Submission No: 027

THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Submissions to The Health and Ambulance Services Committee

Mental Health Bill 2015

Mental Health (Recovery Model) Bill 2015

October, 2015

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The Queensland Nurses' Union (QNU) thanks the Health and Ambulance Services Committee (the Committee) for the opportunity to comment on the *Mental Health Bill 2015* and the *Mental Health (Recovery Model) Bill 2015.*

The QNU has spent considerable effort in providing detailed comments on the original *Mental Health Bill 2014* (now the *Mental Health Recovery Model Bill 2015)* and the exposure draft of the *Mental Health Bill 2015.* Here, we attach our original submissions for consideration by the Committee.

Mental health is a complex and sensitive area of care. We welcome any moves to strengthen the rights of the family, carers and other support persons, who can play an important role in a person's care and recovery. We continue to be mindful of the potential impact on the workloads of mental health nurses and seek the Committee's assurance that the QNU and our members will be properly consulted in respect to any changes that could occur if either of these Bills in enacted.

Attachment 1 Submission to the Health and Community Services Committee - *Mental Health Bill 2014*

Attachment 2 Submission to the Department of Health - *Mental Health Bill 2015*

Attachment 1

Submission to The Health and Community Services Committee

Mental Health Bill 2014

January, 2015

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Introduction

The Queensland Nurses' Union (QNU) thanks the Health and Community Services Committee for the opportunity to comment on the *Mental Health Bill 2014* (the bill).

Nurses[1] are the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives, enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 50,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

At the outset, we express our concern that the Newman government would refer a bill of such size and complexity to the Committee and expect meaningful comments within a short timeframe that includes the Christmas break. We can only assume that this is a deliberate strategy to curb the amount of commentary and give free rein to the government to pass the bill. Our comments are therefore general and address the matters of most concern to our members at this time. There may be other issues that arise as we become more aware of the possible effects of the Bill.

Our submission responds to the key aspects of the Bill outlined in the *Explanatory Notes*. Our comments are in the highlighted boxes.

Treatment Authorities

Treatment authorities are made under the Bill by authorised doctors and provide a lawful authority to treat a person with a mental illness who lacks the capacity to consent to treatment. A person may be placed on a treatment authority if an authorised doctor believes that the treatment criteria apply to the person and that there is not a less restrictive way to provide treatment and care for the person, for example, under an advance health directive. Key elements of the treatment criteria are that the person lacks capacity to consent to treatment for a mental illness and there is a risk of serious harm to the person or others.

The QNU has concerns around the Advanced Health Directive (AHD) in that:

[1] Throughout this submission the terms 'nurse' and 'nursing' are taken to include 'midwife' and 'midwifery' and refer to all levels of nursing and midwifery including RNs, Midwives, ENs and AINs.

- clinical staff may be unfamiliar with the AHD provisions;
- the level of community awareness is unknown so reliance on the AHD may be premature at best;
- it is unclear which legislation will prevail in the event of a "legally untreatable patient";
- the patient rights advisor will require legal knowledge or at least a sound understanding of the AHD and its legal ramifications.

A person subject to a treatment authority is to be treated in the community, on a community category of the authority, unless an authorised doctor decides that the person's treatment and care needs can only be met by the person being an inpatient.

The QNU requests additional staffing and resources to accommodate the increased workload across all services, sectors and categories of patients bearing in mind that there are private sector Authorised Mental Health Services (AMHSs) at present.

Authorised doctors are responsible for treatment authorities and may amend a person's treatment authority by changing the category of the authority, the conditions on the authority or the nature and extent of limited community treatment (which enables treatment in the community for up to 7 days).

Persons in custody

A person in custody, for example in a watch-house or in prison, may be transferred to an authorised mental health service for an assessment to decide if a treatment authority should be made for the person, or for the treatment and care for the person's mental illness.

