an evaluation of the implementation of the MHA 2016 (the evaluation), within two years of its commencement. The evaluation was conducted by the Mental Health Alcohol and Other Drugs Branch (MHAODB) in the Department of Health and commenced in July 2017. This report will be provided to the Chief Psychiatrist, members of the Inter-departmental Executive Committee (IDEC) responsible for monitoring the implementation of the MHA 2016, and others involved in the administration of the Act.

The evaluation considered:

- the implementation of key new initiatives of the MHA 2016; and
- the change management processes associated with implementing the MHA 2016.

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

This report: describes MHA 2016 implementation activities; summarises the evidence of the extent to which key initiatives of the MHA 2016 were achieved in its first full year of operation (2017-18), where possible this was compared with the last full year of operation of the MHA 2000 (2015-16); reports performance across key areas of the MHA 2016; and makes findings to inform ongoing monitoring and/or enhancements to the operation of Queensland's new mental health legislative scheme.

This report is not intended to provide general activity reporting about the operation of the MHA 2016. Information and performance data is available in the *Chief Psychiatrist Annual Report 2017-2018*.

The evaluation found the implementation of the MHA 2016 was generally effective; the new provisions included in the Act are operating as intended and supporting less restrictive ways and patient rights focused treatment and care. Key outcomes of the changes as a result of the MHA 2016 include:

- To support patients and their support persons to understand their rights under the MHA 2016, new independent patient rights advisers (IPRAs) engaged in 12,356 interactions with patients and/or support persons, and provided 18,859 service delivery activities in 2017-18.
- As a result of a more robust examination and assessment application process, the MHRT made 440 examination authorities in 2017-18, compared with 1,261 justice examination orders made in 2015-16 (during the last full year of the MHA 2000's operation).

- In line with updated treatment criteria in the MHA 2016, which aim to better support individual rights, a treatment authority (TA) may only be made if there is no less restrictive way for the person to receive treatment and care for the person's mental illness. In 2017-18, 8,016 TAs were made, representing a slight reduction from the previous two years (8,147 and 8,152 were made in 2016-17 and 2015-16 respectively).
- In line with safeguards introduced by the new regulatory framework for the use of physical restraint, 2,067 physical restraint events occurred in 2017-18. The regulation of physical restraint ensures it is only used when necessary, and if required, done in an appropriate way that is safe, managed and monitored. This is the first time physical restraint has been systematically recorded in Queensland mental health settings.
- For minors, there was a 53 per cent reduction in the number of seclusion events (down from 295 events in 2015-16, to 139 events in 2017-18) and a 42 per cent reduction in the number of associated minors (down from 91 minors in 2015-16, to 53 minors in 2017-18). The average number of seclusion events per minor reduced by 19 per cent, from an average of 3.2 seclusion events per minor in 2015-16 to an average of 2.6 seclusion events per minor in 2017-18.
- Magistrates are using their new powers to make decisions about whether the person was of unsound mind at the time of an offence, or is unfit to stand trial. In 2017-18, 413 simple offence matters were dealt with in the Magistrates Court, rather than the MHC. One hundred and twenty-eight matters were dismissed because a Magistrate was satisfied the person was either of unsound mind when the offence was allegedly committed, or unfit for trial, and 285 matters were adjourned due to a person's temporary unfitness for trial.
- The expanded Court Liaison Service (CLS) is operating effectively and plays a critical role in supporting Magistrates to make decisions through the provision of medico-legal reports on unsoundness of mind and unfitness for trial. In 2017-18, the CLS received 9,164 referrals (including paper-based triage processes) for mental health assessments of adults (n 8,351) and children and youth (n 813).
- The more targeted psychiatrist report regime introduced by the MHA 2016 resulted in 106 psychiatrist reports being received under the new provisions for patients charged with a serious offence in 2017-18. In 2015-16, 1,745 mandatory psychiatrist reports were received, for patients charged with any offence, by the former Director of Mental Health. This represents a 94 per cent reduction in the total number of psychiatrist reports developed.
- In 2017-18, 63 references to the MHC were made by the Chief Psychiatrist following receipt of a psychiatrist report. In 2015-16, the former Director of Mental Health made 188 references to the MHC. This represents a 66 per cent reduction in the number of references to the MHC by the Chief Psychiatrist following a psychiatrist report.
- The MHRT revoked 95 forensic orders (FOs) and replaced them with a treatment support order (TSO) in 2017-18. Ninety-two of these TSOs were made with a community category, allowing these patients to receive treatment in the community, rather than as an inpatient.
- Legal representation was provided at no cost to patients at 2,541 MHRT hearings in 2017-18, including 157 hearings involving minors.

Because the evaluation considered a limited data set (for the reporting period 2017-18, the first full year of operation of the MHA 2016), preliminary results indicate that for some improvements

and changes envisaged by the MHA 2016 it is too early to see any substantive change or make definitive findings. The following areas have shown little change or require more time for the policy intent of the changes to be realised:

- The number of FOs made in 2017-18 (n 105), was similar to the number of FOs (n 118) made in 2015-16. It is anticipated new powers for Magistrates to deal with simple offences and the ability for the MHC to make TSOs where appropriate, may result in a reduction in the number of FOs made.
- As at 30 June 2018, 13 per cent (n 720) of involuntary patients had one or more nominated support persons (NSPs) appointed, compared to 18 per cent (n 948) of involuntary patients with an allied person as at 4 March 2017. The report notes the new NSP process left a gap for patients with long term loss of capacity, who are unlikely to be able to appoint a NSP. Uptake of NSPs will continue to be monitored.

While the evaluation found that the MHA 2016 was effectively implemented and is supporting less restrictive ways and patient rights focused treatment and care, three themes emerged which require further action: targeted training and education, refined performance outcome monitoring, and improved data quality and analysis.

To support improvements across these areas, the Chief Psychiatrist will work with hospital and health services (HHSs) and other stakeholders to consider the best way to address areas of concern.

The Chief Psychiatrist continues to monitor the operation of the MHA 2016 and address practice issues as they arise.

2. Review of the MHA 2000

The MHA 2016 is one of the most complex legislative frameworks in the health portfolio. Development of the MHA 2016 was informed by a comprehensive review, commencing in June 2013 with the public release of Terms of Reference which framed the directions of the legislative reform. Further community input was sought through release of a Discussion Paper in May 2014 outlining the policy proposals, and a consultation draft Bill in May 2015.

Widespread stakeholder consultation was undertaken throughout the review process. This included meetings, workshops and forums held across the State at key points, as well as consideration of over 300 written submissions. An extensive range of stakeholders were engaged in the process, including mental health patients and their carers, mental health and general health service providers, victims of offenders who were dealt with under the MHA 2000, legal and health professional organisations, the judiciary, a broad range of government and non-government agencies, statutory bodies and officers, and members of the wider community with an interest in mental health care. These stakeholders made an invaluable contribution to the review.

Collaboration with stakeholders was also an important aspect of the practice changes required by the MHA 2016 to ensure readiness for its significant reforms. While led by the Department of Health, the success of implementation was largely attributed to partnerships with HHSs and

collaboration with other government agencies and statutory bodies/officers directly impacted by the new legislation. Consultation with patients and carers was equally critical in ensuring the operation of new initiatives was effective and addressed the intent of the MHA 2016 principles.

The MHA 2016 was passed by the Queensland Legislative Assembly on 18 February 2016 and commenced on 5 March 2017, repealing the MHA 2000. Commencement followed a 12 month implementation project.

3. Project description

The MHA 2016 resulted in major changes to the delivery of mental health services in Queensland. It is critical that the significant investment made by government in the implementation of the MHA 2016 is evaluated to ensure its effectiveness and identify opportunities for improvement.

Connecting care to recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services (Connecting care to recovery 2016-2021) provides the current framework for future action and investment for state-funded mental health alcohol and drug system. Strengthening patient rights under the MHA 2016 is one of five priorities under *Connecting care to recovery 2016-2021* and includes three key service initiatives which required monitoring and evaluation as part of the implementation. The timely roll out of these initiatives was critical for commencement of the MHA 2016:

- Establishment of a network of IPRAs, with a statewide coordinator and 28 IPRA positions at public AMHSs across the State.
- Significant expansion of the Queensland Health CLS for adults and children, with 32 additional clinical and administrative positions to support new Magistrate functions under the MHA 2016.
- The provision of legal representation at specific MHRT hearings at no cost to the patient, through Legal Aid Queensland (LAQ).

Additionally, as part of the development of the MHA 2016, the Department of Health committed to reviewing a number of key initiatives within two years of the commencement:

- Legislative provisions relating to the less restrictive way and in particular the safeguards available to persons receiving treatment and care in AMHSs under an AHD, or with the consent of an attorney and/or guardian.
- Legislative provisions applicable to patients in regional, rural and remote areas, particularly regarding assessing a person subject to a recommendation for assessment, and reviewing a TA if not made by a psychiatrist.
- The IPRA model and its implementation in HHSs.
- The implementation of the provisions in the MHA 2016 that enable Magistrates to dismiss charges on the basis of unsoundness of mind or unfitness for trial, including the effectiveness of the CLS.

4. Evaluation focus

Key evaluation questions and measures have been mapped to ensure a spread of measures across a range of different evaluation elements or domains. These domains include effectiveness, efficiency and process and are broadly mapped across key areas of the new MHA 2016; however, the key evaluation areas of the MHA 2016 may align to more than one evaluation domain.

The measures were assessed using a range of qualitative and quantitative data sources. Quantitative data were collected primarily from the MHA 2016 module of the Consumer Integrated Mental Health Application (CIMHA), as well as data collections held by HHSs, the Queensland Forensic Mental Health Service (FMHS), the Queensland Police Service (QPS), Queensland Ambulance Service (QAS), the Department of Justice and Attorney-General (DJAG), the Department of Communities, Disability Services and Seniors (DCDSS), and statutory authorities such as the MHC, the MHRT and the Office of the Public Guardian. Qualitative data were collected through stakeholder surveys, meetings, forums and workshops, as well as through audits and descriptive reviews.

Consultation on the evaluation measures was undertaken through a range of approaches including consideration by relevant stakeholder reference groups comprised of service providers, statutory authorities, and patient and carer representatives. These reference groups include the MHA 2016 IDEC, the MHA 2016 Implementation Committee, and the MHAODB auspiced Senior Leadership Group.

The evaluation considered how the objectives and principles of the new legislation have been applied, and whether key changes to the legislative scheme have been effectively implemented. The key changes were considered as follows:

- **Implementation:** Whether the change management processes associated with implementation were effective, particularly the readiness of HHSs.
- **Processes:** Whether processes for patient rights and less restrictive ways have been improved through implementation of the MHA 2016, including through increased used of alternatives to involuntary treatment (for example, AHDs and SDMs) and patient involvement in treatment decisions.
- **Efficiency:** Whether enhancements within the court processes have resulted in the appropriate diversion of individuals from the criminal justice system.

4.1 Scope and limitations

The scope of the evaluation was the operational implications of the implementation of the changes introduced by the MHA 2016. The evaluation was not intended to be a review of the provisions of the Act, the operation of the Act or compliance with the Act. The purpose of the evaluation was to consider how the policies, set by government with the commencement of the MHA 2016, had been implemented. The evaluation did not seek to review these policies, or to consider alternatives to the policies. This approach was taken with due regard to the extensive process of review which had occurred over the four years prior to the introduction of the MHA 2016. For this reason, a review of other jurisdictional practices, and national and international literature was not undertaken other than where it directly related to findings relating to improving operational capabilities.

Although other reforms relevant to the delivery of mental health services in Queensland occurred concurrently with, or after, implementation of the MHA 2016, the evaluation was limited to the impact of the new policies implemented by the MHA 2016 and the associated implementation and change management processes. Other reforms and initiatives relevant to the delivery of mental health services in Queensland include: *Our Future State: Advancing Queensland's Priorities* suicide prevention and reduction strategies, and work to consider improvement to Queensland's forensic disability service system. Any implementation activities arising from the evaluation will be considered in the context of these initiatives.

5. Data sources and methods

Qualitative and quantitative data sources were used to evaluate the implementation of the MHA 2016. Data outcomes in this report are displayed at a statewide level. In some circumstances a breakdown of individual AMHS data is provided, where relevant.

Quantitative data were extracted from the Mental Health Act module in CIMHA by the MHAODB Clinical Systems, Collections and Performance Unit. More than 62 CIMHA reports were extracted and analysed by the evaluation team, and where possible data was checked against available external data sets held by other government agencies, statutory authorities or individual HHSs. Where available, performance of the MHA 2016 was compared between the first full year of its operation (2017-18) and the final full year of operation of the MHA 2000 (2015-16).

Qualitative data were collected through community forums, targeted stakeholder surveys, meetings and submissions from stakeholders, the *Your Experience of Service* (YES) surveys undertaken in October and November 2016 (during the last year of operation of the MHA 2000) and October and November 2017 (after commencement of the MHA 2016) and the pilot of the *Carer Experience Survey* (CES) undertaken alongside the 2017 YES survey.

Community consultation included two forums for patients, carers and support networks held in Brisbane and Townsville. Surveys were also distributed and made available to community members via the evaluation website targeted at the following groups:

Group	Number of participants/ responses	Survey participant completion rate
Patients, carers, support persons and family members	38	89.5%
Advocates, legal representatives and other service providers	54	88.9%
Victims of persons with mental illness	15	87.5%
Magistrates Court legal sector	104	90.5%

Surveys seeking views on the change management process for implementation, IPRAs, and the Assessment and Risk Management Committee (ARMC) were distributed to HHS staff:

Implementation area	Number of participants/ responses	Survey participant completion rate
Change management and implementation	292	82.5%
IPRAs	46	69.6%
ARMC	113	86.7%

6. Implementation activities

6.1 Information, education and training

Preparation for the implementation of the MHA 2016 involved significant work to ensure staff readiness for the provisions of the new Act.

Information and updates were distributed to staff using various mechanisms including internal Queensland Health email communications (for example, DG Connect and e-alerts), an implementation newsletter, memorandums, meetings, workshops, the Queensland Health Intranet Spotlight, the Department of Health internet site, posters, messages from the Minister for Health (video and email), and letters.

Administrators and administrator delegates in AMHSs also played an integral role in implementing the MHA 2016 locally by ensuring delivery of education and training to staff, developing and delivering local resources, and ensuring the compliance, data and record-keeping requirements of the new Act were met. Key contacts and champions were also appointed in HHSs to assist with implementation.

Comprehensive competency-based education and training packages were developed, including the Queensland Health iLearn MHAE-C modules for authorised doctors, psychiatrists and authorised mental health practitioners (AMHPs), and the Queensland Centre for Mental Health Learning (QCMHL) *QC13 Capacity Assessment (face-to-face workshop)* and *QC40 MHA 2016 Capacity Assessment Training and Advance Health Directives (eLearning)* modules commissioned by Queensland Health.

The QCMHL modules were commissioned to deliver online and face-to-face education and training sessions and resources specific to the capacity assessment and AHD provisions of the MHA 2016.

As at 30 June 2018, 4,058 Queensland Health staff had completed the iLearn module for AMHPs and 1,076 had completed the module for authorised doctors and psychiatrists since they were made available in early 2017. In addition, 185 people external to Queensland Health completed the module for AMHPs and 203 people completed the module for authorised doctors and psychiatrists. This cohort of people is likely to be staff from private sector AMHSs and members of the public.

Competency-based iLearn training on the MHA 2016 was delivered to **1,076 authorised doctors and psychiatrists** and **4,058 authorised mental health practitioners** (as at 30 June 2018)

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

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

Tables 1 and 2 provide an overview of workshops delivered by QCMHL, and the number of participant completions for each module by HHS as at 30 June 2018.

Table 1. QC13 Capacity Assessment (face-to-face) workshop

HHS	Workshops delivered	Participants
Cairns and Hinterland	2	20
Central Queensland	2	34
Mackay	1	13
Metro North	2	24
Metro South	1	14
South West	1	4
Sunshine Coast	3	33
Torres and Cape	2	12
West Moreton	4	38
Total	**18**	**192**

Table 2. QC40 – MHA 2016 Capacity Assessment Training and Advance Health Directives (eLearning)

HHS	Capacity module completions	AHD module completions
Cairns and Hinterland	27	23
Central Queensland	123	113
Central West	3	3
Children's Health Queensland	11	8
Darling Downs	123	106
Gold Coast	234	217
Mackay	222	208
Metro North	427	394
Metro South	70	53
North West	7	7
Other	63	58
South West	13	12
Sunshine Coast	299	285
Torres and Cape	2	1
Townsville	44	38
West Moreton	70	56
Wide Bay	201	198
Total	**1939**	**1780**

Note: 'Other' includes people from private sector AMHSs, interstate government departments, non-government organisations, other Queensland Government departments, universities and other tertiary institutions (for example, TAFE).

Training remains available to staff working within the mental health sector across the range of professional streams and statutory roles including nursing, allied health professionals, doctors, mental health practitioners and psychiatrists.

The Office of the Chief Psychiatrist continues to regularly liaise with AMHSs to assist with change management, including through regular feedback to clinical and executive directors at Senior Leadership Group meetings; administrator delegate forums; Chief Psychiatrist newsletters; and regular meetings with the MHRT.

Other agencies also undertook training and implementation activities. Notably, QPS developed the *Vulnerable Persons Training Package* comprising online learning products and face-to-face workshops to increase police officers' knowledge and understanding about the changes arising from the MHA 2016.

6.2 Consumer Integrated Mental Health Application (CIMHA)

CIMHA, the statewide mental health clinical information system, is the designated patient record for the purposes of the MHA 2016. CIMHA underwent extensive enhancements to support the MHA 2016 and to capture information required for monitoring and reporting purposes.

Improving business efficiency was a key objective in the system redevelopment. Some of the more significant enhancements include enabling an interface between CIMHA and the Queensland Courts, CIMHA and MHRT information systems (currently pending MHRT system enhancements), and the creation of intelligent forms and templates to improve accuracy and reduce data entry burden.

Another key development was a module for recording AHDs and appointed SDMs and ensuring the information is now also available to other health services through The Viewer, a web based application that sources key patient information from a number of Queensland Health enterprise clinical and administrative systems.

Training for mental health service staff was conducted across the State to support implementation of the system enhancements.

To improve standardised processes for the completion of MHA 2016 forms and CIMHA data entry across all AMHSs, the Office of the Chief Psychiatrist is currently reviewing and updating the *Administrator Delegates Manual – Mental Health Act 2016*. This review is intended to resolve identified practice issues by providing greater guidance and direction to administrator delegates responsible for data entry and record-keeping.

6.3 Working groups and committees

From early 2016, a number of working groups were established to support the implementation of the MHA 2016.

6.3.1 Inter-departmental Executive Committee (IDEC)

The IDEC was established to facilitate inter-departmental dialogue to ensure that sound and timely decisions regarding MHA 2016 implementation issues were made by senior officers from key government agencies, and to ensure the resolution of issues in support of the implementation of the MHA 2016. Membership comprises the Department of Health, QPS, DJAG, the Children's Health Queensland (CHQ) HHS, the Queensland Mental Health Commission (QMHC), the Office of the Public Guardian, the Department of the Premier and Cabinet, and DCDSS. The terms of reference for the IDEC were expanded to include consideration of the evaluation.

6.3.2 *Less Restrictive Ways Project* expert reference group

The *Less Restrictive Ways Project* expert reference group was established from April to June 2018 to support the *Less Restrictive Ways Project*. The reference group provided direction and expert input into the development of resources for clinicians in mental health for statewide distribution and use. See paragraph 7.5.1.1 for more information regarding the *Less Restrictive Ways Project*.

6.3.3 Court Liaison Service (CLS) steering group

A CLS steering group was established to provide a forum for discussion, resolution of issues and expert advice in relation to the implementation of the provisions of the MHA 2016 regarding the Magistrates Court. The group was made up of representatives from the Queensland Magistrates Court, QMHC, Office of the Director of Public Prosecutions, LAQ, Aboriginal and Torres Strait Islander Legal Service, Queensland Law Society, Queensland Bar Association, QPS prosecutions, the Public Guardian and government stakeholders.

6.3.4 Classified Patient Committee (CPC)

The CPC was established to support the operation of the MHA 2016. It provides a forum for discussion, review and resolution of issues, and advice about the Chief Psychiatrist policies for the transportation, admission, treatment and care, and return of classified patients.

6.3.5 Tri-Agency Absent without Approval (AWA) Committee

The Tri-Agency AWA Committee was established in July 2017 to embed statewide processes that support the effective cross-agency operation of the MHA 2016 in relation to patients absent without approval.

6.4 Collaborative partnerships

The implementation, and ongoing administration, of the MHA 2016 involves significant collaboration and information sharing processes with relevant agencies, including the Office of the Public Guardian, QPS, QAS, LAQ, and DCDSS. The Department of Health is currently working with QPS, Queensland Corrective Services, and the Parole Board to develop memorandums of understanding for information sharing processes that support the operation of the MHA 2016.

6.5 Policies and practice guidelines

The MHA 2016 enables the Chief Psychiatrist to make policies that are binding on any person who performs a function under the MHA 2016. In preparation for the commencement of the MHA 2016, the Chief Psychiatrist developed 38 policies and practice guidelines. All policies and practice guidelines were made available to Queensland Health staff in February 2017 and published online from 5 March 2017. The Office of the Chief Psychiatrist continues to monitor and refine policies and practice guidelines as necessary to address policy issues as they arise.

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

6.6 Amendments to the MHA 2016

Since its enactment, a number of clarifying amendments have been made to the MHA 2016 in response to issues identified during implementation planning and since commencement.

6.6.1 Statements made by a person during assessment and examination – *Mental Health Amendment Act 2017*

The *Mental Health Amendment Act 2017* amended the MHA 2016 to clarify that oral and written statements made by a person:

- during an assessment regarding unsoundness of mind or fitness for trial; and
- during an examination conducted pursuant to a Magistrates Court examination order

are not admissible in evidence against the person in any criminal or civil proceeding.

The *Mental Health Amendment Act 2017* also made a number of clarifying and technical amendments to the MHA 2016 and the *Public Health Act 2005* to address issues identified during preparation for implementation of the MHA 2016. These amendments ensured the MHA 2016 and relevant provisions in the *Public Health Act 2005* operate as intended.

These amendments took effect from commencement of the MHA 2016 on 5 March 2017. See paragraph 7.8.1.6.1.1 for more information regarding these amendments.

6.6.2 Classified patients period of detention – *Hospital Foundations Act 2018*

The *Hospital Foundations Act 2018* amended the MHA 2016 to:

- clarify that the period of detention a person serves in an AMHS under the MHA 2016 is counted as a period of imprisonment or detention for a custodial sentence;
- clarify that only time spent on an inpatient category order is counted as a period of imprisonment or detention, and, for example, time spent on a community category order will not be counted; and
- enable government agencies to share information about the pre-sentence custody of an inpatient in an AMHS in certain circumstances.

These amendments took effect from 29 March 2018. However, the provisions relating to time counted as a period of detention or imprisonment retrospectively apply from 5 March 2017.

7. Evaluation results, conclusions and interpretation

7.1 Change management

Two hundred and ninety-two staff representing the majority of AMHSs and a variety of professional streams responded to the change management survey developed to inform the evaluation. These included administration officers, AMHS administrators and administrator

delegates, authorised doctors including psychiatrists, AMHPs, consumer consultants, carer consultants, court liaison officers, educators, executive and senior management, forensic liaison officers, Indigenous health and mental health workers, IPRAs, the MHRT coordinator, mental health information managers, MHA 2016 implementation project officers, policy and project officers, recreation officers, and treating team staff (including case managers, medical, nursing and allied health staff) and team leaders. Table 3 provides the breakdown of survey participants, by AMHS.

representing the majority of authorised mental health services, and a variety of professional streams,

responded to the survey.