Psychiatrist reports

If a person subject to a treatment authority, forensic order or court treatment order is charged with a serious offence, the person or someone on the person's behalf, may request that a psychiatrist report be prepared on whether the person was of unsound mind at the time of the alleged offence or is unfit for trial. The chief psychiatrist may also direct a psychiatrist report for a person if a person is charged with a serious offence and the chief psychiatrist believes it is in the public interest. A serious offence is an indictable offence other than an offence that must, under the Criminal Code, be heard by a magistrate.

Individuals charged with indictable/serious offences who may have a defence of unsound mind or unfitness for trial should be automatically **offered** a psychiatric report rather than the person

or their representative needing to request this report.

It is unclear how the person or their representative will know how to proceed and they may be disadvantaged in the absence of this knowledge. This approach potentially shifts responsibility and costs to the patient/family or nominated representative for legal advice to make a request.

Mental Health Court

The Mental Health Court hears references on whether persons charged with a serious offence were of unsound mind at the time of an alleged offence or unfit for trial. Where the court determines a person was of unsound mind at the time of the alleged offence or unfit for trial, the court may make a forensic order or a court treatment order (see below) for the person. Forensic orders may be a forensic order (mental condition) or a forensic order (disability).

In making an order, the court must also determine the category of the order (inpatient or community) and, if the category is inpatient, any limited community treatment for the patient. Authorised doctors must not amend a person's forensic order by changing the category of the authority, the conditions on the authority or the nature and extent of limited community treatment, unless the amendment is in accordance with decisions of Mental Health Court and the Mental Health Review Tribunal.

The QNU regards this as a positive and significant safeguard.

If the court determines a person is unfit for trial, but the unfitness is not of a permanent nature, the matter of the person's fitness for trial is referred to the Mental Health Review Tribunal for regular review.

For forensic orders for specified offences, the court may impose a non-revoke period of up to 7 years for the order.

Magistrates Courts

Magistrates courts may discharge persons charged with an alleged offence if the court considers the person appears to have been of unsound mind at the time of the alleged offence or is unfit for trial.

Magistrates courts may also order that a person before the court be examined by an authorised doctor to decide if a treatment authority should be made for the person or to make recommendations about the person's treatment and care.

The QNU believes that in order to implement this provision and to support appropriate and timely access to assessment, all AMHSs should have court liaison officers in the workforce. This could reasonably be a role for an Nurse Practitioner (NP).

In our submission to the Review of the *Mental Health Act 2000*, the QNU strongly advocated for Mental Health Nurse Practitioners. A NP is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The NP role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations.

The NP role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The NP's scope of practice is determined by the context in which they are authorised to practice (Australian Nursing and Midwifery Council, 2006). Such roles have existed in Queensland since 2006.

Treatment and care of patients

Authorised doctors and administrators of authorised mental health services have responsibilities for the treatment and care of patients under the Bill. An authorised doctor must examine patients and record in the patient's health records the treatment and care to be provided to the patient.

To the extent practicable, decisions in relation to the treatment and care of a patient are to be decided in consultation with the patient and the patient's family, carers and other support persons.

Administrators must take reasonable steps to ensure that the patient receives the appropriate planned treatment and care. The administrator must ensure the systems for recording planned and actual treatment can be audited.

We acknowledge that record of treatment should form part of the clinical notes but it needs to be located in a consistent and standard part of the file in a standard /format or efficiency to mitigate risk of missing important changes to treatment.

Workloads associated with increased administrative tasks need to be monitored so that these responsibilities do not impinge on patient safety.

The performance of electroconvulsive therapy and non-ablative neurosurgery (such as deep brain stimulation) is regulated under the Bill. Psychosurgery is prohibited under the Bill.

Mechanical restraint and seclusion

The use of mechanical restraint and seclusion on involuntary patients in authorised mental health services is regulated under the Bill. The use of mechanical restraint in an authorised mental health service must be approved by the chief psychiatrist. Mechanical restraint and seclusion may only be used if it is necessary to protect the patient or others from physical harm and there is no less restrictive way of providing treatment and care to the patient.

Reduction and elimination plans are used to approve the use of mechanical restraint and seclusion by the chief psychiatrist in the context of eliminating its use for the patient.

We point out that workplace health and safety must be taken into account when using mechanical restraints and/or seclusion as a form of confinement. Nurses must not be exposed to violent situations through the use of these measures. Further, we seek clarification on who will undertake this action.

Rights of involuntary patients and others

The Bill provides for a statement of rights for involuntary patients to be made available to patients. Public sector authorised mental health services must employ or engage a patient rights adviser in the service to advise patients and the patient's family, carers and other support persons of their rights under the Bill.

Subject to a patient's right to privacy, a patient may be visited by family, carers and other support persons. The patient may also be visited by a health practitioner, or a legal or other adviser.

If a patient has a nominated support person or personal guardian or attorney, any notices to be given to a patient must also be given to the nominated support person or guardian.

A patient may request a second opinion about the patient's treatment and care if an authorised mental service has been unable to resolve a complaint about the treatment and care.

The only safeguard around a second opinion relies on policy and is not pre-emptive, i.e. the patient or family needs to raise a complaint rather than seek access to another option. The Bill states 'the administrator must make arrangements to obtain the second opinion in compliance with a policy or practice guideline'.

We seek clarification on whether this policy or practice guideline will be developed centrally by the Chief Psychiatrist or responsibility for development devolved to each Hospital and

Health Service.

Chief psychiatrist

The chief psychiatrist is appointed under the Bill to protect the rights of involuntary patients in authorised mental health services. This is also extended to voluntary patients in authorised mental health services, such as those being treated under advance health directives.

The chief psychiatrist makes policies and practice guidelines, which persons in authorised mental health services must comply with. The Bill states a number of areas for which policies must be made, including the application of the treatment criteria, the use of mechanical restraint and seclusion, and the treatment and care of forensic patients.

The chief psychiatrist must also prepare an annual report on the administration of the Bill.

Information notices

Victims of unlawful acts may apply to receive specific information about the person who committed the unlawful act, including when community treatment is authorised for the person. Schedule 1 of the Bill outlines what information is to be provided.

We recommend that the definition of 'victim' includes their family/loved ones so that it is in line with family-centered and recovery-focused care

Mental Health Review Tribunal

The Mental Health Review Tribunal continues under the Bill with responsibility for reviewing:

- treatment authorities;
- forensic orders;
- court treatment orders;
- the fitness for trial of particular persons;
- the imposition of monitoring conditions that involve a tracking device; and
- the detention of minors in high security units.

The Mental Health Review Tribunal also hears applications for:

- examination authorities, which authorise the involuntary examination of a person;
- the approval of regulated treatments (electroconvulsive therapy and non-ablative neurosurgery); and

- the transfer of forensic patients and patients on court treatment orders into and out of Queensland.

The Bill states when periodic reviews of treatment authorities, forensic orders and court treatment orders must take place. Patients, or someone on behalf of the patient, may apply for a review of an authority or order at any time.

In reviewing treatment authorities, forensic orders and court treatment orders, the Mental Health Review Tribunal has the power to confirm or revoke an authority or order on the basis of the criteria stated in the Bill. In reviewing treatment authorities, forensic orders and court treatment orders, the tribunal may also change the category of the authority or order, or change limited community treatment under the authority or order.

The Bill represents a major improvement to the legislative framework that applies for persons with a mental illness under the *Mental Health Act 2000*. These improvements can be grouped in six areas:

- Strengthened support for patients
- Improved health service delivery
- Strengthened community protection
- A more transparent and fairer Act
- Improved legal processes
- Greater value in health services.

It is not immediately apparent to us that this Bill strengthens community protection or that it is more transparent and fairer.