Table 3

AMHS	Number of participants
Bayside	8
Belmont Private	1
Cairns Network	15
Central Queensland Network	2
Children's Health Queensland	38
Darling Downs Network	29
Gold Coast	16
Greenslopes Private	1
Logan Beaudesert	12
Mackay	1
New Farm Clinic	0
Princess Alexandra Hospital	23
RBWH	32
Redcliffe Caboolture	17
Sunshine Coast Network	11
The Park	4
The Park High Security Program	2
The Prince Charles Hospital	16
Toowong Private	5
Townsville Network	18
West Moreton	17
Wide Bay	18
Other	6
Total	**292**

A summary of survey findings is provided below.

7.1.1 Information and updates

Ninety-six per cent of survey respondents felt information and updates about the incoming MHA 2016 were effectively communicated to mental health services and stakeholders. At a local level, 76 per cent of respondents agreed that training and education about the MHA 2016 was a priority for staff within their HHS prior to commencement. Sixty-four per cent of respondents had access to a key contact/champion within their HHS.

At the time of the survey (October/November 2017), 60 per cent of respondents indicated training and education about the MHA 2016 were still available within their HHS.

7.1.2 Readiness for commencement

Overall, 51 per cent of survey participants reported that implementation activities (including training and education tools) assisted them to feel moderately to well prepared prior to commencement of the MHA 2016. When asked how prepared they generally felt at the time of the survey (October/November 2017) to perform their role under the MHA 2016, the proportion of respondents who felt moderately to well prepared had increased to 76 per cent.

	Not at all prepared	Slightly prepared	Moderately prepared	Well prepared	Not applicable
Prior to commencement	11%	21%	34%	17%	17%
October/November 2017	3%	21%	49%	27%	-

7.1.3 Training and education needs

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

Respondents nominated a number of areas as requiring training and education for stakeholders involved in the provision of care and treatment to patients under the MHA 2016. These included MHA 2016 forms, AHDs and capacity, processes for patients who are absent without approval, attorneys and guardianship, CLS, ARMC, CIMHA, interagency liaison - QPS and QAS, emergency examination authorities, TSOs, MHRT – role and requirements, and minors.

7.1.3.1 Queensland Centre for Mental Health Learning (QCMHL)

QCMHL provided feedback regarding its training courses, including some of the early and ongoing clinician needs following the implementation of the MHA 2016, which may assist in developing

future training strategies and identifying key areas requiring practical support. The QCMHL submission provided a summary of issues identified by QCMHL staff through training and support roles, and key themes from the evaluation of training programs.

Feedback from training participants at the capacity assessment workshop identified an increase in participant confidence in all areas, including capacity assessment in the context of the MHA 2016, determining matters of capacity, and identifying decision makers under the MHA 2016. In addition, the following informal feedback was identified by QCMHL during the delivery of this workshop:

- More in-depth discussion and questions around capacity and involuntary treatment is occurring in the training. This has been useful for clinicians, and has prompted reflection about less restrictive ways of meeting patient needs.
- Discussion around accessing and using the AHD allowed for patient rights to be explored in more detail.
- Clinicians want more clarity about how and where to document capacity assessment for different decisions.
- Some practice issues associated with the implementation of the MHA 2016 have created challenges. For example, people who were under involuntary treatment orders (ITOs) under the MHA 2000 and were transitioned to TAs under the MHA 2016 may have lost their decision making/advocacy supports, since the allied person role ceased and the provisions of the MHA 2016 require a person to have capacity to appoint a NSP.
- Finding MHA-related resources can be a challenge, for example, difficulty locating the AHD form on the MHA 2016 website.

7.2 Improved patient rights and support

While the provisions for the support and protection of involuntary patients under the MHA 2000 afforded positive outcomes for patients, the review of the MHA 2000 identified scope to strengthen patient rights and protections. In recognition of this, the protection of patient rights is a paramount consideration under the MHA 2016 and extensive safeguards are included to ensure the protection of patient rights at all stages of involuntary treatment and care, and to strengthen the rights of family, carers, and other support persons.

A range of resources were developed to assist patients, families, carers and other support persons to understand the MHA 2016, including the development of a *Statement of Rights*, brochures and forms relating to AHDs and NSPs, and associated explanatory material. HHSs had a lead role in facilitating awareness and understanding amongst patients and support persons at the local level. In addition, Aged and Disability Advocacy Australia (ADA Australia) and Queensland Advocacy Incorporated (QAI) were funded to deliver consumer and carer education relating to AHDs across the State.

7.2.1 New nominated support person (NSP) provisions

The principles of the MHA 2016 establish that support persons are to be involved in decisions about treatment and care to the greatest extent practicable (subject to the patient's right to

privacy). While this principle applies broadly, the MHA 2016 also makes provision for a patient to nominate one or two people to support them in their treatment and care if they are, or become, an involuntary patient under the Act. The patient's NSPs receive all notices required to be given to the patient under the MHA 2016, can discuss confidential information with the treating team, and can support or represent the patient at MHRT hearings.

As at 30 June 2018, six per cent (n 1,201) of all mental health patients (n 20,272) had one or more NSP. When the MHA 2000 was repealed, 1,187 of all mental health patients had an allied person. Of the 5,715 involuntary patients as at 30 June 2018, 13 per cent (n 720) had one or more NSP. On 4 March 2017, prior to the commencement of the MHA 2016, 18 per cent (n 948) of the existing 5,147 involuntary patients had an allied person.

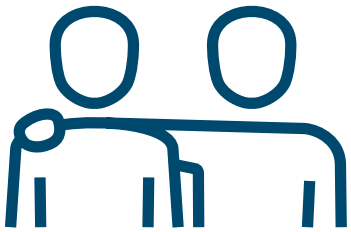
While the number of all mental health patients with a registered support person has increased since the commencement of the MHA 2016, the number of involuntary patients as at 30 June 2018 with one or more NSPs was lower than the number of patients who had an allied person when the MHA 2000 was repealed. This may be due to a variety of factors including that the role of allied person did not automatically transfer to that of NSP under the MHA 2016. Additionally, the introduction of the need for a patient to have capacity to appoint a NSP (a reform aimed at strengthening patient rights) contrasts with the previous requirement under the MHA 2000 for an administrator to appoint an allied person if one was not already appointed, and the administrator is satisfied a patient did not, at the time, have capacity to appoint one.

Stakeholders indicated that the requirement for capacity was a barrier to a NSP being appointed for patients. It is expected the number of NSPs will grow during the life of the MHA 2016 as patients gain capacity to appoint a NSP of their own accord, and the NSP provisions are discussed with patients by treating teams and IPRAs.

Ninety-two per cent (n 5,237) of the 5,715 involuntary patients as at 30 June 2018 had one or more key contact recorded in their CIMHA record. The MHA 2016 NSP process has left a gap for patients with long term loss of capacity, who are unlikely to be able to appoint a NSP. While a patient without capacity will not be able to appoint a NSP, they are still able to be supported by other support persons.

In line with the provisions made for NSPs and in recognition of the crucial role they play in supporting patients throughout all stages of treatment, care and recovery, the evaluation considered the number of MHRT hearings attended by NSPs during 2017-18. In total, 847 hearings were attended by a NSP. While this equates to seven per cent of the total number of MHRT hearings in 2017-18 (n 12,335), the MHA 2016 allows a person who is the subject of an MHRT proceeding to be represented by a NSP, a lawyer or another person, and supported by another member of a person's support network.

HHSs may improve uptake of NSPs by looking for opportunities to discuss the NSP provisions with patients, including when a patient regains capacity. HHSs may also consider alternative approaches for patients with long term loss of capacity, including improvements to support person involvement for patients who do not have an appointed NSP.



During 2017-18,

nominated support persons

attended

847 MHRT hearings, which represents seven per cent of all MHRT hearings during the period.

7.2.2 Patient and carer experiences

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

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

A comparison of data obtained from the 2016 (MHA 2000) and 2017 (MHA 2016) Queensland Health YES surveys found that under the MHA 2000, 77 per cent of involuntary patients stated their experience of having their rights and responsibilities explained to them was either good, very good or excellent, and 23 per cent stated their experience was poor or fair. Under MHA 2016, 79 per cent stated their experience was either good, very good or excellent, and 21 per cent stated their experience was poor or fair. While this represents only a slight increase in satisfaction under the MHA 2016, this indicates that rights and responsibilities continue to be explained to a high proportion of involuntary patients. Additionally, the 2017 pilot CES survey which canvassed the experiences of carers within mental health services found that on average carers rated their experience of understanding their rights and responsibilities as 4.4 out of 5.

The 2016 YES survey also found that under MHA 2000, 82 per cent of involuntary patients stated they usually or always had opportunities for their family and carers to be involved in their treatment and care if they wanted, and 18 per cent stated they never, rarely or sometimes had opportunities. By comparison, the 2017 YES survey identified that under MHA 2016, 83 per cent stated they usually or always had opportunities, and 17 per cent stated they never, rarely or sometimes had opportunities. The 2017 pilot CES survey also found that on average:

- carers rated their experience of being involved in decisions affecting their family member, partner or friend as 4.3 out of 5;
- carers rated their experience of being given the opportunity to discuss the care, treatment and recovery of their family member, partner, or friend (even, if for reasons of confidentiality, they could not be told specific information) as 4.5 out of 5; and
- carers rated their experience of being involved in the planning for the ongoing care, treatment and recovery of their family member, partner or friend as 4.5 out of 5.

Additionally, the 2016 YES survey found that under the MHA 2000, 82 per cent of involuntary patients stated their opinions about the involvement of their family or friends in their care were usually or always respected and 18 per cent stated their opinions were never, rarely, or sometimes respected. The 2017 YES survey identified 83 per cent stated their opinions were usually or always respected and 17 per cent stated their opinions were never, rarely, or sometimes respected. While these numbers remained consistent over the survey periods the evaluation considered that over 80 per cent of patients stating their opinions were usually or always respected was a positive outcome in relation to the level of importance the role of family and support persons is given.

7.3 Independent patient rights advisers (IPRAs)

All health practitioners operating under the MHA 2016 must provide patients and their support persons with information and assist them to understand their rights. In line with the intent to strengthen patient rights under the MHA 2016, 28 IPRA positions were created to assist public AMHSs across the State to support patients to understand and exercise their rights. To support this significant reform, a statewide IPRA network, comprising all IPRAs, was established to facilitate sharing of resources and consistent service delivery across the State. A statewide coordinator is appointed to provide support and leadership for the IPRA network. The statewide coordinator reports directly to the Chief Psychiatrist.

A key function of the IPRA role is to ensure patients and their NSPs, family, carers and other support persons are aware of their rights under the MHA 2016, including to assist with liaison between clinical teams, patients and support persons. To ensure the independence of the role, the MHA 2016 requires each chief executive responsible for public sector mental health services to employ one or more IPRAs through direct employment within a HHS (however not within the service's mental health service) or through contract arrangements with a non-government organisation.

7.3.1 Allocation of resources

The total number of IPRAs located within AMHSs depends on the population of each HHS region, with some regions sharing an IPRA with a neighbouring HHS. A total of 28 full-time IPRA positions are funded across the State. During the 2017-18 period, on average 24 IPRA positions were filled. Table 4 outlines the number of funded IPRA positions and appointments as at 30 June 2018, and the line management arrangements set out for each HHS including smaller HHSs which receive IPRA service provision from a larger network identified as (+ name of HHS).

Table 4

HHS	Funded IPRA FTEs	IPRA appointments	Line management area
Cairns and Hinterland (+ Torres and Cape)	2	2	Legal Services, Medical Services
Central Queensland (+ Central West)	2	2	Rural and District-wide Services
Children's Health Queensland	1	1	Medical Services
Darling Downs (+ South West)	2	2	Media and Communications
Gold Coast	3	3	Safety Governance and Risk Management
Mackay	1	1	Human Resources and Engagement
Metro North / Metro South	10	6	Aftercare
Sunshine Coast	2	2	Safety, Quality and Innovation
Townsville (+ North West)	2	2	Clinical Governance
West Moreton	2	2	Clinical Governance
Wide Bay	1	1	Clinical Governance
Total	**28**	**24**	

Note: Metro North / Metro South HHS IPRAs are employed by the non-government sector (Aftercare).

7.3.2 Implementation

Forty-six staff representing all HHSs and a variety of professional streams, predominantly comprising IPRAs (n 20), IPRA line managers (n 7), and purchasers of IPRA services (n 1), responded to the IPRA survey developed to inform the evaluation. Feedback indicates that the implementation of the IPRA role across the State has been somewhat inconsistent, with some uncertainty about how IPRA functions are to be undertaken. The identified inconsistencies are attributed to varying approaches to rights advice, IPRA documentation, and data collection.

Feedback also indicated there are concerns regarding processes for engagement between HHSs and the Department of Health and the Office of the Chief Psychiatrist; staffing resources for IPRAs; inconsistent reporting mechanisms and requirements across HHSs; limited ability of some IPRAs to gain access to CIMHA; and limited ability of IPRAs to attend the MHRT.

With regard to the establishment of the IPRA role within HHSs, IPRA line managers and purchasers of IPRA services consistently stated in their feedback that the IPRA role was working well and that they felt the role was very important for mental health patients and mental health staff to better understand patient rights under the MHA 2016.

Other stakeholders provided feedback that IPRAs were invaluable because: they facilitate positive collaboration across the treating team to identify less restrictive ways; they play a key role in building capacity of others to understand patient rights and support clinicians to follow up outstanding issues for patients; and they provide a valuable referral option where a patient has questions or concerns about their treatment which would benefit from an IPRA supported conversation with the patient's treating team. However, some stakeholders raised concerns that there was still a lack of understanding by patients, HHS staff, clinicians and non-government mental health service providers regarding the IPRA role.

7.3.2.1 Training and support for IPRAs

IPRAs who participated in the evaluation survey (n 20) provided the below feedback in relation to their feelings of readiness to perform their role, and need for future education and training:

- Fifty-seven per cent stated they felt the Queensland Health iLearn MHA 2016 online training module helped them to feel moderately to well prepared when they started in their role as an IPRA and 62 per cent said the same for the QCMHL training modules. Twenty-nine per cent stated they felt the CIMHA training workshops helped them to feel moderately to well prepared when they started in the IPRA role, 45 per cent stated the question was not applicable to them;
- Ninety per cent of IPRAs stated they felt moderately to well prepared to perform the functions of their role at the time of the survey (November/December 2017) and identified AHDs and capacity; attorneys and guardianship; ARMC; engaging IPRAs; CLS; absence without approval; provisions relating to assessing and treating patients in regional, rural and remote areas; MHA 2016 forms; and CIMHA as areas of focus of future training and education for stakeholders involved in the provision of care and treatment to patients under the MHA 2016.

The IPRA network routinely participates in a number of education and training activities, including:

- value based practice within mental health;
- stakeholder presentations and workshops were delivered to: Queensland Voice; Association of Relatives and Friends of the Mentally Ill (ARAFMI); the Office of the Public Guardian; statewide advocacy services (QAI, ADA Australia, and LawRight); the MHRT; LAQ; and Queensland Health (Forensic Mental Health, Cultural Capability Unit, and CHQ);
- complex case discussions; and
- IPRA operational workshops.

There are a number of regular statewide IPRA meetings and working groups in place to provide ongoing training and support opportunities:

Statewide meetings	Fortnightly IPRA peer support meetings (informal and voluntary)
	Monthly statewide IPRA Network meetings
Working groups	IPRA working group (policy)
	IPRA Information Advisory Committee
	IPRA Data / Reporting Working Group
	IPRA Aboriginal and Torres Strait Islander group

7.3.3 Service provision

There are centralised IPRA support processes and resources, including consistent spreadsheets to capture file notes and service delivery activities, which have been shared between IPRAs across the State. HHSs manage ongoing issues through local issue registers and escalation processes. Despite this, the evaluation identified that there is scope for processes for HHS engagement with the Office of the Chief Psychiatrist and others under the MHA 2016 regarding patient rights issues to be clarified.

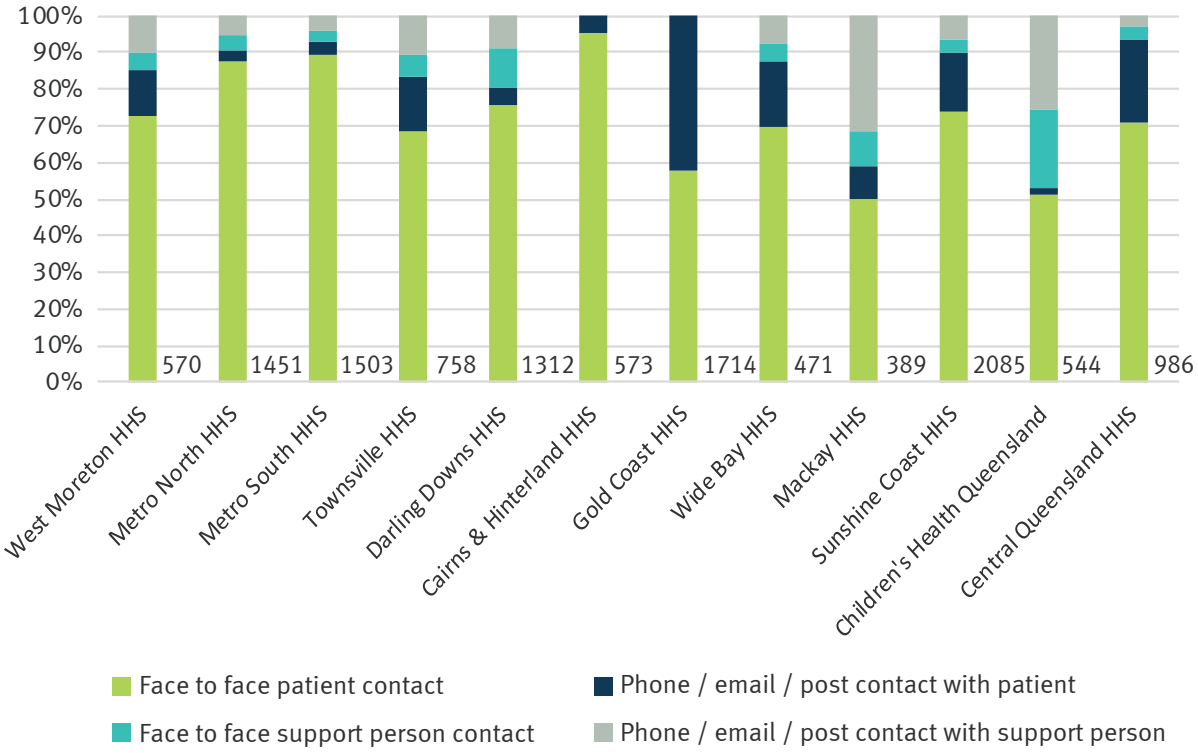
To support service delivery, patient rights videos were released in late 2018. West Moreton HHS was funded to develop and design these videos. Videos are used across all HHSs and may be accessed online on a patient's mobile device, on HHS tablets (via a patient rights app), and on local HHS smart televisions. This model allows HHSs to send SMS messages to patients enclosing a link to the videos, or suggest patients download the patient rights app to view the videos on their mobile devices.

In 2017-18, IPRAs provided advice to 6,987 patients through 12,356 interactions and 18,859 service delivery activities with patients and/or support persons. Seventy-six per cent of interactions occurred within an inpatient unit and 39 per cent of initial interactions occurred within the first five days of a patient's service episode. The average amount of time spent with a patient and/or support person was 31 minutes.

Feedback from survey responses provided during the survey of patients, carers and support persons in November/December 2017 identified that 45 per cent of the 38 respondents were unaware of the IPRA role and 13 per cent had discussed their experiences of the MHA 2016 with an IPRA.

Figure 1 provides a breakdown of patient and/or support person interactions (n 12,356) across HHSs. The data provided in Figure 1 is not intended to be a comparison of performance, but is provided as a guide as to where patient and support person interactions are happening across HHSs.

Figure 1. Count of patient and/or support person interactions by HHS (2017-18)



Note: There may be an overlap in these figures where patients and support persons were seen together.

Figure 2 provides the timing of initial IPRA interactions with patients during their service episode (2017-18).

Figure 2. Timing of interactions with patients (2017-18)

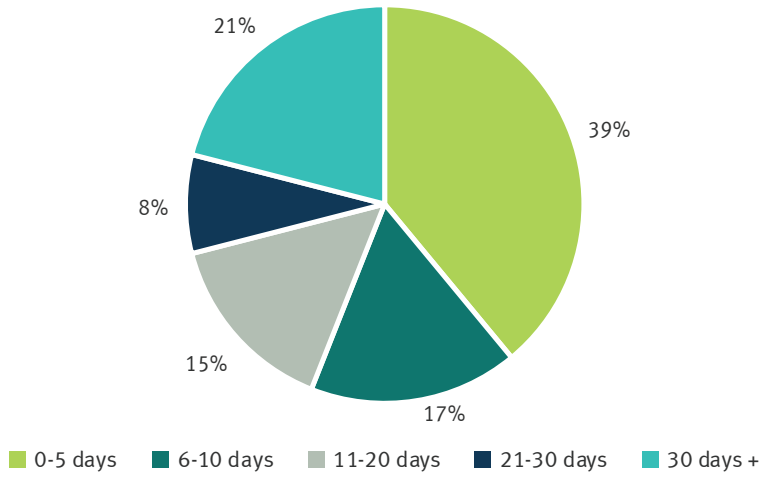
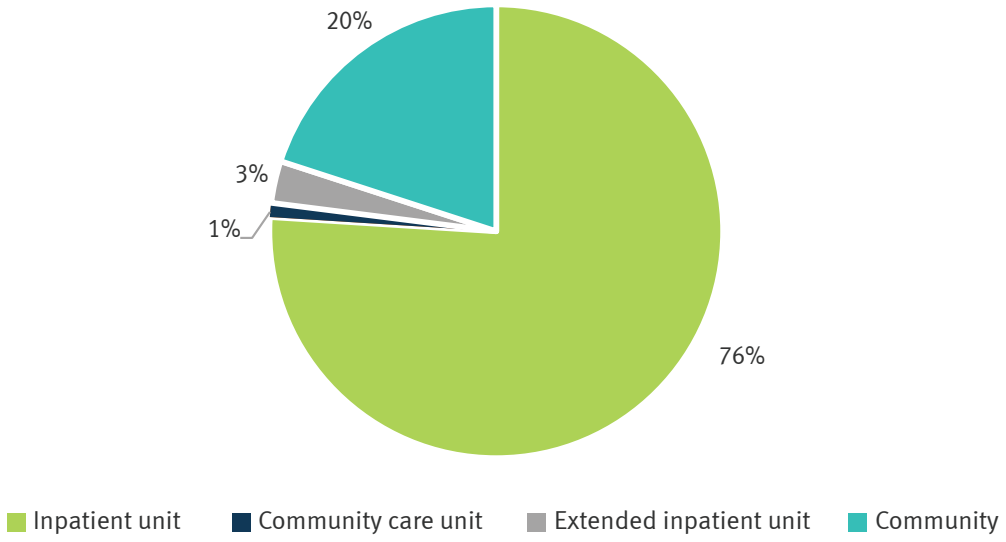


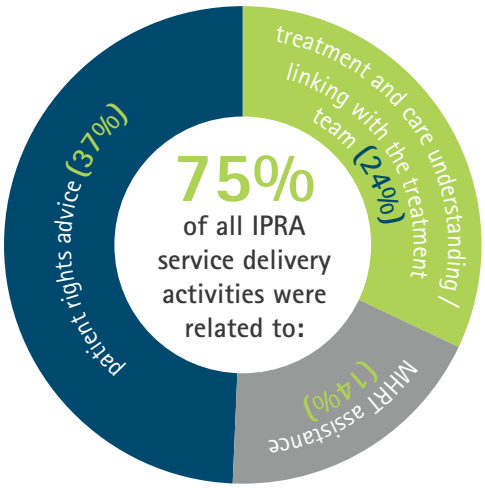
Figure 3 provides a breakdown of locations where IPRAs interacted with patients (2017-18).