If the government wants us to believe that relying on monitoring devices and an emphasis on restraint strengthens community protection, we would argue that these initiatives appear to be driven as much by restricting absconders and the associated costs as it is about maintaining public safety.

For example, the use of obvious monitoring devices, such ankle bracelets, that are commonly used for tracking offenders, contribute to marginalisation and stigma. We believe that other, less obvious GPS devices should be considered. Further, the need for a monitoring device should be linked to the clinically assessed risk in addition to the potential for patients to abscond.

We are concerned the Bill reflects an overall shift to more restrictive practices. We continue to recommend that the new Act balances the individual's access to least restrictive care with public safety, the safety of our members, other mental health staff and other patients.

Strengthened support for patients

The Bill will strengthen patient rights by improving the criteria by which a person is placed on a treatment authority (to replace an involuntary treatment order under the previous Act, to focus on a person's lack of capacity to consent to treatment and the risk of serious harm to the person or others. The Bill will require an authorised doctor to consider whether a person may be treated in a "less restrictive way" before making a treatment authority. This includes treating the person under an advance health directive, or with the consent of the guardian or attorney.

We question how this operates when the individual has only given consent to refuse treatment because under *s.12 – (2) and (3) For subsection (1)(b), the person's own consent only is relevant.*
(3) Subsection (2) applies despite the Guardianship and Administration Act 2000, the Powers of Attorney Act 1998 or any other law.

In conjunction with this, persons will be given the opportunity to nominate a "nominated support person" to support the person's treatment and care at a future time if the person becomes unwell and loses capacity to consent to treatment. A nominated support person has a variety of roles under the Bill, including receiving all notices that must be given to the patient, being able to discuss confidential information about the patient, and supporting the patient or representing the patient at hearings of the Mental Health Review Tribunal.

The Bill will strengthen the rights of the family, carers and other support persons, who can play an important role in the person's care and recovery. The Bill requires authorised doctors to involve family, carers and other support persons in decisions about the patient's treatment and care, subject to the patient's right to privacy. The Bill states that patients have a right to be visited by support persons, health practitioners and legal or other advisers at any reasonable time.
The use of seclusion and mechanical restraint on involuntary patients is an area receiving attention nationally. The Bill supports the move to reduce and eliminate the use of seclusion and mechanical restraint in a number of ways, including the introduction of reduction and elimination plans that provide for the approval of mechanical restraint and seclusion in the context of a strategy of its elimination for the patient.

The Bill requires public sector authorised mental health services to engage a patient rights adviser to support patients and their support persons in understanding how the mental health legislation operates, especially patients rights. This includes advising patients and support persons on how the Mental Health Review Tribunal operates, and the person's rights at tribunal hearings.

The rights of patients at tribunal hearings will be strengthened by stating that a patient may be supported at the tribunal by a nominated support person or another person nominated by the patient. Also, the patient may be represented at the tribunal by a lawyer or another representative. For tribunal specified hearings, the Bill requires the tribunal to provide a lawyer at no cost to the patient. The hearings that this applies to are for any review involving a minor, for reviews where the Attorney-General is represented, for “fitness for trial" reviews, for applications involving electroconvulsive therapy and for the review of certain monitoring conditions.

The Bill also removes the barriers to interstate transfers of involuntary patients where this may be of benefit to the patient's treatment, care and recovery. Interstate transfers are beneficial where the patient returns to closer proximity to family, carers and other support persons.

Improved health service delivery

The Bill will remove the ambiguity in the current Act about where treatment and care can be provided. The Bill will allow treatment and care to be provided in any place that is clinically appropriate. The restrictions on the use of audio-visual technology in the current Act will be removed.

Given the nuances of non-verbal interactions clinicians may not be comfortable with the removal of this restriction.