Figure 3. Location of interactions with patients (2017-18)



With regard to the 18,859 service delivery activities provided by IPRAs, 75 per cent of these interactions were in relation to the following service areas (per cent of all activity):

- patient rights advice (37 per cent);
- treatment and care understanding and linking with the treating team (24 per cent); and
- MHRT assistance (14 per cent of all activity).



The top five common themes identified by IPRAs during their day to day work with patients and support persons, were (including per cent of all activity):

- explanation of treatment plan and discharge plan (10 per cent);
- leave conditions (10 per cent);
- medication issues (9 per cent);
- link patient with treating team (9 per cent); and
- MHRT issues (9 per cent).

The Department of Health committed to reviewing the IPRA model and its implementation in HHSs within two years of the commencement of the MHA 2016. While limited, the available data

suggests that HHSs have successfully implemented the IPRA model, and no significant changes are required to the model. While HHSs are continuing to develop capacity to support the IPRA role and embed a patient rights focus, some work needs to be done to explore service delivery outcomes and performance reporting for the model to determine the impact of the IPRAs in HHSs. The Office of the Chief Psychiatrist will continue to work with the statewide coordinator to monitor IPRA activity and governance to inform any future changes to the operation of the IPRA model, formalise IPRA reporting mechanisms, and explore IPRA service delivery outcomes.

7.4 Simplified examination and assessment processes

The provisions leading to the involuntary treatment of persons with a mental illness under the MHA 2000 were complex. The provisions of the MHA 2016 are intended to strengthen the rights of mental health patients and improve health service delivery by simplifying and more clearly defining the steps required to commence involuntary examination and assessment of a person.

Specifically, the justice examination order (JEO) and emergency examination order (EEO) provisions of the MHA 2000 have been replaced in the MHA 2016 with the examination authority (EA) and emergency examination authority (EEA) provisions.

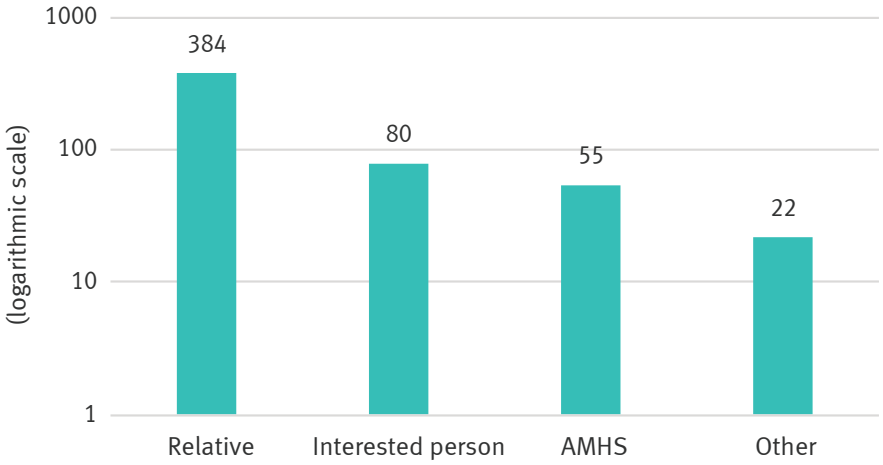
7.4.1 Examination authorities (EAs)

The MHA 2000 enabled any member of the community to apply to a Justice of the Peace or Magistrate to have another person involuntarily examined for a mental illness through a JEO. Although rarely relied upon, this process was subject to complaints of inappropriate and vexatious use. The MHA 2016 introduced more robust processes for the making of EAs which simplified the statutory involuntary examination and assessment process, and intended to strengthen patient rights and improve health service delivery. An EA is applied for through the MHRT on an approved form, which must include a statement by a doctor or AMHP about whether the circumstances of the person may be grounds for making the EA.

During 2017-18, the MHRT finalised 552 EA applications (including 541 applications made in 2017-18 and 11 applications made in 2016-17). As a result of the more robust examination and assessment application process, the MHRT made 440 EAs in 2017-18 (The *Chief Psychiatrist Annual Report 2017-2018* provides a breakdown of EAs by AMHS), compared with 1,261 JEOs made in 2015-16 (during the last full year of the MHA 2000's operation). Of the 440 EAs that were made, 40 per cent resulted in a TA being made for the patient (n 175), compared to a conversion rate of 24 per cent under the MHA 2000.

Applications were received from a range of stakeholders including family members, interested parties, AMHSs, and other applicants. Figure 4 provides a breakdown of applications received (n 541) by applicant type.

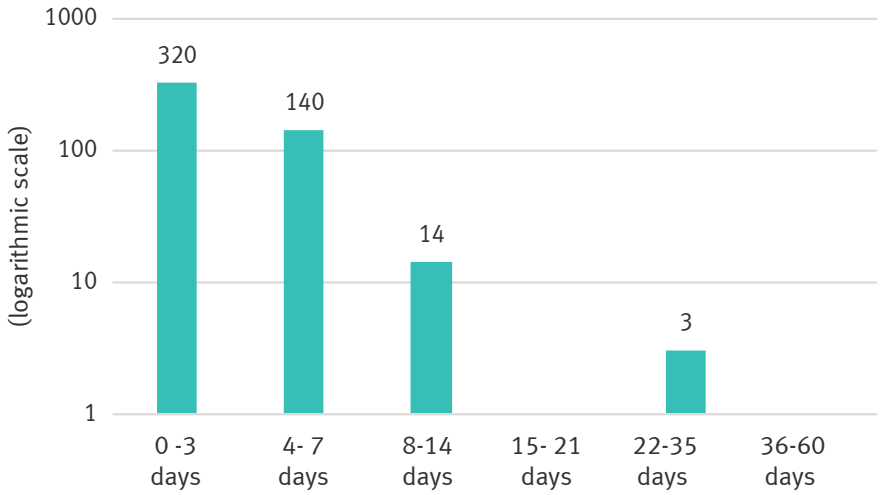
Figure 4. EA applications received by MHRT by applicant type (2017-18)



Note: 'Other' category includes, for example QPS, QAS, ex-partners and neighbours.

Of the 552 applications finalised, 80 per cent (n 440) resulted in an EA being issued (involving 414 patients). A further 13 per cent (n 75) of applications were withdrawn and seven per cent (n 37) were refused. Of the 477 applications where an EA was either issued or refused by the MHRT, 67 per cent (n 320) were decided within three days from the receipt of the application. Figure 5 provides a breakdown of all decision timeframes.

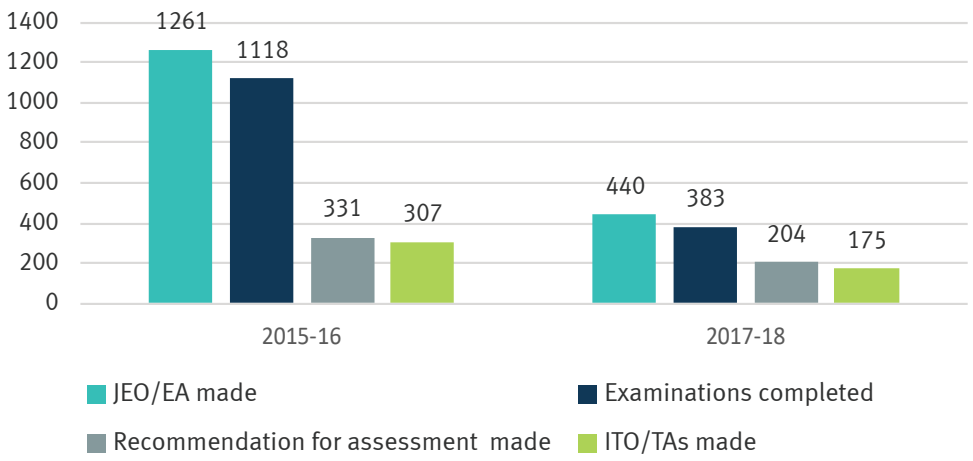
Figure 5. Time taken by MHRT to issue or refuse an EA application from date of receipt (2017-18)



Once issued, an EA is in force for seven days. Of the 440 EAs issued, 383 examinations took place within this timeframe (the average timeframe was 4.5 days from MHRT decision to examination) and 57 EAs expired before an examination could take place. Of the 383 examinations that occurred, 204 resulted in a recommendation for assessment, and 179 resulted in no recommendation for assessment being made.

Of the 204 recommendation for assessments made, 175 proceeded to a TA. Twenty-nine did not proceed to a TA, as either one or more of the treatment criteria no longer applied, or the involuntary assessment ceased, expired or was revoked. Figure 6 provides a comparison between 2015-16 and 2017-18 of the conversion of the number of JEOs/EAs issued, the number of recommendations for assessment made and the number of recommendations for assessment that converted to ITOs/TAs.

Figure 6. Comparison of conversion rate from JEO/EA issued - to examination - to recommendation for assessment - to ITO/TA made - 2015-16 and 2017-18



While there has been a 65 per cent reduction in the number of JEOs/EAs made, roughly the same proportion are resulting in a completed examination (89 per cent in 2015-16 and 87 per cent in 2017-18). Additionally, there has been an increase in the proportion of JEOs/EAs that resulted in a recommendation for assessment: 26 per cent of JEOs in 2015-16 and 46 per cent of EAs in 2017-18. There has also been a significant increase in the proportion of JEOs/EAs that resulted in an ITO or TA being made: in 2015-16, 24 per cent of JEOs made resulted in an ITO being made, and in 2017-18, 40 per cent of EAs that were made resulted in a TA being made for the patient. This suggests that the more robust examination and assessment process is resulting in a more targeted application of EAs.

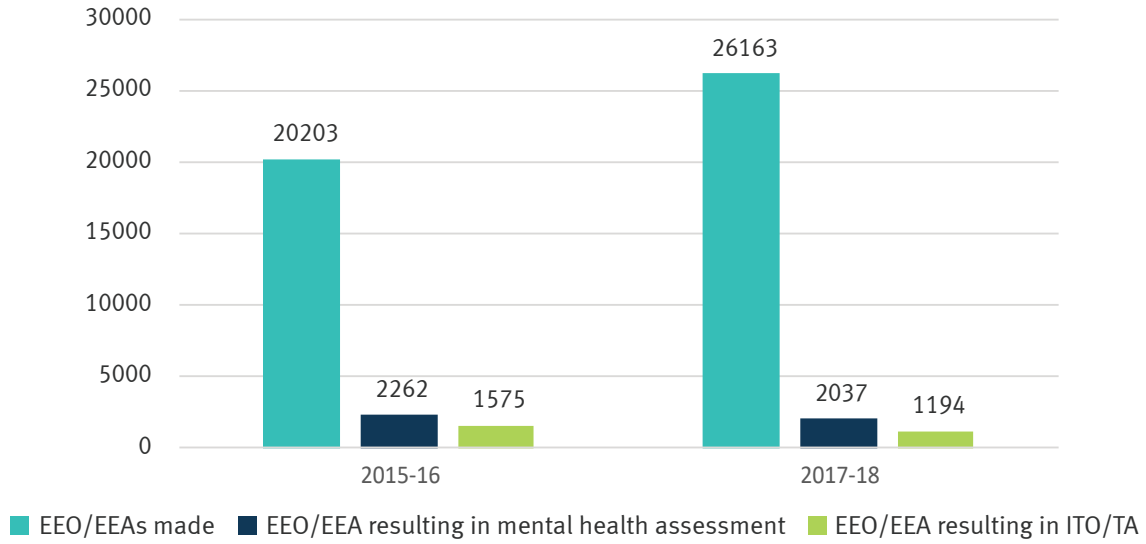
7.4.2 Emergency examination authorities (EEAs)

The review of the emergency examination order (EEO) provisions of the MHA 2000 found that the majority of presentations to a public health service facility under an EEO were related to persons suffering from the adverse effects of alcohol or other drug consumption or experiencing a situational crisis, rather than from a mental illness. As a result, these provisions were relocated to the *Public Health Act 2005*, creating a new form of authority, an emergency examination authority (EEA). The intent of this change was to ensure mental health legislation is confined to only those matters that are within its intended scope, and to ensure that persons presenting with alcohol and other drug use related problems are not inappropriately placed under the MHA 2016.

Due to the evaluation's focus on the implementation of the MHA 2016, this project did not extensively evaluate the provisions of the *Public Health Act 2005* relating to EEAs. However, where the *Public Health Act 2005* provisions overlap operationally with the MHA 2016, the evaluation considered these circumstances. The evaluation notes the work of the *Metro North Statewide Emergency Department Emergency Examination Authority Implementation Project Report – Recommendations for implementation of amendments to the Public Health Act 2005* in Emergency Departments which considered the *Public Health Act 2005* provisions more extensively, particularly in the context of the impact of the amendments on emergency department activity.

Figure 7 compares outcomes relating to EEOs in 2015-16 (under the MHA 2000) and EEAs in 2017-18 (under the *Public Health Act 2005*). The 2016-17 reporting period is omitted because it straddles both Acts, which prevents reliable comparison.

Figure 7. Comparison of conversion rate from EEO/EEA issued - to assessment - to ITO/TA made - 2015-16 and 2017-18



Note: While not a direct comparison, the evaluation considered EEOs ended under the MHA 2000 in 2015-16 and EEAs made under the *Public Health Act 2005* in 2017-18 to be appropriate for comparison.

Note: Reporting of EEO/EEA numbers varies between Queensland Health/QAS/QPS. As a result, the number reported in the *Director of Mental Health Annual Report 2015-2016* (n 14,039) differs from the numbers provided for the evaluation (n 20,203).

The uptake of EEAs in 2017-18 indicates there has been an increase in the use of emergency examination powers since the provisions were relocated to the *Public Health Act 2005*. While this increase may be attributed to a number of factors, it indicates that the provisions are being used to ensure that there is targeted assessment for people to receive appropriate health care or treatment. The number of EEAs which result in a recommendation for assessment has remained consistent, indicating that patients are still receiving mental health care and treatment where it is required.

The evaluation identified that there is some confusion regarding the assessment period guidelines, in particular when an assessment period commences, ceases and expires. While this does not result in any safety issues for individuals, it has led to discrepancies with data entry and record-keeping. The evaluation found there is scope for HHSs to improve compliance with EEA assessment policies and practice guidelines to ensure data is accurately recorded.

7.5 Strengthened safeguards for treatment and care

The implementation of the MHA 2016 was an opportunity to strengthen safeguards for the treatment and care provided to involuntary patients and to optimise patient outcomes. As a result, the MHA 2016 specifically provides that the objects of the Act are to be achieved in a way that:

- safeguards the rights of persons;
- is least restrictive of the patients' rights and liberties; and
- promotes the recovery of a person, and the person's ability to live in the community, without the need for involuntary treatment and care.

The Department of Health committed to an evaluation of the legislative provisions relating to the less restrictive way within two years of the commencement of the MHA 2016. In particular, the review was to consider the safeguards available to persons receiving treatment and care in AMHSs under an AHD, or with the consent of an attorney and/or guardian. This section details how less restrictive ways have been implemented since the commencement of the MHA 2016. The Office of the Chief Psychiatrist will continue to monitor the application of these legislative provisions.

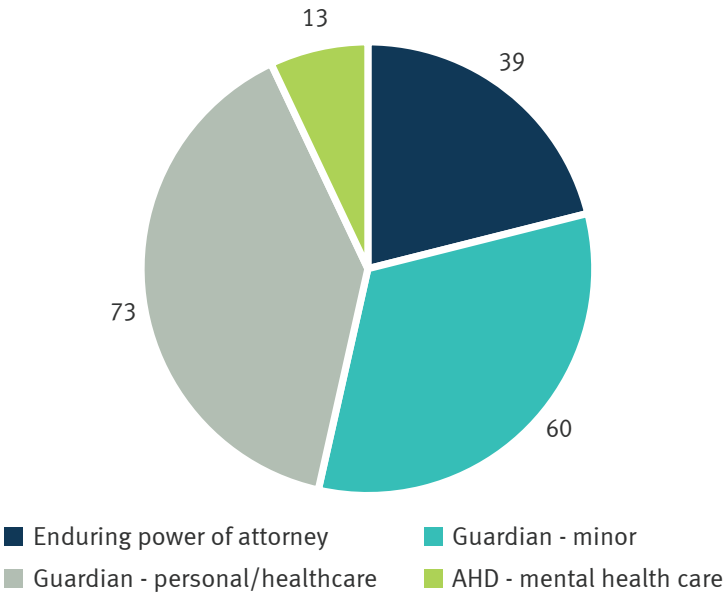
The 2016 YES survey found that under the MHA 2000, 79 per cent of involuntary patients stated they were usually or always listened to in all aspects of their treatment and care, and 21 per cent stated they were never, rarely or sometimes listened to. The 2017 YES survey identified that under the MHA 2016, 78 per cent of involuntary patients stated they were usually or always listened to, and 22 per cent stated they were never, rarely or sometimes listened to.

7.5.1 Less restrictive ways

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

In 2017-18, of the 8,016 TAs made, 185 TAs were made for patients who had an existing AHD or SDM, Figure 8 provides the breakdown of type of AHD or SDM patients on a TA had. There is no available data to compare the number of TAs made for patients with an existing AHD or SDM prior to the commencement of the MHA 2016.

Figure 8. Existing AHD or SDM for patients who had a TA made by type (2017-18)



Information about how and whether treating teams were relying upon less restrictive ways was not readily available. The evaluation found that in order to determine the uptake of less restrictive ways, improvements could be made to CIMHA to allow delegates to record details when less restrictive ways have been relied upon and the type of less restrictive way used, including AHDs and SDMs.

The surveys conducted by the evaluation asked respondents whether the MHA 2016 has promoted less restrictive options to involuntary treatment. Key feedback included:

- Fifty-nine per cent of advocates, legal representatives and other service providers (54 respondents) agreed the MHA 2016 has promoted less restrictive alternatives to involuntary treatment.
- The role of the IPRAs was highlighted by some respondents as useful in assisting to identify less restrictive ways.
- Seeking a parent's consent as a less restrictive way was being used well in adolescent mental health units.

However, some stakeholders identified concerns about how well the MHA 2016 had promoted less restrictive ways:

- Fifty-eight per cent of patients, carers and support persons (38 respondents) did not agree that the MHA 2016 has promoted less restrictive ways.
- Stakeholders highlighted some concerns about how well less restrictive ways are working in practice, including:
  - patients interpreting less restrictive ways as meaning they do not need to engage with

mental health services;

- difficulties with requiring patients to consent to participate in less restrictive ways; and
- difficulties translating less restrictive ways into practice.

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

7.5.1.1 *Less Restrictive Ways Project*

During implementation it was identified that changes in the MHA 2016 which require clinicians to determine less restrictive ways created some challenges for clinicians in practice. These challenges included: knowing which options are less restrictive; identifying SDMs for providing consent to treatment; and providing care to patients who are admitted to an inpatient unit under a SDM.

The *Less Restrictive Ways Project* operated from April to June 2018 as a collaboration between Gold Coast Health and the MHAODB. The purpose of the project was to develop resources to assist clinicians across Queensland mental health services to implement legislative policy relating to less restrictive options for providing mental health treatment and care. This included resources to:

- guide clinical decision making about applying a less restrictive alternative to TAs; and
- provide practical assistance to clinicians to provide treatment and care under a less restrictive way.

The resources were informed by consultation and a statewide expert reference group, with diverse representation from metropolitan services, regional and rural services, inpatient and community services, adult and child and youth services, Aboriginal and Torres Strait Islander mental health, IPRAs and other Queensland Government departments.

As a result of the project, resources to assist clinicians have been developed and will be rolled out across the State. The project also made recommendations for: CIMHA improvements; improvements to the AHD – Mental Health form and resources; training and education for mental health clinicians to better understand and apply less restrictive ways; enhanced safeguards for people receiving treatment in less restrictive ways; and a further evaluation of how less restrictive ways resources are being used by clinicians, and whether they have led to improvements in documentation of less restrictive practices.

7.5.2 Treatment authorities (TAs)

The MHA 2016 replaced ITOs with a new TA. The MHA 2016 provides that a TA can only be made if a person lacks capacity to consent, and the absence of treatment is likely to result in serious harm or deterioration in the person's mental or physical health or imminent serious harm to the person or others.

In line with the MHA 2016's updated treatment criteria that aim to better support individual rights, a TA may only be made if there is no less restrictive way for the person to receive treatment and care for the person's mental illness. The MHA 2016 affirms that a person is presumed to have capacity to make decisions about their treatment, and has the right to consent or not consent to treatment. Further, the MHA 2016 provides that if the person has the capacity to make decisions with the support of someone else, the person is taken to have capacity to make healthcare decisions.

In 2017-18, 8,016 TAs were made (the *Chief Psychiatrist Annual Report 2017-2018* provides a breakdown of TAs made by AMHS), representing a slight reduction from the previous two years, however the number of TAs in place as at 30 June 2018 indicates that the number of TAs continues to rise. Table 5 provides the statewide rate of ITOs and TAs made per 10,000 population over the last six years.

Table 5

Reporting period	Population	ITO/TA made	ITO/TA made per 10,000 population	Six-year average annual change
2012-13	4,568,205	6508	14.2	2.6%
2013-14	4,651,359	6601	14.2	
2014-15	4,719,925	7458	15.8	
2015-16	4,778,854	8152	17.1	
2016-17	4,927,629	8147	16.5	
2017-18	5,012,176	8016	16	

Table 6 provides the statewide rate of ITOs and TAs as at 30 June per 10,000 population over the last six years.

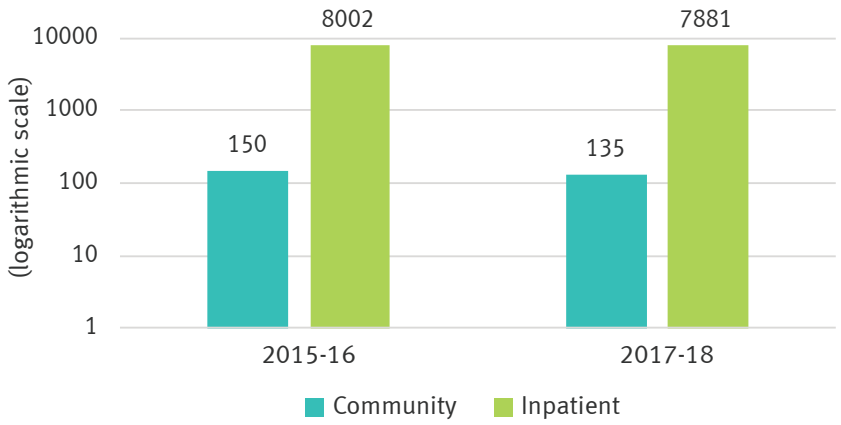
Table 6

Reporting period	Population	ITO/TA as at 30 June	ITO/TA as at 30 June per 10,000 population	Six-year average annual change
2012-13	4,568,205	3638	8.0	2.8%
2013-14	4,651,359	3828	8.2	
2014-15	4,719,925	4110	8.7	
2015-16	4,778,854	4200	8.8	
2016-17	4,927,629	4340	8.8	
2017-18	5,012,176	4764	9.2	

The MHA 2016 provides that when a TA is made, the default category must be community, unless the person's treatment and care cannot be met in the community.

Figure 9 shows the category of initial TAs made in 2015-16 and 2017-18. The data shows that the proportion of community category TAs made in 2017-18 was 1.7 per cent, which is roughly the same when compared to community category TAs made in 2015-16 (1.8 per cent).

Figure 9. TAs made by category type 2015-16 and 2017-18



In 2017-18, TAs most commonly ended when they were revoked (95 per cent, n 7,196). Figure 10 shows the count of TAs ended (n 7,561) in 2017-18 by reason type (the *Chief Psychiatrist Annual Report 2017-2018* provides a breakdown of TAs ended by AMHS).

Figure 10. TAs ended by reason (2017-18)

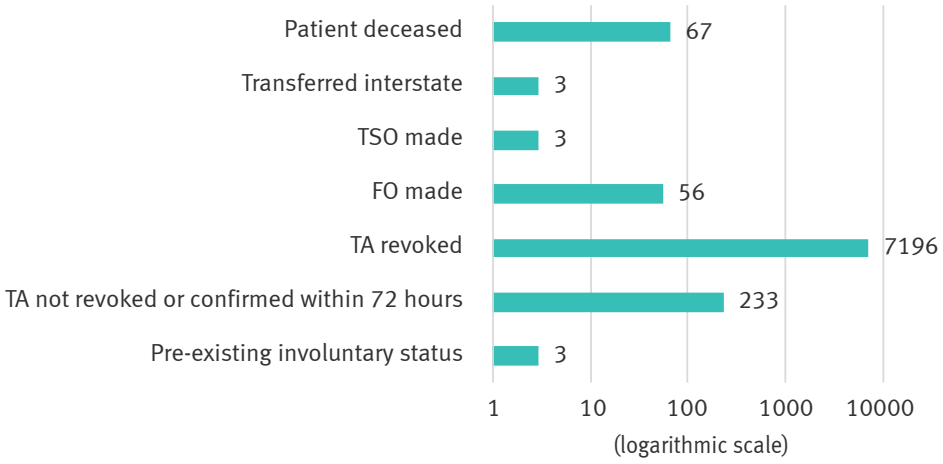
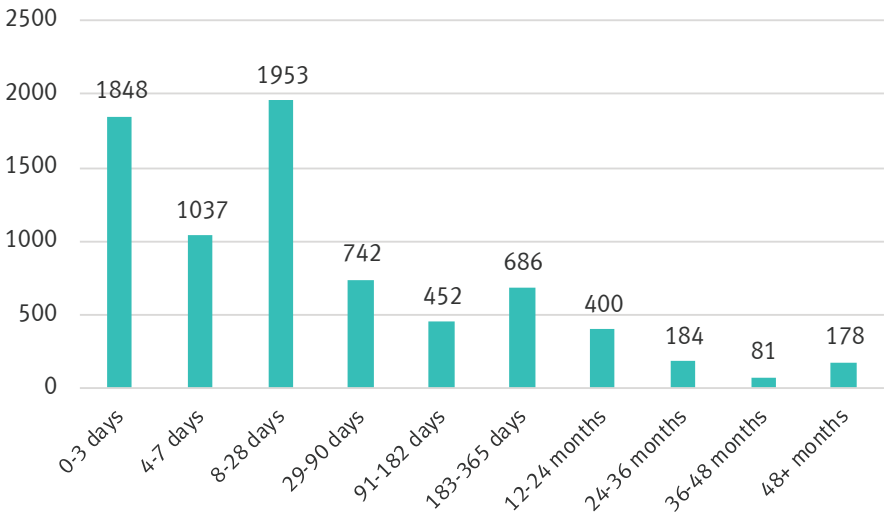


Figure 11 shows the duration of TAs ended in 2017-18 by days/months.

Figure 11. Duration of TAs ended by day/month (2017-18)



7.5.3 Improved care planning

7.5.3.1 Care plans

The core skill set of mental health clinicians includes comprehensive assessment, formulation and individualised care planning. Care planning links the needs, goals and aspirations of patients and their families and carers to quality and evidence-based health and social care interventions. The care planning process should promote patient and support person involvement in treatment and care. Clinician-patient discussion regarding care plans should also lead to discussions about less restrictive ways of treatment including making an AHD or the use of SDM.

Table 7 details the proportion of mental health service episodes for both voluntary and involuntary patients with a care plan documented in CIMHA as at 1 January 2018 compared to 30 June 2018 per HHS. This date was chosen based on available data. The below shows that overall the average proportion of mental health service episodes with a documented care plan has increased by 57.2 per cent (from 18.9 per cent as at 1 January 2018 to 29.7 per cent as at 30 June 2018).

Table 7

HHS	Proportion as at 1 January 2018	Proportion as at 30 June 2018
Cairns and Hinterland	21.6%	64.6%
Central Queensland	14.4%	16.7%
Central West	0	0
Children's Health Queensland	16.2%	20.5%
Darling Downs	28%	26.9%
Gold Coast	21.2%	46.3%
Mackay	41.9%	41.2%
Metro North	30.1%	31.7%
Metro South	16.8%	13.4%
North West	14.6%	25.9%
South West	1.9%	20.6%
Sunshine Coast	9.3%	28.1%
Torres and Cape	30.9%	48.3%
Townsville	23.6%	43.2%
West Moreton	19.6%	19.8%
Wide Bay	12%	27.7%
Statewide	**18.9%**	**29.7%**

Note: Data for care plans is not available prior to 1 January 2018.

The 2016 YES survey found that under the MHA 2000, 79 per cent of involuntary patients stated their experience of developing a care plan that considered all of their needs was either good, very good or excellent, and 21 per cent stated it was either poor or fair. The 2017 YES survey identified that under the MHA 2016, 80 per cent stated their experience was good, very good or excellent, and 20 per cent stated it was poor or fair.

While the proportion of service episodes where there is a documented care plan as at 30 June 2018 increased by over 50 per cent compared to 1 January 2018, overall numbers are still low.

To improve how care plans are used in AMHSs to support less restrictive ways, involve a patient's support persons, and align to a patient's recovery goals and needs, the MHAODB is promoting the use and quality of care plans through several initiatives including:

- The development of a separate care plan clinical document with the introduction of the MHA 2016 which promotes greater consumer collaboration and linkage of care provided to the consumer's recovery goals.

- The measurement strategy for implementation of *Connecting care to recovery 2016-2021*, includes the proportion of mental health service episodes with a documented care plan as one of the indicators against the patient centred system performance domain.
- The Mental Health Alcohol and Other Drugs Statewide Clinical Network has identified care planning as a priority and is planning for the commencement of a quality improvement collaborative to focus on care planning.

The MHAODB, supported by the Mental Health Alcohol and Other Drugs Statewide Clinical Network will continue to monitor the proportion of service episodes with a documented care plan, and support HHSs to improve the use and quality of care plans.

7.5.3.2 Advance health directives (AHDs) and substitute decision makers (SDMs)

Under the *Powers of Attorney Act 1998* a person may give directions about their future health care through an AHD, which comes into effect if the person loses capacity to make decisions. The MHA 2016 actively promotes the use of AHDs as an alternative to involuntary treatment. This reform supports a recovery-oriented approach by giving individuals greater control over future healthcare by enabling them to determine and consent to treatment and care when they have decision-making capacity.

The MHA 2016 provides that a person must be treated under an AHD if their treatment and care needs can reasonably be met under the AHD. Where this is not possible and a TA is made, the views, wishes and preferences expressed in the directive must be taken into account by an authorised doctor in deciding the treatment and care to be provided.

Other alternatives to involuntary treatment promoted in the MHA 2016 include consent for treatment and care provided by a parent (for a minor) or a SDM for healthcare (for an adult), for example, a guardian appointed by the Queensland Civil and Administrative Tribunal or an attorney appointed by the person. A TA cannot be made if the person's treatment and care needs can reasonably be met under these arrangements.

The QCMHL was commissioned by Queensland Health to deliver AHD training to support implementation of the MHA 2016. QCMHL reported that due to the timing of the training (before the commencement of the MHA 2016) training participants were seeking more practical examples of how the AHD would work in practice. Two areas participants sought to clarify were: in what circumstances an AHD can be overridden by the service; and whether an AHD became redundant if it could be overridden too easily or at the convenience of the health service. QCMHL suggested that this illustrates a level of confusion and uncertainty in balancing safety and consumer rights. Training on AHDs is also offered by ADA Australia in conjunction with QAI. QAI reports that its delivery of this training has demonstrated a limited understanding of AHDs by clinicians, but that there is a high level of interest and participation in this training package.

Advocates, legal representatives and other service providers who responded to the survey provided feedback that AHDs are a valuable tool for managing decision making and allowing increased patient input when unwell. However, staff indicated that while clinicians wanted to be more proactive in suggesting patients make an AHD, usually by the time the treating team is involved there are concerns that the patient no longer has capacity to make an AHD.

The evaluation considered the number of AHDs and SDMs recorded for involuntary patients at two distinct points in time, as at 1 July 2017 and as at 30 June 2018. There was a 47 per cent increase in the number of AHDs/SDMs recorded for involuntary patients (from 402 to 589), and a four per cent increase for voluntary patients (from 916 to 952). The number of involuntary patients with one or more AHD or SDM at the same points in time were 344 (as at 1 July 2017) and 490 (as at 30 June 2018). These two cohorts of patients may not include the same patients.

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

Figure 12 represents the number of AHDs and SDMs recorded for involuntary patients by type.

Figure 12. AHDs and SDMs recorded for involuntary patients by type - as at 1 July 2017 and 30 June 2018

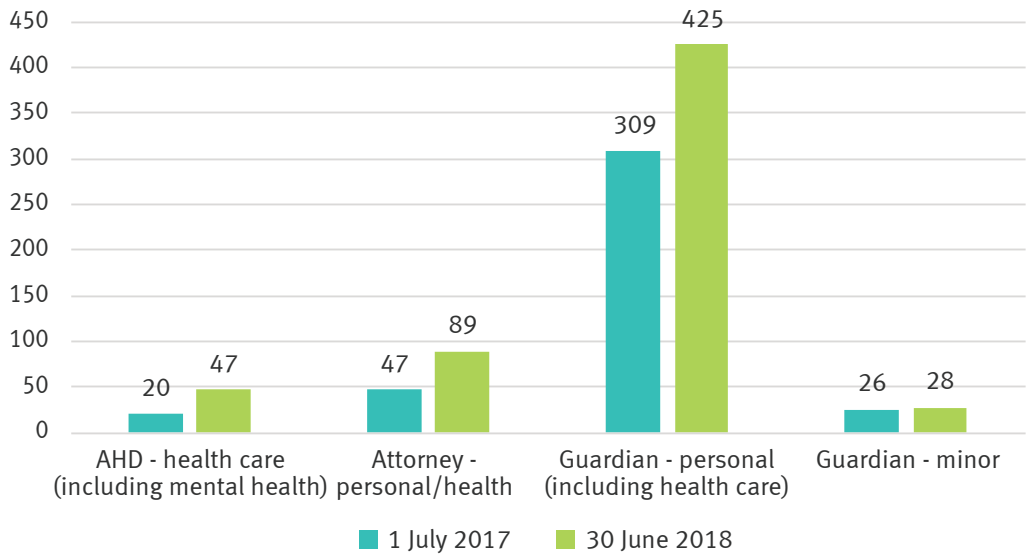
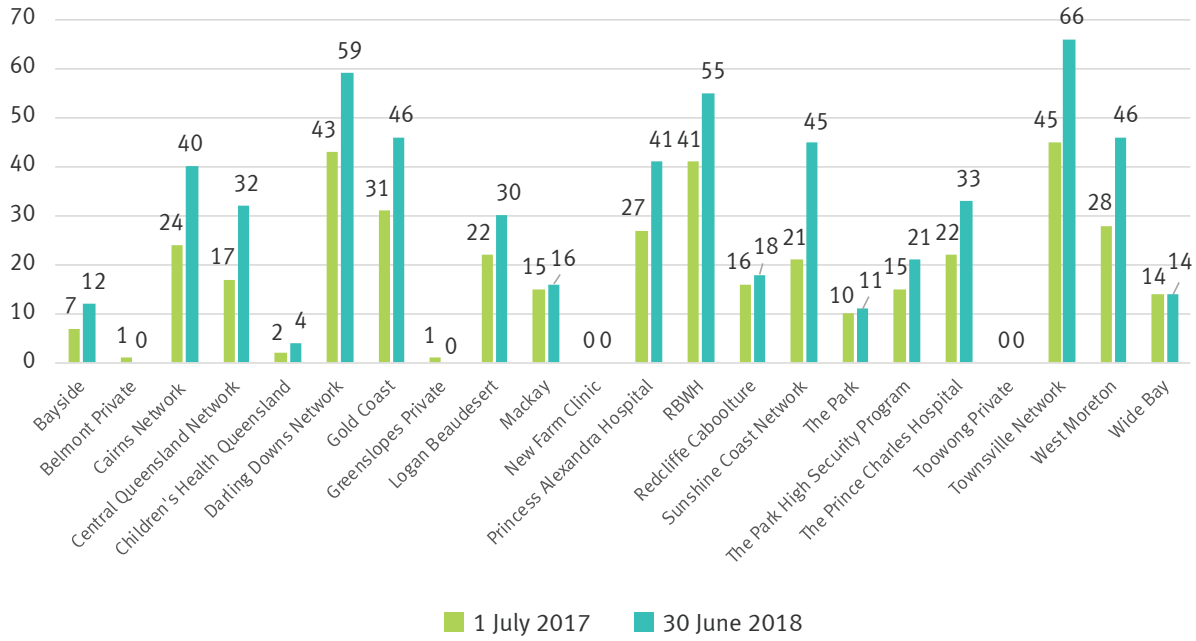


Figure 13 represents the breakdown of AHDs and SDMs by AMHS as at 1 July 2017 and 30 June 2018.

Figure 13. AHDs and SDMs recorded for involuntary patients by AMHS - as at 1 July 2017 and 30 June 2018



While the use of AHDs has increased since the MHA 2016 commenced, the evaluation found that HHSs may improve uptake of AHDs by looking for opportunities to discuss the making of an AHD with patients, for example, when a patient regains capacity.

7.5.4 Rural and remote provisions

The MHA 2016 introduced the following specific provisions for application in AMHSs declared by the Chief Psychiatrist as rural and remote AMHSs:

- the same authorised doctor may make a recommendation for assessment, and perform the actual assessment, if the authorised doctor is the only authorised doctor available; and
- where an authorised psychiatrist reviews the making of a TA by an authorised doctor who is not a psychiatrist, the review must take place within seven days, rather than three days, if it is not reasonably practicable to perform the review in three days.

The introduction of these provisions was intended to facilitate improved access to treatment and care under the MHA 2016, where necessary, for persons experiencing mental illness in need of acute treatment in rural and remote areas.

The Department of Health committed to an evaluation of the legislative provisions applicable to patients in regional, rural and remote areas within two years of the commencement of the MHA 2016. However, since the commencement of the MHA 2016, these provisions have not yet been relied upon, therefore no AMHS has been declared a rural and remote AMHS. Mental health services in rural and remote areas have continued to link with an AMHS that can undertake the necessary assessment and reviews in line with the requirements of the MHA 2016. The Office of the Chief Psychiatrist will continue to monitor the application of these provisions.

7.6 Strengthened safeguards for regulated practices

The review of the MHA 2000 provided an opportunity to build on the existing safeguards of the MHA 2000 for restrictive practices. Comprehensive safeguards and oversight measures have been included in the MHA 2016 to support the reduction, and where possible, elimination of these practices. In addition to increased regulatory oversight for seclusion and mechanical restraint, the MHA 2016 also introduced safeguards and reporting measures for physical restraint and the use of medication.

The MHA 2016 provides for clear authorisation criteria, mandatory reporting requirements, and clinically focused reduction and elimination plans, in addition to requiring the Chief Psychiatrist to issue policies and practice guidelines on the use of seclusion, mechanical restraint and physical restraint. These practice guidelines are mandated for AMHS staff and align with state and national priorities to reduce and eliminate seclusion and restraint (including under the *Connecting Care to Recovery 2016-21 Measurement Strategy*, *The Fifth National Mental Health and Suicide Prevention Plan*, the *National Principles to support the goal of eliminating mechanical and physical restrain in mental health services*, the *National Standards for Mental Health Services 2010*, the *National Safety and Quality Health Service Standards*, and the *National safety priorities in mental health: a national plan for reducing harm)*.

The Queensland Government, through the Department of Health, MHAODB and the QMHC, has partnered with the National Mental Health Safety and Quality Partnerships Standing Committee (SQPSC) and the National Mental Health Commission (NMHC) to target the reduction of seclusion and restraint as a national priority. The SQPSC monitors the implementation of seclusion and restraint reduction initiatives and is a key partner of the NMHC project focusing on reducing seclusion and restraint.

The MHA 2016 continues ECT as a regulated treatment and includes increased safeguards and oversight of ECT, including requiring the approval of the MHRT in all cases where the person is a minor, and the appointment of legal representation at no cost for patients at hearings where an application for ECT is being considered.

7.6.1 Changes to the regulation of restrictive practices

7.6.1.1 Reduction and elimination plans

Under the provisions of the MHA 2000, a specific program was established that enabled the Director of Mental Health to approve seclusion and restraint minimisation plans for patients within The Park High Security Program. The aim of the program was to assist in reducing and,

where possible, eliminating the use and duration of seclusion and restraint, and to ensure statutory oversight by the Director of Mental Health of these restrictive practices. The MHA 2016 refers to these plans as reduction and elimination plans (R&E plans) and the policy and practice guidelines requires them to be implemented across all AMHSs. R&E plans can be approved by the Chief Psychiatrist for mechanical restraint only, seclusion only, or both seclusion and mechanical restraint.

Under the Chief Psychiatrist policy and practice guidelines it is recommended practice for an R&E plan to be in place in all instances where a patient is secluded or mechanically restrained. However, an R&E plan must be in place for any patient that is secluded or mechanically restrained for more than nine hours in a 24-hour period. The approval of an R&E plan does not replace authorisation of each individual period of seclusion or mechanical restraint, and an authorisation form and medical review must be completed and undertaken by an authorised doctor every three hours, as required under the Chief Psychiatrist policy and practice guidelines.

A total of 659 R&E plans involving 141 patients (note: patients may have had more than one R&E plan across the reporting period) were approved in 2017-18. The majority (71 per cent) of R&E plans approved in 2017-18 were approved for patients at The Park High Security Program (468 R&E plans), followed by The Park (67 plans) and The Prince Charles Hospital (32 plans). A breakdown of all approved R&E plans and patients by AMHS is available in the *Chief Psychiatrist Annual Report 2017-2018*.

In 2017-18,

659 reduction and elimination plans were approved

across the majority of AMHSs.

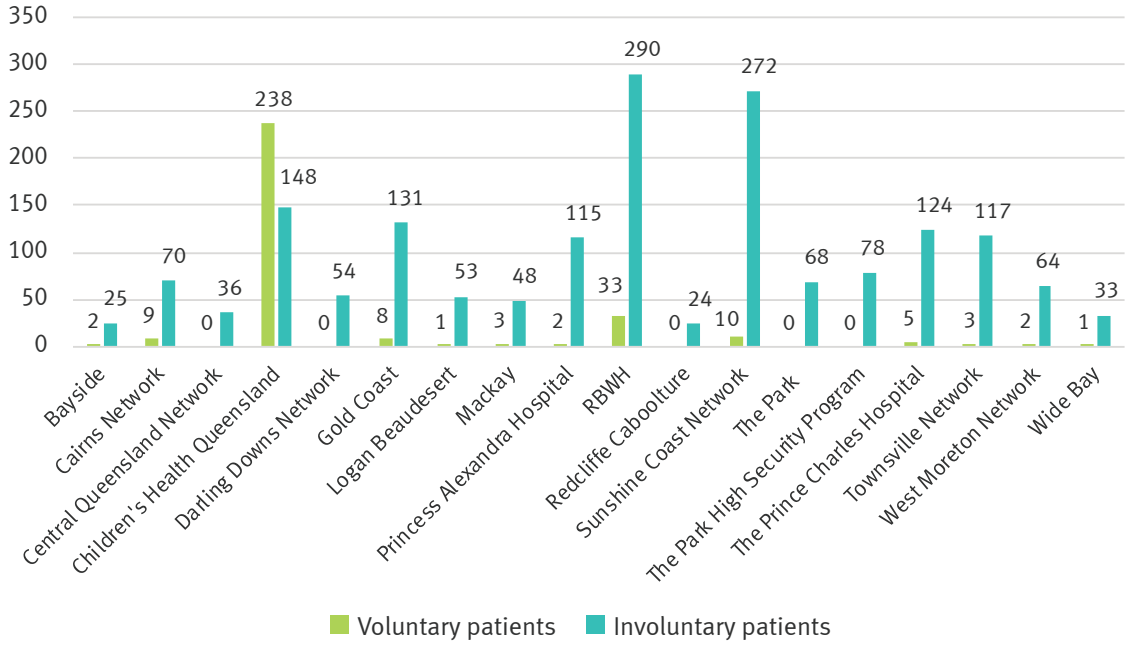
7.6.1.2 Physical restraint

Only mechanical restraint and seclusion were regulated restrictive practices under the MHA 2000. The MHA 2016 introduced the regulation of physical restraint for patients in AMHSs. Physical restraint, of a patient, generally refers to the use by a person of his or her body to restrict a patient's movement. It is an offence under the MHA 2016 for a person to use physical restraint on a patient other than allowed under the Act, which requires the use of physical restraint to be authorised by an authorised doctor or a health practitioner in charge of an inpatient unit or other unit within an AMHS, if satisfied that there is no other reasonably practicable way:

- to protect the patient or others from physical harm;
- to provide treatment and care to the patient;
- to prevent the patient from causing serious damage to property; or
- for a patient detained in an AMHS, to prevent the patient from leaving the service without permission.

During 2017-18, there were 2,067 physical restraint events (including emergency restraint events) involving 700 patients. Figure 14 provides a breakdown of physical restraint events by AMHS.

Figure 14. Physical restraint events by AMHS (2017-18)



Note: Data includes physical restraint events across all AMHS service types.

7.6.1.2.1 West Moreton HHS review of physical restraint under the MHA 2016

From October 2017, West Moreton HHS undertook a review of the implementation of the physical restraint changes and key barriers to their implementation (the WMHHS review). The WMHHS review explored changes in practice since the commencement of the MHA 2016 and sought to identify progress towards complying with the Chief Psychiatrist policy and practice guidelines regarding physical restraint, and to identify alternatives to prone restraint. The policy provides that the prone (face down) position should be avoided wherever possible, and where it occurs it must not exceed two minutes.

As part of the review, WMHHS: facilitated focus groups with 37 nursing staff from three hospitals; and conducted a survey of HHS nursing directors (of 19 nursing directors contacted, 15 responded).

Key feedback from nursing directors and staff included:

- Nursing staff noted they were more vigilant of restraint duration and more attentive to the patient's safety.
- Nursing staff questioned the rationale for the two minute time limit for the use of prone restraint, and suggested it may cause mistakes as staff rush to comply with the time limit.

- HHSs are placing a greater emphasis on de-escalation in an effort to reduce the need for physical restraint, but the practice of physical restraint had not substantially changed.
- While strategies had been employed to make staff more aware of the MHA 2016, some nursing directors had difficulty describing specific training in relation to alternatives to prone restraint.
- While most nursing staff could identify relevant databases for recording physical restraint events, some staff had difficulty identifying where to document the use of physical restraint.

The WMHHS review examined data collected in CIMHA and at a local level to identify reporting and monitoring issues. The review found wide variation across the State in the reporting of physical restraint events, suggesting differences in recording practices.

The Chief Psychiatrist continues to support HHSs to ensure the use of physical restraint is a last resort where less restrictive interventions have been unsuccessful or are not feasible, and any harm to patients and staff caused by the use of physical restraint is reduced.

The evaluation found that while the regulation of physical restraint has been well embedded across the State, based on the WMHSS review there are opportunities for HHSs to improve data entry for physical restraint events to improve data quality.

7.6.1.3 Seclusion

There were a number of changes to the use of seclusion under the MHA 2016. Seclusion may only be used for an involuntary patient who is subject to a TA, FO or TSO, or a person absent without permission from another state or territory who is detained in an AMHS.

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. An extension beyond this time may be approved under an R&E plan. A 12-hour extension may be authorised to allow an R&E plan to be prepared for a patient and must be approved by a clinical director in the AMHS. An extension of seclusion may only be granted once for each period of an admission in which the patient requires acute management. In an emergency, a health practitioner in charge of an inpatient or other unit within an AMHS may seclude a person for up to one hour. Emergency seclusion may be authorised for no more than three hours in a 24-hour period.