The Bill strongly supports recovery orientation for patients with a mental illness. This is achieved through matters such as:

- requiring that patients on treatment authorities be treated in the community unless the patient must be admitted to an inpatient unit to meet the patient's treatment and care needs
- enabling the Mental Health Review Tribunal to “step-down” a patient on a forensic order, to a court treatment order or treatment authority, when it is appropriate to do so
- enabling treatment to be provided at any clinically appropriate place in the community
- removing barriers to interstate transfers, which can assist a patient’s recovery
- strengthening the use of advance health directives, which gives a person greater control over their future health care
- empowering a person to appoint a nominated support person to support the person during the acute phase of an illness, and
- ensuring equal rights of persons with a mentally illness at law.

The Bill requires authorised doctors to decide and record the treatment and care to be provided to a patient. To better align with clinical practice, this will be recorded in the patient's health records rather than in a separate “treatment plan" as is required and the current Act.

The Bill emphasises the importance of involving family, carers and support persons in decisions about the patient's treatment and care, including when the patient returns to the community. This aligns with good clinical practice and will improve health service delivery and lead to better patient outcomes.

The QNU welcomes all of the above.

Strengthened community protection

To the extent that the legislation deals with persons who have committed unlawful acts, it is important that the community is adequately protected from any future unlawful behaviour.

The Mental Health Court will be able to set a non-revoke period for forensic orders of up to 7 years for serious violent offences such as murder, rape and grievous bodily harm. This will give victims and the wider community greater certainty in the period after a forensic order is made.

The legislation will strengthen powers to deal with persons who abscond. This will include clearer powers for police to detain and return such persons. Authorised mental health services will be required to provide police with a risk assessment of persons, so that police can give priority to responding based on identified risks to the persons or others.

The Bill includes a statement of principles for supporting victims of unlawful acts to guide persons responsible for administering the legislation.

Confidentiality restrictions on government agencies will no longer restrict the ability to approach a person to offer victim support services.

Victims of unlawful acts who receive information notices about a patient will be given information on the reasons a patient is given community treatment to assist the victim to understand the considerations that have gone into such a decision.

The requirement to obtain a second psychiatric opinion to revoke forensic orders for serious violent offences will be retained and expanded to include offences such as grievous bodily harm. The Bill will result in a more targeted and appropriate range of forensic orders, enabling those responsible for administering the forensic provisions to focus their resources on individuals of most concern to the community .

A more transparent and fairer Act

The Bill will remove justices examination orders and replace them with a substantially more limited process where a person, in consultation with an authorised mental health service, may make an application to the Mental Health Review Tribunal for an examination authority.

Notwithstanding our concerns regarding access and rights, the QNU would support training for authorised JPs and suggest it is also offered for magistrates. The magistrate or JP should contact the nurse HP/Medical Officer prior to issuing the order. We can foresee that this may increase the workload of nurses and mental health staff in intake and triage and therefore we expect these areas to be properly resourced.

The Bill provides for clear and consistent criteria for statutory decisions. This is of critical importance given the restrictions on a person's liberties that may be exercised under the Bill. The Bill will also require the publication of chief psychiatrist policies and practice guidelines, and expand the requirements for the annual report.

We seek clarification on the role of clinicians and consumers/carers /family in policy development.

The Bill clearly states the circumstances in which a person may be involuntarily transported to, from, and within an authorised mental health service, and the safeguards that apply when this occurs. These provisions will be more transparent and fairer for those administering the legislation and for the persons being transported.

The provisions in the Bill clearly outline when and to whom notices are to be provided. Where the Bill requires the patient to be provided with a notice by an administrator, the chief psychiatrist or the tribunal, the notice must also be given to a nominated support person, personal guardian or attorney.

Improved legal processes

The Bill rectifies a major deficiency in the current legal framework in Queensland, by expressly enabling magistrates to discharge persons who appear to have been of unsound mind at the time of an alleged offence or unfit for trial.

Magistrates will also be able to refer matters to the Mental Health Court where it appears there may be grounds for the court to make a forensic order or court treatment order for the person.