Because the safety and care of patients, staff and the community is the priority for HHSs, in some circumstances it may be necessary to seclude a patient prior to a TA being made. In 2017-18, there were 35 seclusion events recorded where a person was on assessment documents and yet to be subject to a TA, which is in breach of the MHA 2016. Each of these seclusion events has been considered by the Chief Psychiatrist and addressed individually with the relevant AMHS. On 27 occasions seclusion was used at the same time a TA was made, and while this is not a breach of the MHA 2016, it may indicate that a TA was being made for the purpose of using seclusion for the person. Of the total 62 occasions, 60 TAs were made and of those, nine TAs were revoked within 48 hours.

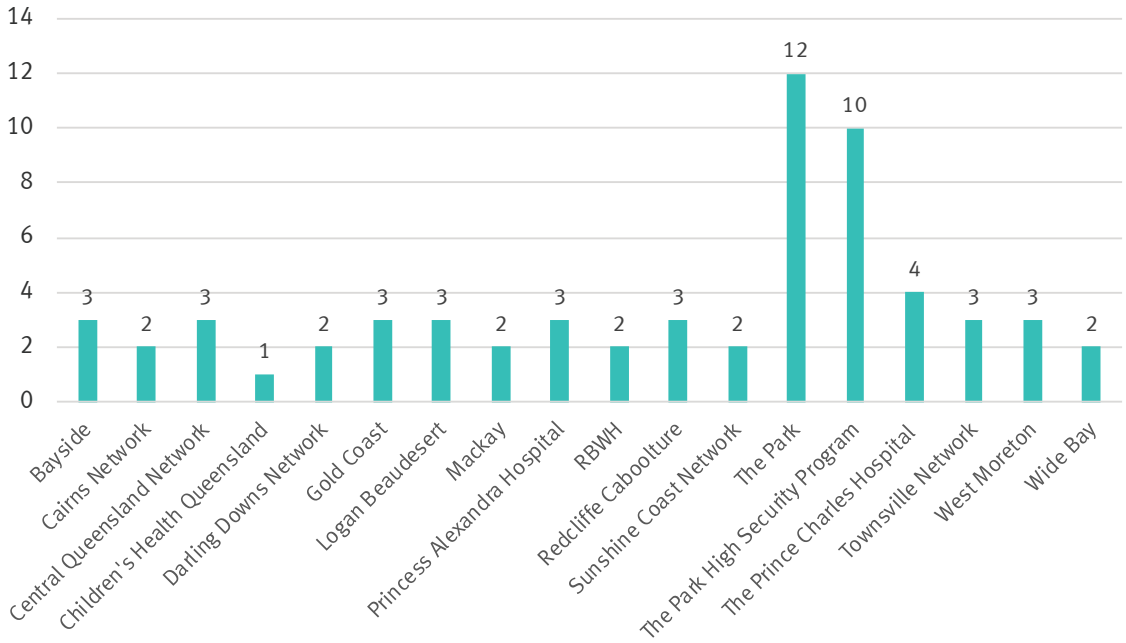
Table 8 provides a comparison of statewide clinical indicators of seclusion between 2015-16 and 2017-18. A breakdown of the previous five years can be found in the *Chief Psychiatrist Annual Report 2017-2018*.

Table 8

Setting	Indicator	2015-16	2017-18
Acute	Seclusion events per 1,000 bed days	9.4	6.1
	Proportion of episodes with one or more seclusion events	3.8%	2.5%
	Average (mean) duration of seclusion events (hours)	3.4	2.6
Extended	Seclusion events per 1,000 bed days	15.9	30.9
	Proportion of episodes with one or more seclusion events	5.6%	10.3%
	Average (mean) duration of seclusion events (hours)	11.3	10.1

In 2017-18, 17,528 authorisations for seclusion were made involving 797 patients (including 1,048 emergency authorisations). Fourteen extensions of seclusion were made involving 14 patients. The *Chief Psychiatrist Annual Report 2017-2018* provides a breakdown of authorisation types and patients by AMHS. The MHA 2016 provides that seclusion may be authorised by an authorised doctor for up to three hours. Figure 15 provides the average duration of seclusion events ended in hours in 2017-18.

Figure 15. Seclusion events ended by average duration in hours (2017-18)



The Chief Psychiatrist continues to work with AMHSs where the duration of seclusion exceeds three hours. The Chief Psychiatrist will continue to monitor seclusion rates across the State and is working closely with AMHSs to identify strategies for reducing the use of seclusion as a therapeutic intervention and promote patient rights focused treatment and care.

7.6.1.4 Mechanical restraint

The MHA 2016 made a number of changes to the use of mechanical restraint under the Act. Consistent with requirements for seclusion, mechanical restraint may only be applied to an involuntary patient who is subject to a TA, FO or TSO, or a person absent without permission from another state or territory who is detained in an AMHS.

Additional safeguards and oversight measures were introduced in the MHA 2016 including changes to the process under the MHA 2000 that allowed an authorised doctor to approve the use of mechanical restraint, provided the device used in the restraint was approved by the Director of Mental Health. The MHA 2016 provides that an authorised doctor can only authorise mechanical restraint with the prior written approval of the Chief Psychiatrist, or in urgent circumstances with verbal approval from the Chief Psychiatrist, which is confirmed by written approval as soon as practicable. The criteria for applying mechanical restraint have also been strengthened to ensure 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 other 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.

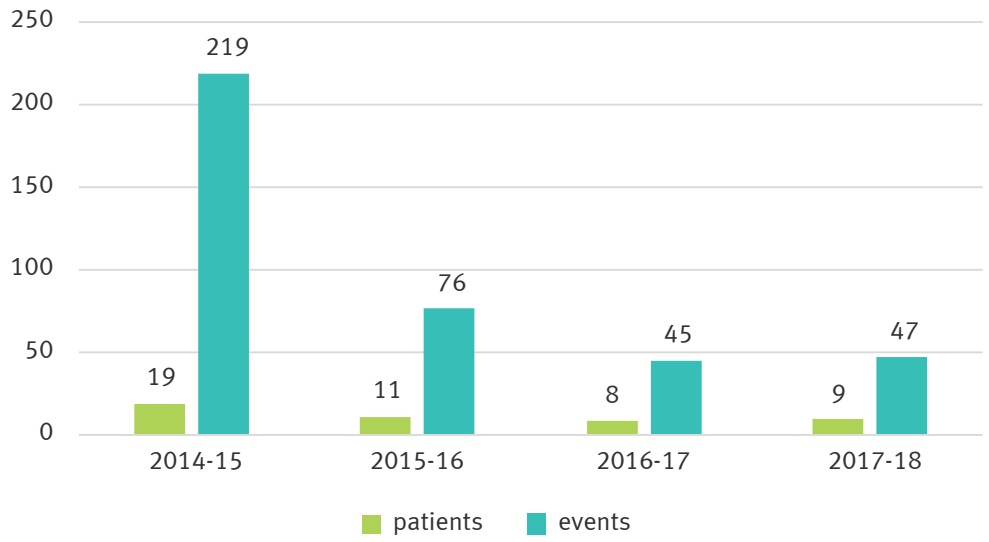
Mechanical restraint may occur for no more than nine hours in a 24-hour period, however may be continued beyond this time if it is approved under an R&E plan.

In 2017-18, nine patients at four AMHSs were involved in 47 mechanical restraint events. These events were authorised via 24 approvals for the use of mechanical restraint by the Chief Psychiatrist. A breakdown of the approvals that resulted in mechanical restraint events at AMHSs where events occurred is provided in the *Chief Psychiatrist Annual Report 2017-2018*.

The average duration of mechanical restraint events was 20 minutes at Sunshine Coast AMHS, 49 minutes at The Park High Security Program, and 82 minutes at The Prince Charles Hospital AMHS.

In line with the work undertaken to reduce the number of mechanical restraint events, Figure 16 provides a comparison of mechanical restraint events and associated patients over the last four reporting periods.

Figure 16. Comparison of mechanical restraint events and number of associated patients across reporting periods



The Chief Psychiatrist continues to monitor the use of mechanical restraint across the State and is working closely with AMHSs to promote patient rights focused treatment and care.

7.6.2 Increased safeguards and oversight of electroconvulsive therapy

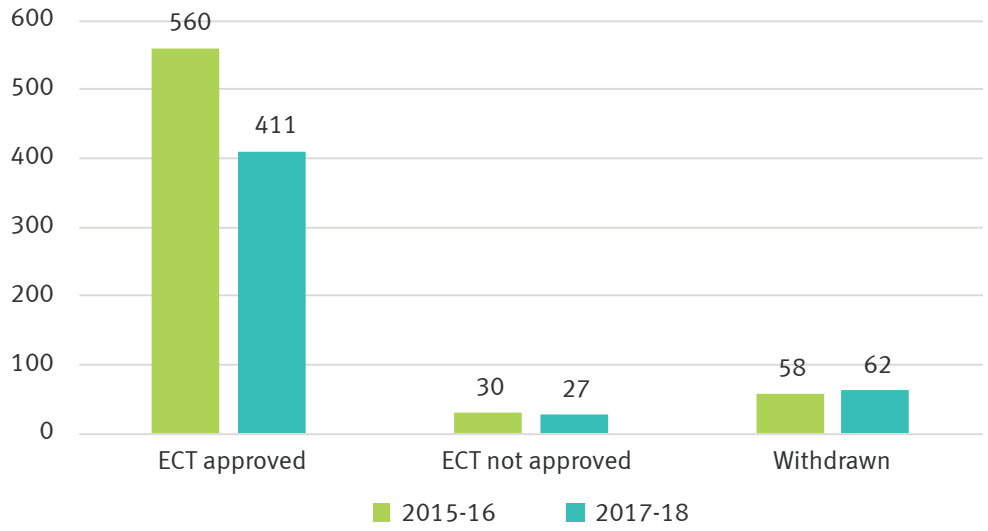
Consistent with the MHA 2000, electroconvulsive therapy (ECT) is a regulated treatment under the MHA 2016 and may only be performed with the informed consent of an adult patient, with the approval of the MHRT, or in emergency circumstances to save an involuntary patient's life or prevent the patient suffering irreparable harm. While many of the provisions between the Acts remain comparable, including the continued role of the MHRT in approving applications for ECT, the MHA 2016 provided an opportunity to increase safeguards and oversight of ECT, including requiring the approval of the MHRT in all cases where the person is a minor, and the appointment of legal representation at no cost for patients at hearings where an application for ECT is being considered.

In recognition of the perceived risks and common concerns often associated with the use of ECT, the increased safeguards and oversight also sought to provide patients, and the wider community, with a level of assurance regarding the clinically appropriate use of ECT in specific situations.

During 2017-18, the MHRT managed 569 matters (involving 372 patients) relating to applications for approval to perform ECT (the *Chief Psychiatrist Annual Report 2017-2018* provides a breakdown of applications by type and AMHS).

Figure 17 provides a comparison of outcomes on ECT applications between 2015-16 and 2017-18.

Figure 17. ECT matters managed by the MHRT 2015-16 and 2017-18 reporting periods



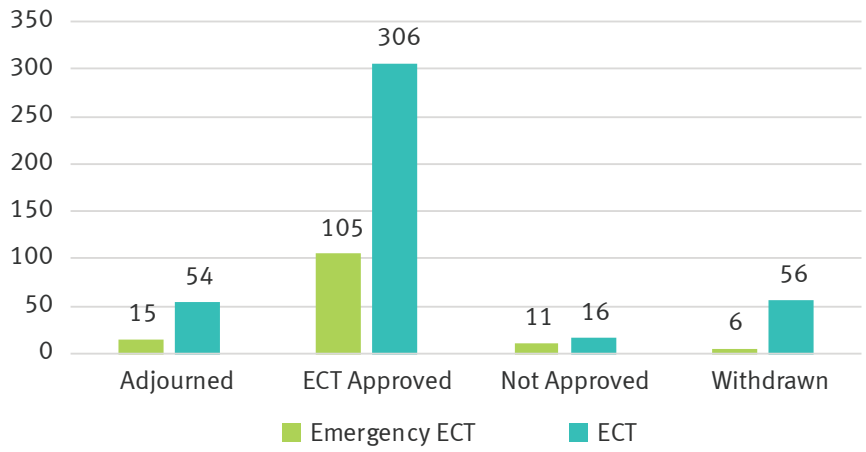
Note: This graph includes ECT and emergency ECT applications.

Note: The MHRT managed 569 matters in 2017-18 relating to applications for approval to perform ECT. Figure 17 excludes 69 adjournments managed by the MHRT.

Between 2015-16 and 2017-18 the number of ECT approvals dropped by 27 per cent (from 560 approvals in 2015-16, to 411 approvals in 2017-18), and the proportion of not approved ECT applications has risen slightly from five per cent (n 30) in 2015-16, to six per cent (n 27) in 2017-18. This indicates that since the MHA 2016 took effect, less applications are being made for ECT treatment and when they are determined by the MHRT, less applications are resulting in an approval.

Figure 18 provides a further breakdown of ECT matters managed by the MHRT in 2017-18, by emergency ECT or general ECT.

Figure 18. ECT matters managed by the MHRT (2017-18)



Note: Emergency ECT was not administered in matters that were withdrawn.

Between 2015-16 and 2017-18 there was a slight increase in the proportion of emergency ECT applications that were not approved by the MHRT; six per cent in 2015-16 (under the MHA 2000) and nine per cent in 2017-18 (under the MHA 2016). The proportion of general ECT applications that were not approved remained consistent at five per cent.

There was no available data to examine the impact of the appointment of legal representation at no cost for patients at hearings where an application for ECT treatment is being considered. The evaluation found that it would be useful to further explore the approval of ECT to determine the impact of the provision of legal representation, and to consider the timeframes for determination of ECT matters by the MHRT.

7.7 Expanded considerations for minors

During the review of the MHA 2000 it was identified that distinguishing between minors (persons under 18) and adults would be beneficial due to the particular issues and vulnerabilities of minors. The MHA 2016 includes provisions intended to support clinical best practices and statutory processes where the needs of minors should be given additional consideration, particularly in circumstances where a minor's rights may be infringed.

These amendments include:

- A principle that requires that, to the greatest extent practicable, a minor must have their best interests recognised and promoted including, for example, receiving treatment and care separately from adults, if practicable, and by having their specific needs, wellbeing and safety recognised and protected.
- A minor may consent to treatment if they have capacity, and a parent may consent on their behalf as part of considering a less restrictive way.
- For the performance of ECT, the approval of the MHRT is required in all circumstances where the person is a minor.
- The MHRT must appoint a lawyer for any hearing involving a minor.
- An administrator of an AMHS is required to notify the Public Guardian:
  - when a minor is admitted to a high security unit or an inpatient mental health unit of an AMHS other than a child and adolescent inpatient unit; and
  - about the use of restrictive practices on a minor.

The Chief Psychiatrist continues to monitor the treatment and care of minors, including the use of restrictive practices.

7.7.1 Less restrictive way – capacity assessment in minors project

The *Less Restrictive Way – Capacity Assessment in Minors* project was established as a collaboration between QCMHL and CHQ Child and Youth Mental Health Service (CYMHS) following a review by CHQ CYMHS of capacity assessment training during the implementation of the MHA 2016. The purpose of the project is to develop online training focused on the use of least restrictive ways with young people. It is anticipated the training will use existing online training platforms available through QCMHL and be developed with input from a range of CYMHS services and experts who form the advisory committee for the project.

7.7.2 Legal representation at hearings

In 2017-18, legal representation was provided at 157 MHRT hearings involving minors, below is the breakdown of hearings by type:

- ECT applications – four hearings;
- FO reviews – seven hearings; and
- TA review – 146 hearings.

7.7.3 Seclusion

In 2017-18, 139 seclusion events occurred involving 53 minors at 10 AMHSs. No minors were secluded for more than nine hours within a 24-hour period, as such no R&E plans were required. Table 9 provides a breakdown of seclusion events and associated minors by AMHS.

Table 9

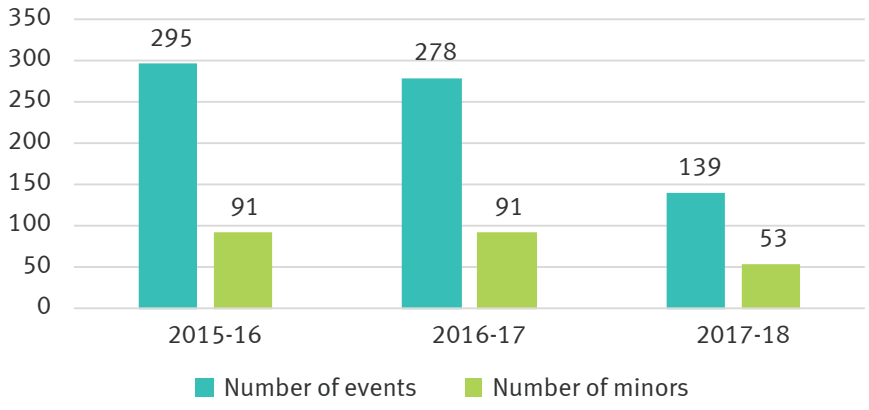
AMHS	Number of events	Number of minors
Central Queensland Network	8	5
Children's Health Queensland	27	10
Darling Downs Network	49	15
Gold Coast	<5	<5
Logan Beaudesert	<5	<5
Mackay	5	<5
RBWH	33	11
Redcliffe Caboolture	<5	<5
Townsville Network	7	<5
Wide Bay	<5	<5
Statewide	**139**	**53**

Note: 53 is a unique count of minors, four minors had seclusion events across multiple AMHSs.

Note: Due to small numbers, AMHSs with less than five events and/or minors involved have been replaced with <5 to reduce the risk of identification of an individual.

Figure 19 provides a comparison of seclusion events and associated minors.

Figure 19. Comparison of seclusion events and number of associated minors across reporting periods



Between 2015-16 and 2017-18, there was a 53 per cent reduction in the number of seclusion events and a 42 per cent reduction in the number of minors involved in these events.

In addition, the average number of seclusion events per minor reduced by 19 per cent. In 2015-16, the average number of seclusion events per minor was 3.2, and in 2017-18 this dropped to an average of 2.6 seclusion events per minor.

7.7.4 Mechanical restraint

In 2017-18, one mechanical restraint approval and event occurred involving a minor. An R&E plan was approved for the minor. To reduce the risk of identification of this patient, the AMHS where this occurred has not been included in this report.

7.7.5 Physical restraint

In 2017-18, 545 physical restraint events occurred involving 131 minors at 13 of the AMHSs. The AMHSs where over five physical restraint events occurred were CHQ (386 events involving 89 minors), the Royal Brisbane and Women's Hospital (RBWH) (118 events involving 25 minors), the Sunshine Coast Network (17 events involving seven minors), and Gold Coast (10 events involving five minors). Seven minors had physical restraint events across multiple AMHSs.

Table 10

AMHS	Number of events	Number of minors
Cairns Network	‹5	‹5
Central Queensland Network	‹5	‹5
Children's Health Queensland	386	89
Darling Downs Network	‹5	‹5
Gold Coast	10	5
Logan Beaudesert	‹5	‹5
Mackay	‹5	‹5
RBWH	118	25
Redcliffe Caboolture	‹5	‹5
Sunshine Coast Network	17	7
Townsville Network	‹5	‹5
West Moreton	‹5	‹5
Wide Bay	‹5	‹5
Statewide	**545**	**131**

Note: 131 is a unique count of minors, seven minors had physical restraint events across multiple AMHSs.

Note: Due to small numbers, AMHSs with less than five events and/or minors involved have been replaced with ‹5 to reduce the risk of identification of an individual.

Data regarding physical restraint events involving minors prior to the commencement of the MHA 2016 is not available because the use of physical restraint was not regulated under the MHA 2000. Based on data available from the first four months of operation of the MHA 2016 (5 March 2017 to 30 June 2017) (325 events), it was projected that the number of physical restraint events in the 2017-18 would be 975. The final number of events is lower than the projected number of events from that four-month period.

7.7.6 Requirement for administrators to notify the Public Guardian regarding minors

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

- To allow the Community Visitor Program to prioritise a visit by a community visitor to that minor and to report back to the Public Guardian, administrators are required to notify the Public Guardian of the admission of a minor to a high security unit or an inpatient mental health unit of an AMHS other than a child and adolescent inpatient unit within 72 hours of admission; and
- Administrators are required to notify the Public Guardian about the use of the mechanical restraint, seclusion or physical restraint involving a minor.

Processes to facilitate the provision of this information were developed in close consultation between the Office of the Chief Psychiatrist and the Office of the Public Guardian.

The Office of the Public Guardian reported that in 2017-18 it received 79 notifications of an admission of a minor to a high security unit or an inpatient mental health unit of an AMHS other than a child and adolescent inpatient unit. The MHA 2016 requires the Public Guardian to be notified about the admission of a minor to a high security unit or an inpatient mental health unit of an AMHS other than a child or adolescent inpatient unit within 72 hours after admission. Seventy-three of the 79 notifications from administrators were received by the Office of the Public Guardian within 72 hours of the minor's admission. The Office of the Chief Psychiatrist will review its internal processes to continue to support administrators to meet this requirement and address non-compliance as it arises.

In 36 of the 79 notifications a community visitor met with a young person as a result of an admission notification. Outcomes for the remaining notifications are outlined below:

- 18 minors were discharged before a community visitor could conduct a visit.
- Eight minors were transferred to the adolescent unit before a community visitor could visit.
- One minor could not be visited because it was unsafe for a community visitor to visit the unit.
- One minor had turned 18 years old before a community visitor could visit.
- Specific follow up action was unable to be determined in relation to 15 notifications.

There is no statutory timeframe for the provision of information to the Public Guardian about the use of mechanical restraint, seclusion or physical restraint on a minor. While there were some initial delays in the reporting of restrictive practices information to the Public Guardian due to

challenges in embedding reporting processes and data generation, processes have since been refined to improve the timeliness of the provision of this information.

The Office of the Chief Psychiatrist and the Office of the Public Guardian will continue to work together to monitor the application of the notification provisions, and determine whether improvements can be made to reporting processes.

7.8 Improvements to the operation of the courts

The review of the MHA 2000 provided an opportunity to reform how people with a mental illness or intellectual disability interface with the justice system. In recognition of the importance of balancing the rights of a person with a mental illness or intellectual disability with the protection of the community, the MHA 2016 sought to improve the operation of the Magistrates Court and the MHC.

Apart from its application for people with mental illness who commit offences, the provisions of the MHA 2016 enable persons with intellectual or cognitive disability to be diverted from the criminal justice system if it is found that they were unsound of mind at the time of allegedly committing the offence or unfit for trial due to their intellectual or cognitive disability. Queensland Health and DCDSS are currently undertaking a joint project to consider how Queensland's forensic disability service system can better support people with intellectual or cognitive disability who have committed offences or are at risk of offending. Due to this ongoing work, the evaluation has refrained from making findings which are specific to the improvement of the forensic disability service system. Any broader implementation activities arising from the evaluation will be considered in the context of the forensic disability service system project.

7.8.1 Magistrates Court

The MHA 2016 removed the mandatory requirement to prepare a psychiatrist report for an involuntary patient on an ITO or FO charged with any offence, regardless of the nature of the offence or the patient's wishes. Instead, the MHA 2016 introduces explicit powers for a Magistrate to dismiss or adjourn a simple offence where the person charged was, or appears to have been, of unsound mind at the time of the alleged offence, or is not fit for trial, and provides that an involuntary patient on a TA, FO or TSO who is charged with a serious offence (for example, an indictable offence other than one that must be heard by a Magistrate) may request a psychiatrist report at no cost to the patient, should they wish to pursue a defence in the MHC.

The introduction of these powers was intended to expand the opportunity for persons who may have a mental health or intellectual disability defence to be dealt with by the court in an appropriate manner. Specifically, the evaluation considered the following new Magistrate powers:

- Section 172 – a Magistrate may dismiss a complaint for a simple offence if they are satisfied, on the balance of probabilities, that the person was, or appears to have been, of unsound mind when the offence was allegedly committed, or is unfit for trial.
- Section 173 – a Magistrate may adjourn court proceedings for a simple offence for up to six months if the person is unfit for trial but is likely to become fit for trial within six months.

- Section 174 – a Magistrate is empowered to refer to Queensland Health or the agency responsible for disability services (either the National Disability Insurance Agency (NDIA) or DCDSS) the mental condition of a person who has been dealt with under section 172 or 173 of the MHA 2016.
- Section 175 – a Magistrate may refer an indictable offence (other than an offence against a law of the Commonwealth) to the MHC if the person appears to have been of unsound mind or is unfit for trial.

The expansion of the Queensland Health CLS was fundamental to implementing the new Magistrate powers (see paragraph 7.8.1.6), including the provision of medico-legal reports on unsoundness of mind and unfitness for trial. In line with the above provisions, Magistrates also have the power to direct the person to attend an AMHS for an examination.

7.8.1.1 Section 172 (unsound mind), and 173 (unfit for trial)

In 2017-18, 413 simple offence matters were dealt with in the Magistrates Court under sections 172 and 173 of the MHA 2016 (128 were dismissed under section 172, and 285 were adjourned under section 173). In a further 288 matters Magistrates considered sections 172 and 173, and determined the provisions did not apply. Table 11 details this data.

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

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

Table 11

Provisions of MHA 2016	Matters dealt with
s172 (dismissed – unsound mind or unfitness for trial)	128
s173 (adjourned – temporary unfitness for trial)	285

7.8.1.2 Section 174 (referral to an appropriate agency)

Under section 174 of the MHA 2016, Magistrates may refer the mental condition of a person who has been dealt with under section 172 or 173 to Queensland Health or the agency responsible for disability services (either the NDIA or DCDSS). As at 30 June 2018, the Magistrates Court had not made any referrals to either Queensland Health or DCDSS under section 174.

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

On 44 occasions the CLS contacted DCDSS to seek advice about whether a person appearing before a Magistrate is linked with disability services. These requests were undertaken with the patient's consent and information from DCDSS was then provided to the Magistrate prior to the decision being made as part of the CLS feedback form.

While a referral may be made to the National Disability Insurance Scheme (NDIS) for an eligibility determination, the Magistrates Court cannot make a direct referral for NDIA services. Support for individuals under the NDIS is based on eligibility (access) criteria set out in the *NDIS Act 2013* (Cth). Upon full scheme transition of disability services to the NDIS, the CLS will only be able to provide information for consumers requiring disability supports to make their own contact with the NDIA. It will be important to ensure that processes for disability support referrals to the NDIA for people with intellectual disability continue to be effectively managed by the CLS upon full scheme transition to the NDIS.

Legal sector survey respondents provided strong support for Magistrates to refer individuals to Queensland Health or disability services. Seventy-two per cent of the respondents agreed that this was a meaningful way of engaging people in treatment and care (18 per cent disagreed and 10 per cent stated this question was not applicable to them) (94 respondents). While the provisions have not yet been relied upon by Magistrates, the evaluation found that these referral pathways (either formal or informal) are an appropriate mechanism for engaging people appearing before Magistrates in treatment and care.

7.8.1.3 Section 175 (references to the MHC)

Section 175 of the MHA 2016 allows a Magistrate to refer an indictable offence (other than an offence against a law of the Commonwealth) to the MHC if the person appears to have been of unsound mind or is unfit for trial. Twenty-four references (plus one amended reference) were received by the MHC from Magistrates in 2017-18. Data provided by the Magistrates Court reports that 67 references were provided to the MHC from Magistrates. It is understood that the difference between the MHC's record of references received and the Magistrates Court record of references made by Magistrates may be due to data entry issues in the Queensland Wide Interlinked Court (QWIC) system or a discrepancy between an intention to file a reference in the MHC and an actual reference being made in the 2017-18 period.

7.8.1.4 Section 183 (Supreme Court and District Court references to the MHC)

Section 183 of the MHA 2016 allows the Supreme Court and District Court to make a reference to the MHC for a person who pleads guilty to a serious offence where the court is reasonably satisfied, on the balance of probabilities, that the person:

- was, or appears to have been, of unsound mind when the offence was allegedly committed;
- for the offence of murder, the person was, or appears to have been, of diminished responsibility when the offence was allegedly committed; or
- is unfit for trial.

In 2017-18, less than five matters were referred to the MHC. Data provided by the Magistrates Court noted that due to the small number of references, the actual number of references has been replaced with less than five to reduce the risk of identification of an individual.

7.8.1.5 Examination orders (EOs)

In addition to the powers for Magistrates to adjourn, dismiss or refer matters, Magistrates may now make an EO when a person charged with a simple offence has, or may have, a mental illness or intellectual disability. A Magistrate may direct the person to attend an AMHS for an examination which may result in a TA being made for the person, the development of a treatment plan for the voluntary treatment of the person, or, if the person is already on an authority or order under the MHA 2016, a change to the person's treatment.

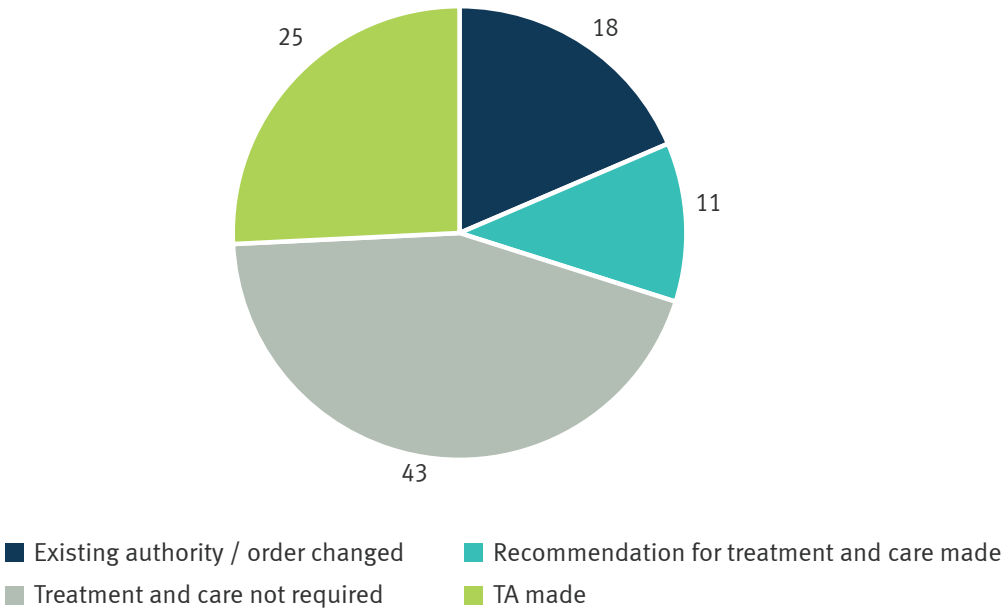
In 2017-18, 95 EOs were made by Magistrates. Figure 20 details EO outcomes following assessment.

In 2017-18,

95 examination orders

were made by Magistrates.

Figure 20. Examination order outcomes (2017-18)



Note: 95 EOs were made in 2017-18. Figure 20 provides 97 EO outcomes because two EOs made in 2016-17 had an outcome in the 2017-18 period.

Table 12 provides a breakdown of the average number of days between when an EO is made and an assessment is undertaken at an AMHS. On 22 occasions a classified admission followed an EO assessment.

Table 12

AMHS	Number of EOs made	Average number of days between EO made and assessment
Bayside	8	4.3
Cairns Network	3	24.7
Central Queensland Network	3	3.3
Darling Downs Network	7	17.1
Gold Coast	14	3.2
Logan Beaudesert	10	3.8
Princess Alexandra Hospital	25	4.5
Redcliffe Caboolture	11	3.4
RBWH	7	4.3
Sunshine Coast Network	1	16
The Prince Charles Hospital	1	0
Townsville Network	4	6
West Moreton	2	1
Wide Bay	1	1
Total	**97**	**6.6**

Note: 95 EOs were made in 2017-18. Table 12 reports on 97 EOs because it includes two EOs made in 2016-17. which had an outcome in the 2017-18 period).

Stakeholder feedback from the legal sector survey (43 respondents) indicates that the process for EOs is generally operating effectively but that there is scope for communication pathways to be improved with HHSs:

- Of survey respondents who responded to this question (n 42), 83 per cent agreed and 17 per cent disagreed advice provided by the CLS in relation to EOs is useful. One respondent stated this question was not applicable to them.
- Of survey respondents who responded to this question (n 37), 54 per cent agreed and 46 per cent disagreed communication pathways with HHSs about EOs are clear and easy to navigate. Six respondents stated this question was not applicable to them.
- Of the eight Magistrates who commented on the benefit of information provided in examination reports, seven agreed the information provided is of benefit to the court.

7.8.1.6 Expansion of the Court Liaison Service (CLS)

When deciding whether a person was of unsound mind at the time of an offence, or is unfit to stand trial, the Magistrates Court is supported by the Queensland Health CLS.

The primary purpose of the CLS is to provide clinical assessments and support diversionary processes into treatment where required for persons detained in court watchhouses or appearing before the Magistrates Court. The CLS was established to assist in the identification of mental health treatment needs and facilitate appropriate referral to services, including diversion from the criminal justice system. The CLS is available to both adults and children and consists of senior health practitioners who assess the person's mental health and provide an assessment report to the Magistrates Court.

While the CLS previously provided assessments relating to a person's mental health care needs, in line with the MHA 2016, it has been expanded to provide medico-legal reports on unsoundness of mind and unfitness for trial and thus plays a critical role in assisting Magistrates in their decisions.

7.8.1.6.1 CLS steering group

A CLS steering group was established to provide a forum for discussion, resolution of issues and expert advice in relation to the implementation of the provisions of the MHA 2016 regarding the Magistrates Court. The group was made up of representatives from the Office of the Chief Magistrate, Queensland Magistrates Court, the Office of the Chief Psychiatrist, FMHS, QMHC, the Office of the Director of Public Prosecutions, LAQ, Aboriginal and Torres Strait Islander Legal Service, Queensland Law Society, the Queensland Bar Association, QPS prosecutions, the Public Guardian and government stakeholders.

During its operation (from May 2016 until August 2018), the steering group considered and refined: referral processes and requests for reports; the format and ownership of reports prepared for the court; how reports are managed (for example, tendered or challenged); the geographical coverage of the CLS; and the CLS model of service.

7.8.1.6.1.1 Legislative amendments

During implementation, the CLS steering group raised concerns that the MHA 2016 may allow statements made by a person during a mental health assessment or examination to be admitted in evidence against the interests of the person. The CLS steering group recommended amendments to the MHA 2016.

As a result, the *Mental Health Amendment Act 2017* amended the MHA 2016 to clarify that oral and written statements made by a person:

- during an assessment regarding unsoundness of mind or fitness for trial; and
- during an examination conducted pursuant to a Magistrates Court examination order

are not admissible in evidence against the person in any criminal or civil proceeding. This amendment ensures people may undergo mental health assessments without risk of self-incrimination.

7.8.1.6.2 Allocation of resources

Approximately $7.7 million was allocated to: HHS CLSs to increase adult services from 17 full time equivalent (FTE) positions to 39 FTE positions; and the CYMHS CLSs to increase to 9.6 FTE positions.

As at 30 June 2018, increased funding to the CLS had delivered the following increased FTEs:

Table 13

AMHS/region	Number of newly funded positions (as part of implementation)	Number of funded positions at commencement of the MHA 2016 (pre-existing + newly funded)	Number of filled positions (as at 30 June 2018)
Cairns AMHS	1 NG7/HP4 0.5 MO2/L26	3 NG7/HP4	2 NG7 1 HP4 0.5 MO2/L26
Townsville AMHS	1.5 NG7/HP4 0.5 MO2/L26	1 NG7/HP4 0.5 MO2/L26 0.5 Registrar	1 HP4 0.5 MO2/L26 0.5 Registrar
Mt Isa		1 NG7/HP4	1 NG7
Mackay AMHS		1 NG7/HP4	1 HP4
Central Queensland AMHS	1 NG7/HP4 0.5 MO2/L26	2 NG7/HP4 0.5 MO2/L26	2 NG7 0.5 MO2/L26
Wide Bay AMHS	1 NG7/HP4	1 NG7/HP4	1 NG7
Metro North HHS (provides services in SEQ)	11.5 NG7/HP4 2.5 MO2/L26 2 AO3	20.34 NG7/HP4 1NG6 3.5MO2/L26 2 AO3 1 HP5 Team Leader	15.65 NG7/HP4 2.8 NG6 3.5 MO2/L26 2 AO3 1 HP5 Psychologist 1 HP4 Psychologist 1 HP5 Statewide Coordinator 1 HP5 Team Leader

7.8.1.6.3 Training and support for CLS staff

Court liaison officers (CLOs) participate in a number of education and training activities prior to receiving accreditation to provide reports to the Magistrates Court, including:

- viewing a series of four videos detailing specific elements of the CLO role, including: legislation, legal overview, report writing, and ethical issues and principles in forensic psychiatry; and

- three training components based on: expert witness testimony, fitness for trial concepts, and soundness of mind concepts.

In addition, a number of regular regional and statewide CLS meetings are in place which provide opportunity for process clarification and training, including:

- a monthly statewide meeting for CLS team leaders and CLOs outside of South East Queensland (SEQ);
- a weekly SEQ business meeting and clinical review process; and
- an annual two-day CLS symposium.

Four specific questions regarding the CLS were included in the change management survey developed to inform the evaluation. Twenty CLS staff provided responses to the questions, a summary of which is below:

- Seventy per cent were supported to attend specific face-to-face training about the requirements of the CLS prior to the commencement of the MHA 2016.
- Participants reported that training about fitness for trial concepts and assessments and unsoundness of mind assessment were of the most use in preparation for the commencement of MHA 2016, followed by training about report writing and identification, screening, assessment and cognitive and intellectual disability referral processes.
- The following areas were nominated as areas requiring further training and education for CLS staff/mental health service providers: assessments - unsound mind/fitness for trial, report writing, CIMHA/QWIC, and child and youth specific training.

7.8.1.6.4 Service provision

Eighty-five per cent of legal sector respondents agreed and 11 per cent disagreed that advice provided in CLS reports relating to fitness and unsoundness of mind was useful in their decision-making (four per cent of respondents stated this question was not applicable to them) (94 respondents). In addition, 80 per cent of survey respondents agreed and 19 per cent disagreed the CLS was readily accessible (one per cent of respondents stated this question was not applicable to them) (94 respondents) and 81 per cent of survey respondents agreed and 18 per cent disagreed reports provided by the CLS are provided in a timely manner (one per cent of respondents stated this question was not applicable to them) (94 respondents).

Eighty-five per cent of advocates, legal representatives and other service providers agreed access to the CLS has resulted in appropriate support for persons with a mental illness appearing before Magistrates Courts (33 respondents).

There was strong support for the CLS with stakeholders generally agreeing the CLS was making pathways smoother and more accessible and 80 per cent of Magistrates surveyed agreeing the CLS was readily accessible. However, CLS staff, legal stakeholders, and advocates, legal representatives and other service providers identified that the demand for CLS services had outweighed expectations, resulting in some delays in the provision of CLS reports.

A total of 9,164 referrals to CLS (including paper-based triage processes) for adults (n 8,351)

and children and youth (n 813) were received in 2017-18. A breakdown of service provision is provided below.

7.8.1.6.4.1 Adult CLS activity 2017-18

In 2017-18, 8,351 referrals (including paper-based triage processes) were received by the CLS. Following triage, 3,537 intake assessments were completed, resulting in 1,568 mental health feedback forms (Form 1), 260 fitness for trial assessments (Form 2) and 571 fitness for trial and unsoundness of mind assessments (Form 3) being presented to the Magistrates Court. 1,138 intake assessments did not result in further assessment or presentation to the court. The remaining 4,814 referrals did not receive an intake assessment due to either refusal of service by the person or no assessment being offered due to triage processes and CLS resource capacity.

In 2017-18, the Court Liaison Service conducted over

3,500 intake assessments

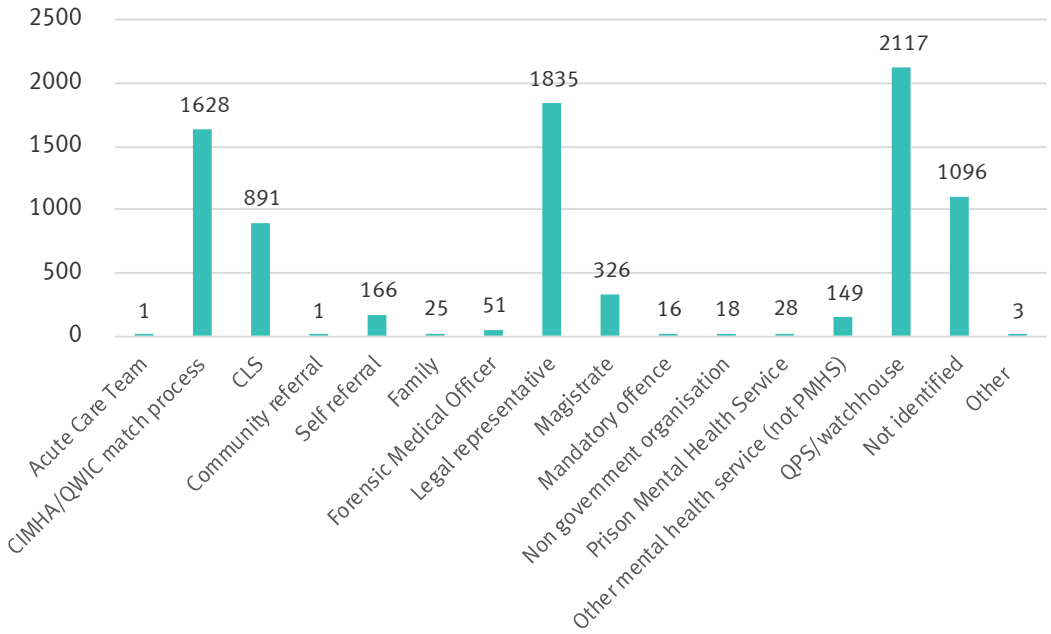
and provided over

800 medico-legal reports to Magistrates

(for adults) about fitness for trial and unsoundness of mind.

Figure 21 provides a breakdown of adult CLS referrals by referral source.

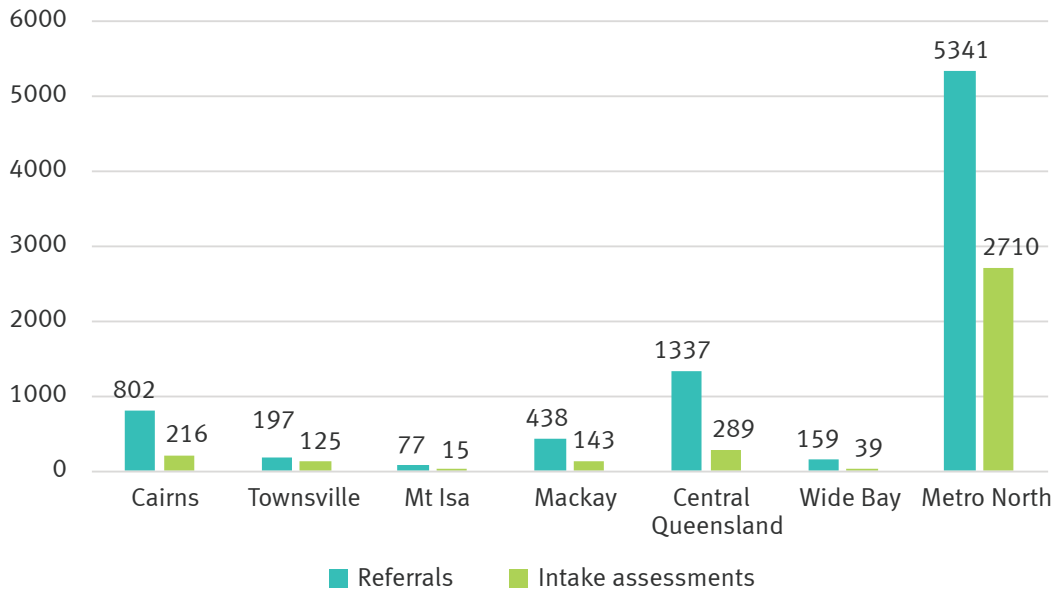
Figure 21. CLS referrals by referral source (2017-18)



Note: Referrals received include computer based matching (for example the CIMHA/QWIC match process) and paper based processes.

Figure 22 provides a breakdown of adult CLS referrals and intake assessments by region.

Figure 22. CLS referrals and intake assessments by region (2017-18)



Note: The Metro North region manages SEQ.

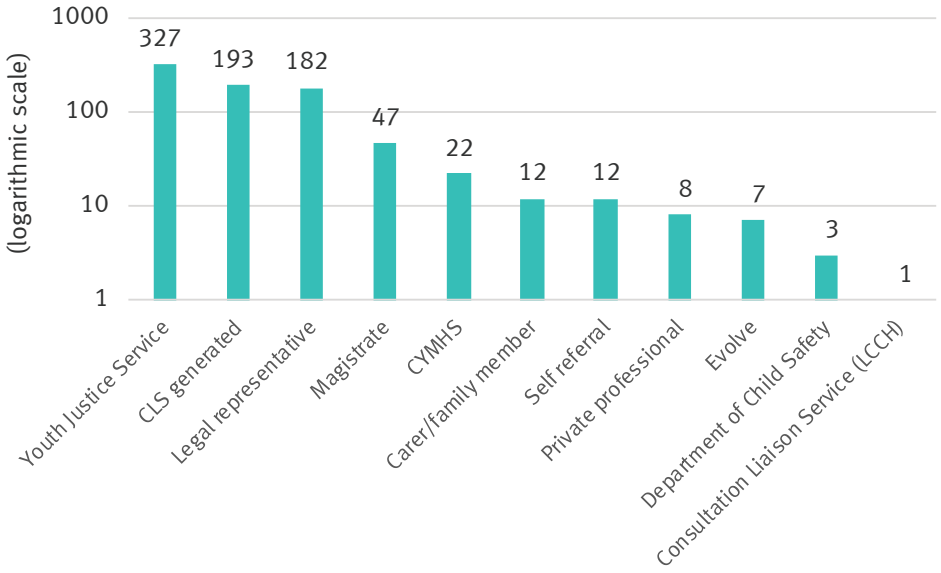
7.8.1.6.4.2 CYMHS CLS 2017-18

813 CYMHS CLS referrals were received in 2017-18, these included:

- 626 mental health assessments;
- 168 fitness for trial assessments; and
- 19 soundness of mind assessments.

Figure 23 provides a breakdown of CYMHS CLS referrals by referral source.

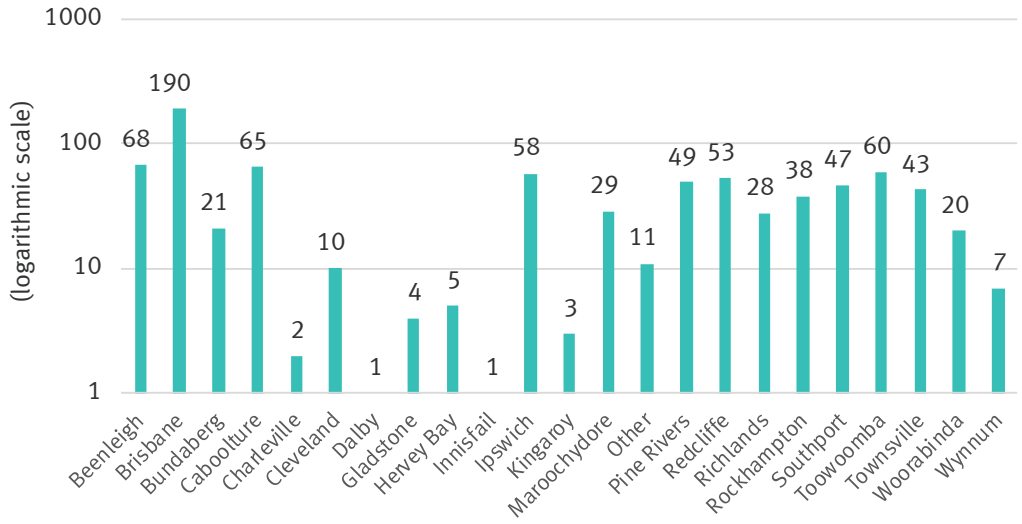
Figure 23. CYMHS CLS referrals by referral source (2017-18)



Note: An additional 76 referrals relating to minors were actioned by the adult CLS team.