The Bill will enable persons charged with serious offences who are currently on an authority or order under the Bill to request that a psychiatric report be prepared on whether the person was of unsound

mind at the time of the alleged offence or unfit for trial. This replaces the current model whereby a person must mandatorily have a report prepared and subsequently referred to the Mental Health Court. The current approach is a breach of an individual's right to decide how to pursue a legal defence.

We reiterate our concerns regarding shifting responsibility and costs on to the patient/family.

The Bill gives the Mental Health Court an additional option of making a court treatment order for a person. The intention of these provisions is to provide a less intensive form of order to apply, for example, where a person's role in a serious offence is relatively minor. Court treatment orders will 'tie' the person to involuntary treatment without the stringent oversight that applies to persons on forensic orders. Unlike forensic orders, the court and the tribunal does not set limits on the extent of community treatment under court treatment orders. As with treatment authorities, this will be the responsibility of authorised doctors in accordance with the criteria established under the Bill. As with treatment authorities, the default category for these persons will be a community category, unless it is necessary for the person to be an inpatient. However, like forensic orders, only the tribunal may revoke a court treatment order.

The Bill also enables the Mental Health Court to consider and decide disputed matters that affect a psychiatrist's opinion, rather than referring the whole matter to the criminal courts as occurs now.

The Bill will clarify the relationship between the Criminal Code and mental health legislation where a jury finds a person of unsound mind or unfit for trial.

The Bill also adopts the Criminal Code's use of "unsound mind".

Greater value in health services

The Bill will replace the current *Mental Health Act 2000*, which is overly complex and difficult to administer. The Bill will reduce the compliance burden on health services in administering the Bill by reducing the volume of forms and other paperwork required under the legislation.

The Bill also rectifies numerous operational problems with the current Act in areas such as the transport of patients, searches in authorised mental health services and notification requirements. The proposals will also result in greater devolvement to authorised mental health services, such as for the appointment of authorised mental health practitioners.

In the case of nurses, the criteria and assessment process need to be consistent with the Australian Nursing and Midwifery Accreditation Council (ANMAC) competency testing.

Links with the Australian College of Mental Health Nurses (ACMHN) standards must be carefully

considered and demonstrate how these elements are relevant to the Authorised Mental Health Practitioner (AMHP) role. ACMHN standards should not be automatically adopted without these considerations.

The removal of mandatory psychiatric reports will also enable clinician's time to be redirected to higher priority clinical areas.

Estimated cost for government implementation

The implementation of the Act will incur one-off implementation costs for education and training, the development of policies, practice guidelines and other supporting material, and the upgrade to the Consumer Integrated Mental Health Application for mental health consumers. These implementation costs are estimated at $5.2 million.

On-going costs will also be incurred for the revised court liaison service (to support the revised role of Magistrates Courts), the establishment of patient rights advisers and the revised Mental Health Review Tribunal functions. These costs are estimated at $12.1M.

Treatment and detention without consent

The proposed Bill will impact on the rights and liberties of individuals by enabling examinations, assessments, treatment and, if necessary, detention without consent.

The underpinning principle of the Bill is that a person who does not have capacity to consent to treatment may be at risk of harm or deterioration in his or her health, with no ability to make decisions to avert these adverse consequences. To remedy this, the proposed Bill will establish legislative arrangements for treatment without consent.

The proposed Bill also empowers the Mental Health Court to impose orders (forensic orders and court treatment orders) on persons charged with offences. These orders authorise involuntary treatment and, if necessary, detention in an AMHS or the forensic disability service. The purpose of these provisions is to protect the community where persons diverted from the criminal justice system may be at risk of harming others.

The Bill will include robust safeguards to protect the rights of individuals on orders or authorities. The Bill is to expressly state that the objectives of the Bill are to be achieved in a way that:

- safeguards the rights of persons;
- affects a person's rights and liberties in an adverse way only if there is no less restrictive way to protect the health and safety of the person or others; and

- promotes the person's recovery, and ability to live in the community, without the need for involuntary treatment and care.

The exercise of all relevant powers under the proposed Bill – involuntary examination, assessment and treatment – may only be undertaken if the statutory decision-making criteria are met. Examination authorities (which authorise entry to premises and an involuntary examination of a person) may only be made with prior clinical input, with the authority to be made by the independent Mental Health Review Tribunal. An examination of a person (to determine whether a recommendation for assessment should be made), and an assessment (to determine whether a treatment authority should be made), are undertaken by appropriately skilled clinicians, with an authorised psychiatrist confirming the authority in all instances.

A person placed on a treatment authority by a psychiatrist has the authority automatically reviewed by the tribunal in 28 days after it is made, with the person having the right to apply to the tribunal for review at any time.

In our view, 28 days is an extensive period of time for an automatic review and places responsibility on the person to seek an earlier timeframe.

The Mental Health Review Tribunal also reviews the continuation of forensic orders.

Psychiatrist examinations for persons charged with serious offences

The proposed Bill will provide for the right of a person on a treatment authority or forensic order who is charged with a serious indictable offence to request a psychiatrist report about whether the person was of unsound mind at the time of the alleged offence or is unfit for trial.

In addition, if the chief psychiatrist (the position which will replace the Director of Mental Health) determines that it is in the public interest, the chief psychiatrist may direct a psychiatrist report for a person charged with a serious indictable offence without the person's consent. This latter authority may be seen as infringing on the rights and liberties of the person who is subject to the psychiatrist examination. The discretion to exercise this power is to be used by the chief psychiatrist only if the chief psychiatrist determines that it is in the public interest to do so. The Bill will provide safeguards for persons undergoing these examinations, including restrictions on the use of the resultant report.

Power of entry to authorised mental health services

The Bill will continue the power under the *Mental Health Act 2000* for authorised officers to visit an authorised mental health service to investigate whether the Bill is being complied with. The exercise of this power does not require a warrant. However, this power of entry is very limited – to authorised

mental health services – nearly all of which are within the public sector. The power is considered reasonable given the need for involuntary patients to have their rights protected.

We seek clarification of whether these same provisions apply to health providers offering this service privately.

Suspension of community treatment

The Bill will continue the power under the *Mental Health Act 2000* for the chief psychiatrist to suspend community treatment for a class of patients if the chief psychiatrist believes there is a serious risk to the life, health or safety of a person or a serious risk to public safety. This power may be seen as infringing individual liberties in that the power may be exercised in relation to a class of persons, regardless of whether an individual constitutes a risk to the community.

However, this power is consistent with the purpose of the Bill in relation to the protection of the community. This power may be exercised, for example, where there are concerns of systemic management issues within an authorised mental health service that need rectification. It may be necessary to suspend community treatment pending the rectification of these issues. As in the current Act, the proposed Bill will incorporate safeguards, including the requirement to consult with the administrator of the AMHS on the impact of suspending community treatment on patients before taking action under these provisions. The chief psychiatrist's decision is appealable to the tribunal.

In our view it is unreasonable to 'punish' a patient for an AMHS deficit particularly when it is anticipated this will be rarely applied.

Monitoring conditions for involuntary patients

The Bill will continue the powers under the *Mental Health Act 2000* for the chief psychiatrist to place monitoring conditions on forensic patients. Monitoring conditions may include a requirement that a patient wear a GPS tracking device while being treated in the community. The requirement to wear such devices may be seen as breaching an individual's rights and liberties.

The purpose of monitoring conditions is to provide an additional level of protection for the health and safety of a patient or others, where warranted. The imposition of monitoring conditions offers a mechanism to quickly locate a patient who has not returned from community treatment where there are concerns about the patient's safety or the safety of others. These conditions may only be placed on an order by the chief psychiatrist, the Mental Health Court or the Mental Health Review Tribunal. As an additional safeguard, the Bill will require that the imposition of monitoring

conditions by the chief psychiatrist be reviewed by the tribunal within 21 days of the conditions being imposed.