Figure 24 provides a breakdown of CYMHS CLS referrals by location.

Figure 24. CYMHS CLS referrals by region (2017-18)



7.8.1.7 Review of new Magistrate powers and the CLS

The Department of Health committed to undertake a review of the provisions that enable Magistrates to dismiss simple offence charges on the basis of unsoundness of mind or unfitness for trial, including the effectiveness of the CLS, within two years of the commencement of the MHA 2016. The intent of the review is to determine whether the new provisions ensure persons who may have a mental health defence or are unfit for trial have an opportunity to be dealt with by the court in an appropriate manner.

The evaluation found that, for people who have committed simple offences, Magistrates are using their new powers to make decisions about whether the person was of unsound mind at the time of an offence, or is unfit to stand trial. This is resulting in simple offence matters being diverted from the MHC and individuals receiving appropriate treatment and care for their mental illness or disability related needs. Magistrates are being well supported by the CLS, including through the provision of: medio-legal reports, informal referrals to health or disability services, and advice regarding the appropriateness of EOs. Queensland Health will continue to monitor the ongoing operation of these provisions.

The expanded CLS is generally operating effectively and has strong support from Magistrates and a range of other stakeholders, including legal sector stakeholders, advocates, legal representatives and other service providers. Queensland Health will continue to monitor the operation of the CLS to ensure communication pathways support referrals to appropriate health and disability related services, and with HHSs regarding EOs. While the CLS is effectively supporting Magistrates to discharge new powers under the MHA 2016, there is limited evidence to determine whether changes are required to support the operation of the CLS. It would be beneficial for performance indicators and service delivery outcomes to be developed to measure whether there are opportunities for the operation of the CLS to be improved.

7.8.2 Mental Health Court (MHC)

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

The MHA 2016 provides that the Act applies only to proceedings for an alleged offence that start after the commencement of the Act. The effect of this provision is that any proceedings on foot prior to the commencement of the MHA 2016 must continue to be dealt with under the provisions of the MHA 2000. As at 30 June 2018, there were 16 MHC references awaiting consideration by the MHC under the provisions of the MHA 2000. It is expected that the full impact of the MHA 2016 provisions on MHC outcomes will not be fully understood until these matters are dealt with.

7.8.2.1 Psychiatrist reports

The review of the MHA 2000 identified a number of issues in relation to the mandatory preparation of a psychiatrist report for an involuntary patient on an ITO or FO charged with any offence. In particular, the review identified the importance of introducing an efficient legislative framework that balances the rights of a person with a mental illness with the protection of the community.

As a result, the MHA 2016 introduced reforms relating to the way in which people with a mental illness interface with the justice system and removed the requirement for mandatory psychiatrist reports for involuntary patients charged with an offence, regardless of the nature of the offence or the patient's wishes. Instead, the MHA 2016 provides that an involuntary patient on a TA, FO or TSO who is charged with a serious offence (an indictable offence other than one that must be heard by a Magistrate) may request a psychiatrist report at no cost to the patient. The request can also be made by a NSP, an attorney or guardian, a lawyer or a parent of a minor. The request is made to the Chief Psychiatrist who may direct that a psychiatrist report be prepared. The Chief Psychiatrist may only give a direction that a report be prepared if satisfied: the patient may have a mental condition; and may have been of unsound mind at the time when the serious offence is alleged to have occurred, or may be unfit for trial; and the preparation of the report is in the public interest.

The report provides the psychiatrist's opinion on whether the patient was of unsound mind at the time of an alleged offence or is unfit for trial, and is intended to assist the patient and their support persons with decisions about further action, including whether to make a reference to the MHC.

In addition, the Chief Psychiatrist may, on the Chief Psychiatrist's own initiative, direct that a psychiatrist report be prepared and/or refer a matter to the MHC if satisfied it is in the public interest.

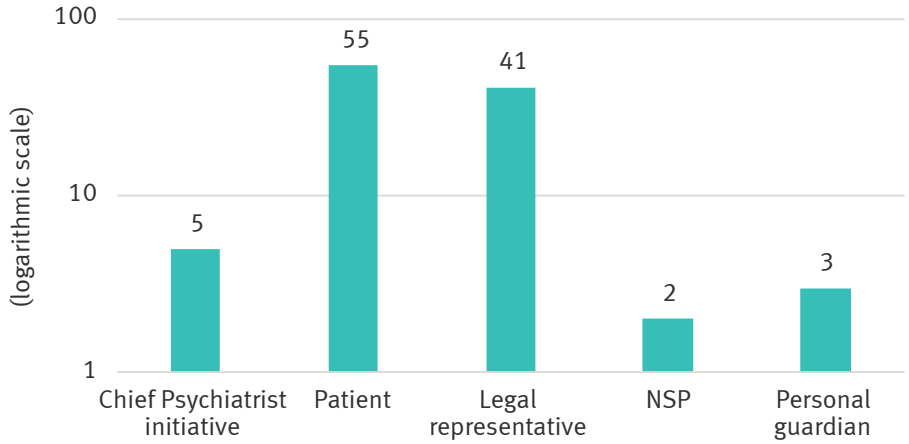
7.8.2.1.1 Application of provisions

The *Chief Psychiatrist Annual Report 2017-2018* notes 197 occasions where the psychiatrist report provisions of the MHA 2016 could potentially be applied for patients charged with a serious offence. On 134 occasions a person was deemed eligible to apply for a psychiatrist report. As at 30 June 2018, 106 psychiatrist reports (relating to 98 patients) were requested under the provisions of the MHA 2016 for patients charged with a serious (indictable) offence, including five directed on the Chief Psychiatrist's initiative.

By comparison, in 2015-16 there were 2,172 reported occasions (involving 1,387 patients) where the psychiatrist report provisions of the MHA 2000 applied, or potentially applied, for patients charged with any offence. While reports were previously provided for all simple and serious offences, this represents a significant reduction in overall numbers of psychiatrist reports provided.

Figure 25 provides a breakdown of reports requested in 2017-18 by applicant type.

Figure 25. Request for psychiatrist report by applicant type (2017-18)



Generally, feedback gathered by the evaluation was positive regarding the new process for psychiatrist reports. However, the evaluation found it is important to ensure patients with low-literacy, intellectual or cognitive disability, acquired brain injury and those from non-English speaking backgrounds are assisted to understand psychiatrist reports.

It was also identified that some patients may find the historical information contained in their psychiatrist report distressing, which may result in barriers to the patient's engagement with their treating team, legal representative or the MHRT.

7.8.2.2 References to the MHC

Two hundred and two references were made to the MHC in 2017-18 including 63 made by the Chief Psychiatrist following the receipt of a psychiatrist report. The Chief Psychiatrist received 106 psychiatrist reports in 2017-18. While 63 reports were used to support a referral to the MHC, the remaining 43 reports may have been used in a number of ways, including being the subject of a reference by a legal representative or the Magistrates Court under section 175, or used in the originating criminal jurisdiction (for example, if the report found the person was of sound mind at the time of the offence and/or fit for trial).

In 2015-16 (under the provisions of the MHA 2000), 223 references were made to the MHC, 188 of these references were made by the former Director of Mental Health. The number of references in 2017-18 represents a large reduction in the number of yearly references to the MHC by the Chief Psychiatrist.

As at 30 June 2018, the MHC was still to consider 16 references made under the MHA 2000, which means that the benefit from the reduction in references is not yet having a significant impact on the workload of the MHC.

7.8.2.3 Forensic orders (FOs)

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

The MHA 2016 allows the MHC to make a TSO as a more appropriate alternative to an FO. As new MHA 2016 references are considered by the MHC, it is anticipated that the uptake of TSOs will increase, resulting in a reduction in the number of FOs made by the MHC. Because the MHC is still considering a number of MHA 2000 references, this reduction has not yet been realised. Changes to the jurisdiction of the Magistrates Court to allow the Magistrates Court to deal with simple offences where a person is of unsound mind or unfit for trial are designed to ensure FOs are made in appropriate circumstances when necessary.

The MHA 2016 provides discretion to the MHC to determine a non-revocation period of up to 10 years when it makes a FO. The MHC may apply a non-revocation period in relation to prescribed offences, which include murder, attempted murder, manslaughter, rape, attempted rape and grievous bodily harm. The MHC has applied the non-revocation period once since the commencement of the MHA 2016. This low uptake may be because the MHC continues to hear MHA 2000 references, under which this provision is not able to be relied upon. The use of this provision may increase as MHA 2016 references are more regularly heard by the MHC.

In 2017-18, 105 FOs were made. Figure 26 compares FOs made over the last six years. While the number of FOs made has slightly reduced since the previous year, it is anticipated that a reduction will be seen over future years, noting MHA 2000 references are still being dealt with by the MHC.

Figure 26. Six year comparison of FOs made across reporting periods

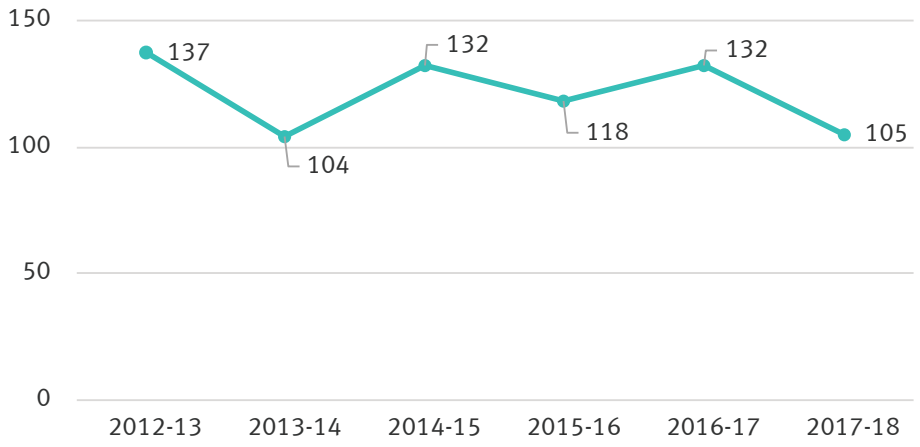


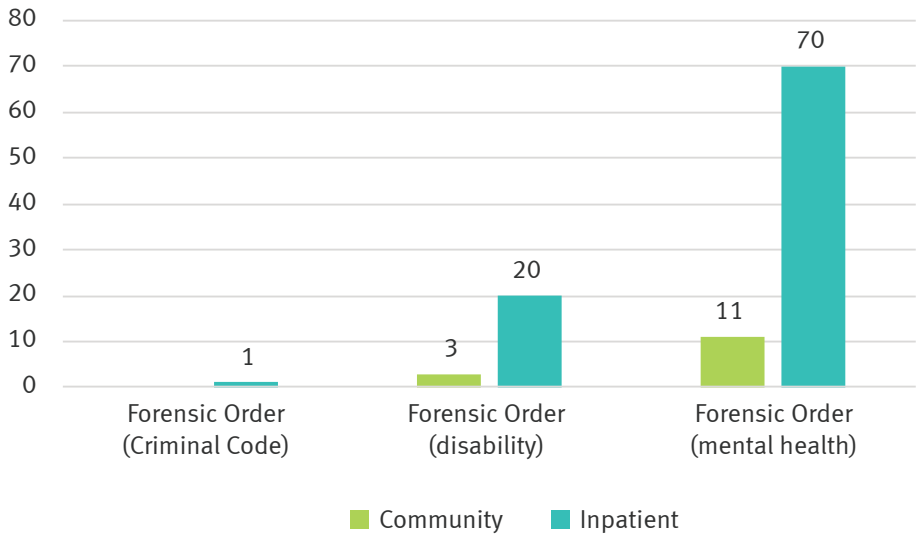
Table 14 provides the statewide rate of FOs as at 30 June per 10,000 population over the last six years.

Table 14

Reporting period	Population	FOs as at 30 June	FOs as at 30 June per 10,000 population
2012-13	4,568,205	734	1.6
2013-14	4,651,359	741	1.6
2014-15	4,719,925	770	1.6
2015-16	4,778,854	792	1.7
2016-17	4,927,629	803	1.6
2017-18	5,012,176	811	1.6

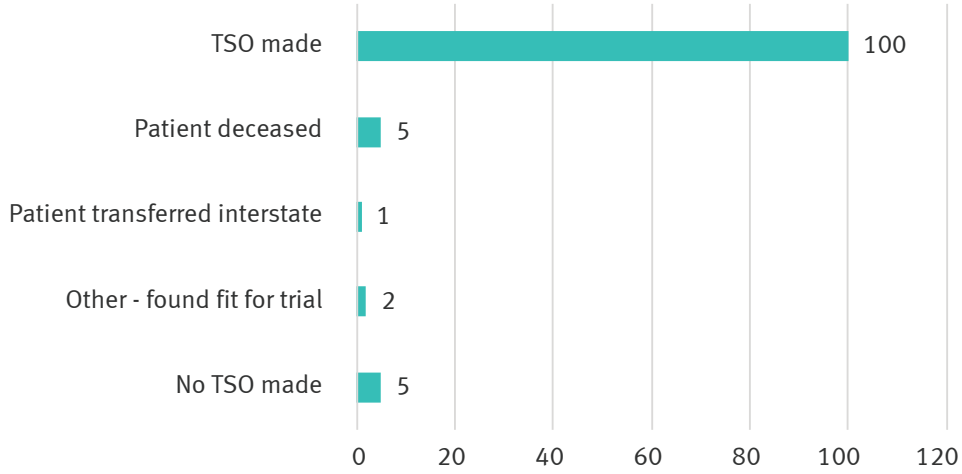
Figure 27 provides a breakdown of FOs made in 2017-18 by type and category.

Figure 27. FOs made by type and category (2017-18)



In 2017-18, a total of 113 FOs were ended (112 forensic orders (mental health) (FO (MH)), and one forensic order (disability) (FO (D)). Figure 28 shows the reasons FOs were ended, including the one FO (D) which was revoked on appeal by the MHC.

Figure 28. FOs ended by reason (2017-18)



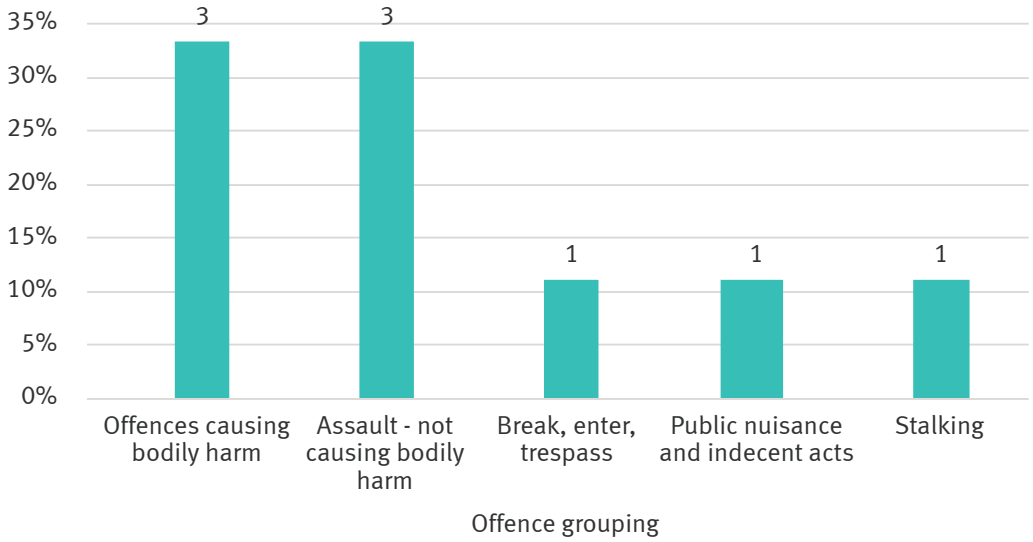
7.8.2.4 New treatment support orders (TSOs) for mental health patients

The MHA 2016 introduced TSOs which may be made by the MHC or the MHRT when considering or reviewing mental health related FOs. A TSO differs from a FO in the way in which treatment in the community is authorised (treatment is either in the community or on limited community treatment, unless inpatient treatment is necessary) and the nature of clinical oversight of the person on the TSO. A TSO allows an authorised doctor to determine the extent of community treatment the person receives.

The MHC can make a TSO when a FO (MH) is not appropriate in the circumstances. This change recognises that placing a person on a FO is not always warranted due to their risk to the community, for example in circumstances where a person's role in an offence was relatively minor.

Figure 29 provides TSOs made by the MHC in 2017-18, by offence grouping.

Figure 29. TSOs made by the MHC by offence grouping (2017-18)



In 2017-18, 104 TSOs were made. Nine of the 104 TSOs were made by the MHC. All nine were made under a community category and no TSOs were made for people who had committed a prescribed offence. This shows that in circumstances where it is not necessary for a person to be placed on an FO, the MHC is relying on TSOs as an alternative option.

The Office of the Chief Psychiatrist will continue to monitor the use and uptake of TSOs by the MHC.

7.9 Mental Health Review Tribunal (MHRT) changes

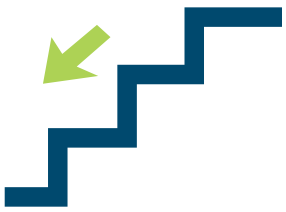
Under the MHA 2016, the MHRT continues its primary function of reviewing the involuntary status of persons with a mental illness and/or intellectual disability. The MHRT's jurisdiction encompasses reviews, applications and appeals. The MHRT reviews TAs, TSOs, FOs, the fitness for trial of particular persons, and the detention of minors in high security units. The MHRT hears applications: for examination authorities, to perform regulated treatments (ECT and deep brain stimulation procedures), and for approvals to transfer patients into and out of Queensland. The MHRT also hears appeals against particular decisions of the Chief Psychiatrist in relation to information notices, and decisions of administrators of AMHSs to refuse to allow a person to visit a patient in their service.

7.9.1 Forensic order (FO) step-down to a treatment support order (TSO)

The introduction of TSOs in the MHA 2016 gives the MHRT the ability, when reviewing a FO (MH), to revoke the FO (MH) and make a TSO which operates as a more appropriate form of order. The purpose of a TSO is to step-down a patient from their FO (MH) as a part of their recovery when it is appropriate to do so. This recognises that continuing some patients on a FO for an extended period is not warranted by their risk to the community.

In 2017-18, the MHRT revoked 95 FOs and replaced them with a TSO. Ninety-two of these TSOs were made with a community category and three with an inpatient category.

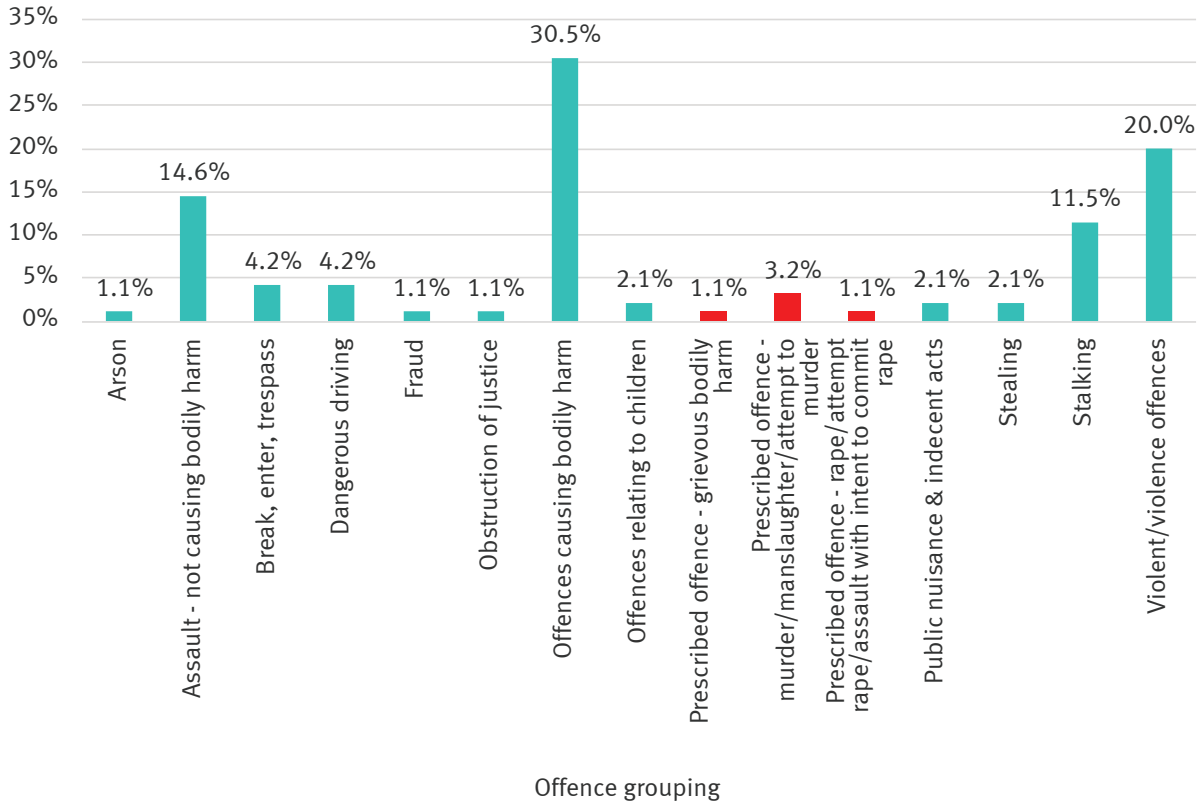
Figure 30 provides TSOs made by the MHRT in 2017-18, by offence grouping.



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

95 forensic orders to treatment support orders.

Figure 30. TSOs made by MHRT by offence grouping (2017-18)



Note: Patients stepped down to a TSO with a prescribed offence had previously spent between eight and 15 years on a FO.

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

7.9.2 New requirement for legal representation at particular MHRT hearings

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

The survey conducted by the evaluation asked respondents whether access to no cost legal representation has improved support for patients in MHRT hearings. Seventy-four per cent of advocates, legal representatives and other service providers agreed that access to legal representation has improved support for patients (42 respondents). This cohort also identified that: improved access to legal advice and advocacy has resulted in increased attendance and engagement at hearings; the requirement for a legal representative to consult with a patient's support network has resulted in better engagement and uptake of NSPs; and legal representatives are useful in identifying and advising or referring in relation to other legal issues, such as housing, debt, criminal matters and domestic violence. Administrator delegates identified that while initially challenging, working with legal representatives is becoming easier due to their increasing experience working with patients.

However, 60 per cent of patients, carers and support persons disagreed legal representation has led to improved support for patients (15 respondents). Some stakeholders who raised concerns about the appointment of legal representatives suggested that:

- the appointment process is difficult for some patients;
- the timing of appointment does not allow representation and advocacy between hearings;
- patients should be able to choose who their legal representative is; and
- many people do not meet the criteria for legal representation.

LAQ is contracted to provide legal representation at MHRT hearings. Representation is provided either directly by LAQ, by private firms, or by community legal centres contracted by LAQ.

In 2017-18, for those patients who were eligible under the MHA 2016 for legal representation, representation was provided at 2,541 MHRT hearings, including at 157 hearings involving minors detailed in section 7.7.2. A breakdown of the remaining 2,384 hearings by type is provided below:

- ECT – 517 hearings;
- fitness for trial – nine hearings;
- FO – 1,788 hearings;

- TA – 13 hearings; and
- other – 57 hearings (other includes hearings related to sole confidentiality orders, non-ablative neurosurgery, applications to transfer out of Queensland, and/or hearings where multiple matters where heard, for example, FO and fitness for trial, FO and ECT etc.).

The evaluation found that the new requirement for the MHRT to appoint a legal representative for matters relating to minors, applications to perform ECT, fitness for trial hearings, or forensic patient reviews where the Attorney-General is legally represented may be one of the factors that contribute to increased adjournments of MHRT hearings. The Office of the Chief Psychiatrist will continue to work with the MHRT to monitor the rate of adjournments.

7.9.3 Amended timeframes for the provision of reports to the MHRT

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

In 2016-17, the percentage of adjournments for hearings under the MHA 2000 (1 July 2016 to 4 March 2017) was 19 per cent, while the percentage under the MHA 2016 (5 March 2017 to 30 June 2017) was 46 per cent. In response to this issue, the Office of the Chief Psychiatrist and the MHRT worked together to develop communication materials for AMHSs regarding the new timeframes.

3,866 adjournments occurred in 2017-18. Due to targeted action to address AMHS compliance with the timeframe, the adjournment rate decreased from 38 per cent (as at 1 July 2017) to 24 per cent (as at 30 June 2018). Data available in the *MHRT 2017/18 Annual Report* provides that across 2017-18, 32 per cent of all adjourned hearings were adjourned due to the clinical reports not being provided to clients within the statutory timeframe.

7.10 Risk assessment and management

The Chief Psychiatrist policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* was implemented to coincide with commencement of the MHA 2016. Operating as a clinical governance framework, the policy strengthens the assessment and risk management of forensic and identified high risk patients. One mechanism introduced under this policy was the establishment of ARMCs in each AMHS.

The ARMC functions as a clinical peer review of the treatment and care of patients subject to a FO, TSO and other patients (whether subject to a TA or voluntary) whose risk profile is assessed as high by their treating team.

An evaluation of the ARMC was undertaken and the *Assessment and Risk Management Committee Evaluation Report* was finalised in December 2017. A summary of the key findings is below:

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

- There are opportunities to improve routine data collection mechanisms for ongoing monitoring and compliance, particularly in relation to ARMCs undertaken for persons charged with a prescribed offence, for people in custody and voluntary patients.
- Although AMHS processes reflect local requirements, the ARMC framework has been inconsistently operationalised across AMHSs, creating challenges for services working across multiple AMHSs, such as the MHRT and Community Forensic Outreach Service.
- A lack of understanding by AMHSs about their obligations to provide information to the MHRT is leading to patient review hearings being adjourned or delayed because ARMC minutes are not being provided to the MHRT prior to review hearings.
- The ongoing operation of ARMCs must align with the implementation of the three-tier risk assessment framework currently being implemented as a recommendation of the When Mental Health Meets Risk: Sentinel Events Review (and other local protocols for assessment of risk).

These findings are being considered as part of the update of the existing *Violence Risk and Management framework*. These changes are due to be finalised by June 2019.

7.11 Improved access to treatment for classified patients

The MHA 2016 expanded the classified patient provisions of the MHA 2000 that provided access to appropriate treatment and care for persons in custody who become acutely unwell through the introduction of a requirement for the Chief Psychiatrist to be notified by a doctor or AMHP if a person in custody is not transported to an AMHS within 72 hours of when an assessment or transfer recommendation has been made.

The amendments intended to provide more timely and equitable access to assessment, treatment or care for a mental illness to persons in custody. This change acknowledges that persons in custody experience barriers to accessing appropriate assessment, treatment and care, due to the increased focus on the risk and security requirements of this patient group. The amendments also intended to provide greater clarity and transparency regarding processes for classified patients, including: the basis on which a person becomes a classified patient; when a person ceases to be a classified patient; and the effect of the classified patient status relating to and on court proceedings.

7.11.1 Classified Patient Committee (CPC)

The CPC was established to support the amendments introduced in the MHA 2016 by providing a forum for discussion, review and resolution of issues, and advice, about the Chief Psychiatrist policy and practice guidelines for the transportation, admission, treatment and care, and return of classified patients. The CPC comprises the Chief Psychiatrist, executive directors of each AMHS, the director of the FMHS, the clinical director of the CLS, the clinical director of the Prison Mental Health Service, and the classified patient statewide coordinator.

The CPC meets at least four times per year to review: referrals made in the preceding three months; policy and operational processes; complex cases; and the minimum number of statewide beds and the breakup of those beds across AMHSs. The CPC may also meet as needed

to resolve concerns about a classified patient referral, admission or return. When a matter cannot be resolved by the CPC, the matter is referred to the Chief Psychiatrist for a decision.

7.11.2 Service provision

During 2017-18, 420 classified patient referrals were made, and on 263 occasions (63 per cent) a patient was admitted to an AMHS. Figure 31 provides a comparison of classified patient admissions across reporting periods (a breakdown of 2017-18 classified patient referral and admission data by AMHS is available in the *Chief Psychiatrist Annual Report 2017-2018*).

Figure 31. Classified patient admissions across reporting periods

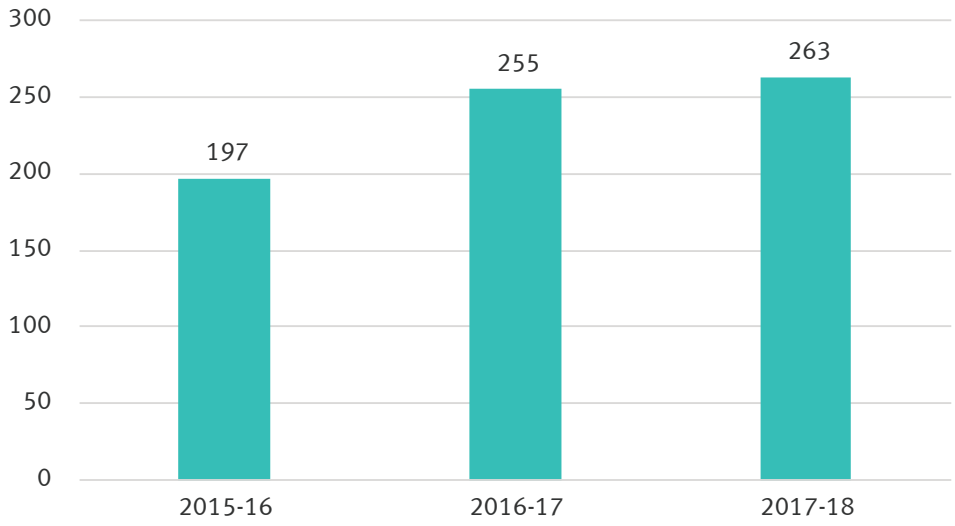
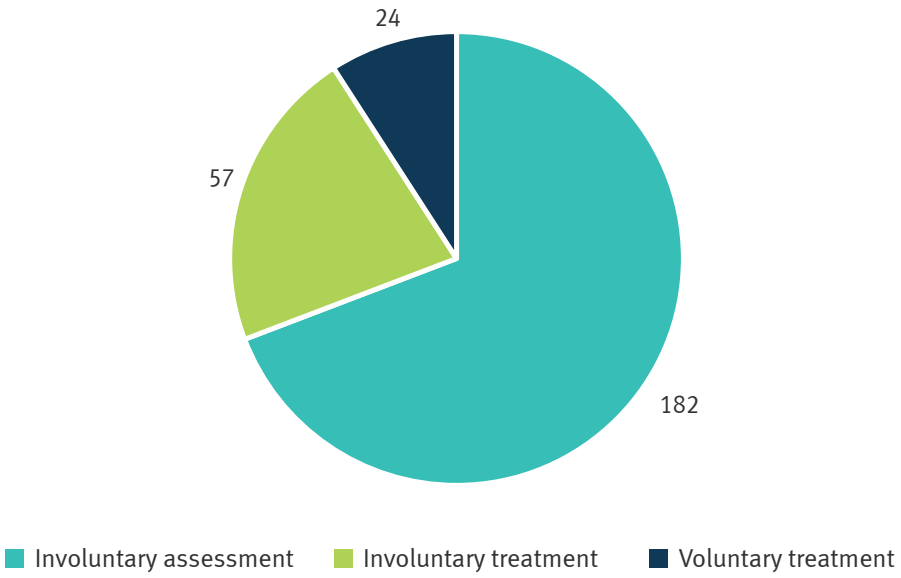


Figure 32 provides a breakdown of classified admissions (n 263) by type in 2017-18.

Figure 32. Classified patient admissions by type (2017-18)



In 2017-18, the average wait-time between referral and patient admission to an AMHS was 11 days. For patients who were not admitted (because they were either released from custody or the referral ceased or expired before admission) the average wait-time was 14 days.

The evaluation found that while an automatic monitoring system was implemented in CIMHA to fulfill the 72-hour notification requirement of the MHA 2016, due to data entry issues the automatic monitoring is not achieving its intended purpose. Currently, the notification timing is triggered by the CIMHA entry reflecting the recommendation for assessment or recommendation for transfer. Recommendations for assessment are on occasion being entered when a decision has been made about the person's transfer to an AMHS, rather than at the time the recommendation for assessment was made. Additionally, there are identified instances where referrals were not entered in CIMHA at the time of the referral. This results in the timeframe for classified admissions not accurately reflecting the time a patient has been waiting to be transferred or the number of referrals for patients who have not yet been admitted to an AMHS. To address this, the statewide coordinator plays an active role monitoring people requiring transfer to an AMHS, and works with relevant agencies to identify individual pathways within 72 hours for people requiring transfer.

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

7.12 Clarified transportation of patients provisions

The MHA 2000 included provisions for the transportation of patients to, from, and within AMHSs, including where a patient is absent without approval. The MHA 2016 provided the opportunity to develop clear and consistent powers and safeguards in relation to transportation provisions to ensure patients subject to the examination, assessment, and treatment provisions of the MHA 2016 can be safely conveyed to, from, or within an AMHS as required.

The MHA 2016 introduced a consolidated set of transportation powers which can be used by authorised persons, including ambulance and police officers, in a range of circumstances, including patients who are absent without approval. The MHA 2016 requires that reasonable efforts are made to encourage patients to return to an AMHS voluntarily before being compelled to return (with the exception of when specific risks associated with the return of a patient have been identified), via an authority to transport absent persons (ATAP).

Generally, police assistance with transport should only be sought where assistance is required for the management of serious risk to the individual or others, and/or it is unsafe for the patient to be returned by an authorised person other than the police officer. If police assistance is required to return a patient, a risk assessment and information about why police assistance is necessary must be provided to police for the matter to be appropriately prioritised.

In July 2017, the Tri-Agency AWA Committee was established to embed statewide processes that support the effective cross-agency operation of the transportation powers of the MHA 2016 for patients who are absent without approval. The Tri-Agency AWA Committee membership comprises Queensland Health, QPS, and QAS and has the following objectives:

- facilitate statewide systemic responses to challenges faced by agencies in relation to ATAP requirements under the MHA 2016;
- identify and operationalise individual agency roles in relation to arrangements for transportation of individuals subject to ATAP requirements;
- identify opportunities for better coordination, collaboration and information sharing between agencies; and
- formalise collaboration between agencies responsible for arrangements for transporting individuals subject to ATAP requirements under the MHA 2016.

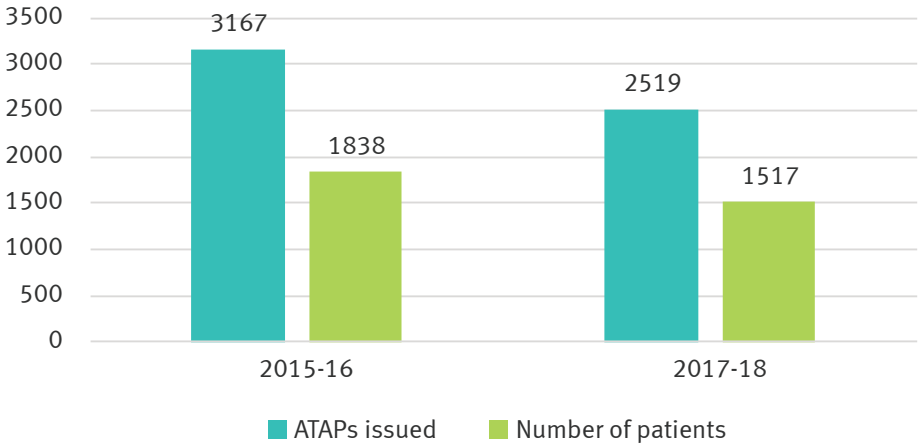
Of the 2,519 ATAPs issued in 2017-18:

- 546 were issued to both police and an authorised person;
- 1,716 were issued to police only; and
- 257 were issued to an authorised person other than police (for example, a health practitioner, appointed employee, or an ambulance officer).

The Tri-Agency AWA Committee continues to monitor the use of ATAPs, and is considering how assessment of serious risk is undertaken by each agency to improve consistency across agencies.

Figure 33 provides a comparison of ATAPs issued and number of associated patients across reporting periods.

Figure 33. ATAPs issued and number of associated patients across reporting periods



7.13 Improved victim support

The provisions in the MHA 2016 that support victims of crime when the offender has been assessed as having a mental illness or intellectual disability were intended to achieve a greater balance between the rights of patients and the rights of victims, and strengthening community protection.

In particular, the MHA 2016: requires persons performing functions under the Act to have regard to principles that apply to victims; aims to improve processes whereby victims receive information relating to FO and TSO patients, via an information notice (IN) or classified patient information (CPI) notice; includes new confidentiality arrangements that apply to victims; and eliminates the requirement for victims to repeatedly submit a victim impact statement at each MHRT hearing.

The MHA 2016 also allows HHS staff to use or disclose personal information to assist in the identification of a person who is, or may be, a victim for the purpose of referring the person to victim support services.

The Queensland Health Victim Support Service (QHVSS) reported that in its experience mental health staff were unclear about whether it was their role to refer victims to QHVSS, unsure about what information they could share, and anxious about breaching confidentiality. The Office of the Chief Psychiatrist and QHVSS continue to work together to embed these referrals within mental health services.

Sixty-seven per cent of survey respondents agreed the principles for victims in the MHA 2016 are considered by decision-makers (for example, the MHRT, Chief Psychiatrist, and treating teams) (12 respondents) and 67 per cent of survey respondents agreed that overall, the MHA 2016 supports persons receiving patient information under the victim provisions in a way that ensures their safety and wellbeing (12 respondents).

7.13.1 Information notices

Approval of an IN is now given by the Chief Psychiatrist, rather than the MHRT, within set timeframes to ensure the timeliness of decisions. Where relevant, victims are now also provided with information about the MHRT's reasons for any increase in the patient's treatment in the community.

The Chief Psychiatrist must ensure that a person entitled to receive information about a patient under an IN receives the information as outlined in the MHA 2016. This includes information about the timing and outcome of MHRT reviews, information about appeals, and information about patient absences if it is relevant to the safety and welfare of the person. Information about a patient being absent is to be given to the person as soon as practicable after the Chief Psychiatrist becomes aware of it. Other information is to be provided within 14 days. The Chief Psychiatrist may make arrangements with the QHVSS to provide the information on behalf of the Chief Psychiatrist.

Under a CPI notice, the Chief Psychiatrist can provide specific information about a classified patient, to a victim or other person affected by an unlawful act committed by the patient. Information may only be provided while the person is admitted as a classified patient in an AMHS from the court or place of custody.

7.13.1.1 Application timeframes

The MHA 2016 requires IN applications from a victim or close relative to be decided within 14 days, and within 28 days if the application is made by another individual. The average duration for an IN application to be decided in 2017-18 was 10 days. Of the 20 IN applications made in 2017-18 (all of which were from either a victim or a close relative of the victim), 18 applications had been approved and two applications pending a decision as at 30 June 2018 were subsequently approved. Two applications were decided outside of the statutory timeframe (one victim application (16 days) and one close relative application (37 days)).

CPI notice applications must be decided as soon as possible after receipt by the Chief Psychiatrist. Of the 14 CPI notice applications received in 2017-18 (all of which were from either a victim or a close relative of the victim), 10 were approved and four were not approved. The average duration of approved CPI notices in 2017-18 was 24 days, and 16 days for those that were not approved. Three of the four applications that were not approved were later resubmitted in 2017-18 and were approved following the submission of further supporting documentation.

7.13.1.2 Information provision timeframes

In 2017-18, the average duration between when an outcome was decided at an MHRT review and when the information was received by the Chief Psychiatrist for IN matters was six days. The average duration between when the Chief Psychiatrist advised the QHVSS of the same was three days. Information relating to CPI notices is provided to notice holders as soon as practicable.

Seventy-seven per cent of survey respondents agreed the amount of patient information they receive meets their expectations (13 respondents) and 62 per cent agreed the amount of patient information they receive helps them understand the patient's progress through the mental health system (13 respondents). Of the 13 respondents who commented on the requirement for the MHRT to explain decisions that increase a person's treatment in the community, four disagreed and seven agreed the amount of information they receive about access to community treatment meets their expectations. Two respondents stated this question was not applicable to them.

7.13.2 Confidentiality and victim impact statements

The MHA 2016 provides new confidentiality arrangements that apply for victims. In particular, a patient is not informed of a Chief Psychiatrist's decision to provide information to the victim, and does not receive a copy of a victim impact statement submitted to the MHC or MHRT. However, information may be disclosed, at the request of a victim, unless the disclosure would adversely affect the health and wellbeing of the patient.

Of the 12 survey respondents who commented on the confidentiality provisions relating to victim impact statements, nine respondents agreed the provisions support victims and their relatives to share their views on the impact of an unlawful act with the MHRT, and two respondents did not agree. One respondent advised they had not had not made a victim impact statement.

Victims are no longer required to repeatedly resubmit victim impact statements at each MHRT hearing. The MHC registrar is now responsible for providing the statement to the MHRT and the MHRT must have regard to the statement in the review of a FO or TSO. The victim may submit a new statement if they choose.

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

Of the 11 respondents who commented on the MHRT taking into account a victim impact statement without the need for a new statement to be prepared for each hearing, two disagreed and five agreed this provision had improved the process for victims. Four respondents advised they had not made a victim impact statement.

8. Next steps

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

The evaluation found there are opportunities to improve processes that support the operation of the MHA 2016 across three key themes: the need for targeted training and education, refined performance outcome monitoring, and data quality and analysis.

Training and education emerged as the key area requiring focus. It is expected that the development of more practical education and training tools will: improve the uptake of less restrictive ways and strengthen patient rights focused treatment and care (including uptake of AHDs and NSPs); compliance with the MHA 2016 and Chief Psychiatrist policies and practice guidelines; improve safeguards and help uphold the principles of the MHA 2016; and improve record-keeping and data quality. The Office of the Chief Psychiatrist will support HHSs to identify education and training needs through the development of a self-audit tool to ensure any education and training is targeted to areas requiring attention. Resources developed through the *Less Restrictive Ways Project* will also be rolled out to assist clinicians across the State, and the *Less Restrictive Way – Capacity Assessment in Minors* project will focus on online training for the use of less restrictive ways with young people.

For some initiatives, the development of service delivery outcomes will lead to refined performance monitoring. While available evidence suggests the IPRA model and the CLS are effectively supporting the operation of the MHA 2016, this evidence was largely based on stakeholder feedback, rather than any performance data. As a result, it was difficult to determine whether there is a need for changes to the service models of these initiatives. To allow for future performance outcome monitoring, performance indicators and service delivery outcomes for the IPRA model and the CLS will be explored.

A common theme across a number of the new requirements of the MHA 2016 was the quality of available data. This may be attributed to the need for further education to assist those keeping records to ensure the accurate recording of information, and to existing limitations of data system specifications. The Office of the Chief Psychiatrist will examine internal data collection systems and is currently reviewing and updating the *Administrator Delegates Manual – Mental Health Act 2016*. This is intended to resolve identified practice issues by providing greater guidance and direction to administrator delegates responsible for data entry and record-keeping. The Office of the Chief Psychiatrist will also work with other stakeholders to consider how data which informs the operation of the MHA 2016 is captured.

A number of specific practical improvements will be explored, including a review of the Chief Psychiatrist policies and practice guidelines, updated forms which provide greater guidance to users, amendments to CIMHA, and the development of resources that support understanding for people with impaired capacity.

In addition to the actions identified by this evaluation, the operation of the MHA 2016 will continue to be monitored, and policies and practice guidelines regularly reviewed and refined to ensure practice issues are addressed as they arise.

9. Use and sharing

The report will be provided to the Chief Psychiatrist and members of the IDEC with responsibility for monitoring the implementation of the MHA 2016. Other key users of this report include mental health service executives and staff, government and non government agencies involved in the care of persons with a mental illness, peak mental health bodies and community members. Distribution of evaluation findings and/or the evaluation report will be determined by the Chief Psychiatrist.

10. Approval and endorsement

☑ Approved	
☐ Revise and resubmit	
Comments:	

Project manager

Name	Ms Amber Manwaring		
Position	Director – Legislative Projects		
Signature		Date	10.04.2019

Project sponsor

Name	Associate Professor John Allan		
Position	Executive Director, Mental Health Alcohol and Drugs Branch		
Signature		Date	23.04.2019

11. Contact officer

If you have any questions regarding this document or if you have a suggestion for improvements, please contact:

Contact officer: Ms Amber Manwaring
Title: Director, Legislative Projects
Phone: 07 3328 9590

Appendix A – Glossary

ADA Australia	Aged and Disability Advocacy Australia
AHD	Advance Health Directive
AMHP	Authorised Mental Health Practitioner
AMHS	Authorised Mental Health Service
ARMC	Assessment and Risk Management Committee
ATAP	Authority to Transport Absent Person
AWA	Absent Without Approval
CES	Carer Experience Survey
CHQ	Children's Health Queensland
CIMHA	Consumer Integrated Mental Health Application
CLO	Court Liaison Officer
CLS	Court Liaison Service
CPC	Classified Patient Committee
CPI notice	Classified Patient Information Notice
CYMHS	Child and Youth Mental Health Service
DCDSS	Department of Communities, Disability Services and Seniors
DJAG	Department of Justice and Attorney-General
EA	Examination Authority
ECT	Electroconvulsive Therapy
EEA	Emergency Examination Authority
EEO	Emergency Examination Order
EO	Examination Order
FMHS	Forensic Mental Health Service
FO	Forensic Order
FO (D)	Forensic Order (Disability)
FO (MH)	Forensic Order (Mental Health)
FTE	Full Time Equivalent
HHS	Hospital and Health Service
IDEC	Inter-departmental Executive Committee
IN	Information Notice

IPRA	Independent Patient Rights Adviser
ITO	Involuntary Treatment Order
JEO	Justice Examination Order
LAQ	Legal Aid Queensland
MHA 2000	*Mental Health Act 2000* (repealed)
MHA 2016	*Mental Health Act 2016*
MHAODB	Mental Health Alcohol and Other Drugs Branch
MHC	Mental Health Court
MHRT	Mental Health Review Tribunal
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NMHC	National Mental Health Commission
NSP	Nominated Support Person
Other support persons	includes carers, family members and legal representatives
QAI	Queensland Advocacy Incorporated
QAS	Queensland Ambulance Service
QCMHL	Queensland Centre for Mental Health Learning
QHVSS	Queensland Health Victim Support Service
QMHC	Queensland Mental Health Commission
QPS	Queensland Police Service
QWIC	Queensland Wide Interlinked Court system
R&E Plans	Reduction and Elimination Plans
RBWH	Royal Brisbane and Women's Hospital
SDM	Substitute Decision Maker
SEQ	South East Queensland
SQPSC	Safety and Quality Partnerships Standing Committee
TA	Treatment Authority
TSO	Treatment Support Order
WMHSS	West Moreton Hospital and Health Service
YES	Your Experience of Service