In our view, such devices do little to assure safety and do nothing to reduce stigma. Such devices are therefore questionable as 'safeguards'. If these devices are used they must be unobtrusive despite the cost and if lost or damaged supplied without cost to the patient.

Additional comments

- The QNU and the Nursing and Midwifery Office Qld made a sound case for the role of Mental Health NPs, yet the Bill fails to recognise the important role they could play in mental health.

- There is no impact assessment of the increased workloads that are likely to result for mental health nurses when there is more demand for services and new IT systems.

- The training schedule for the new Act, AHDs and other elements of the transition must be included in the costings and time accounted for in service profiles.

- On-line training must be completed during working hours.

- The mechanisms for "red tape reduction" are not necessarily consistent with established best practice for clinical care or best practice for risk management of fellow human beings.
- The recommendations do not seem to adequately recognise the needs of Aboriginals, Torres Strait Islanders and people from culturally and linguistically diverse backgrounds. The QNU supports culturally safe practice in all settings. We acknowledge that this is a legislative attempt to address a very significant and sensitive matter previously neglected but will defer to the expertise of relevant stakeholders for detailed commentary and appropriate wording of the principles.

- The CIMHA IT system has not been reliable and data entry has NOT been factored into BPF or work days in community services. The QNU has witnessed the shifting of administrative work to nurses without the extra resources to cope with the demand. Appropriate administrative and IT staff are required for electronic records. Access to hardware and reliability of software/programs are factors which may impact negatively on nurses' workloads and clinical time.

- Health practitioner (section s505A) - the changes for a local Administrator to appoint

– NOT DMH - leads to variations i.e. lack of standardisation - reliability and validity if there is no central responsibility and accepted criteria for appointing a Health Practitioner (HP).

- We welcome the continuing appointment of AMHPs as it acknowledges the contemporary recovery and partnership approach in mental health care and recognises their important clinical role. It is however disappointing the Mental Health NPs are not featured.

- We have the following safety concerns for staff and other patients around admissions from the watchhouse or prison:

  - It has been our experience that when a local Authorised Mental Health Service(AMHS) does not have the capability to manage the prisoner staff injuries have resulted despite QNU objections and those from nurses themselves;
  - Transfer from an AMHS to medium and high secure facilities does not always proceed readily;
  - The Director, Mental Health should not be able to order an AMHS where acceptance of the prisoner has been declined;
  - Access to secure facilities should be a priority. If necessary further beds should be opened to ensure that offenders, particularly those assessed with potential for or history of actual violence, are managed in an appropriate environment for the safety of other patients and staff and are not subject to undue delays in accessing inpatient mental health care.

References

Australian Nursing and Midwifery Council (2006) *National Competency Standards for the Nurse Practitioner.*

Acronyms

AMHP	Authorised Mental Health Practitioner
AMHS	Authorised Mental Health Service
BPF	Business Planning Framework
CIMH	Consumer Integrated Mental Health Application
DMH	Director of Mental Health
GP	Involuntary Treatment Order
HHS	Hospital and Health Service
ITO	Involuntary Treatment Order
JP	Justice of the Peace
MH	Mental Health
MHNIP	Mental Nurse Inceptive Program
MHS	Mental Health Service
MO	Medical Officer
NaMOQ	Nursing and Midwifery Office Qld
NP	Nurse Practitioner
OVRAT	Occupational Violence Risk Assessment Tool
QAS	Queensland Ambulance Service
RANZCP	Royal Australian and New Zealand College of Psychiatrists

Recommendations

1. Involuntary examinations and assessments

Issues identified	Review recommendations
• Too many documents leading to involuntary treatment. Changes constitute a loss of the two steps in the involuntary treatment process - assessment and then treatment. This may 'reduce red tape', however, the QNU requires further clarification about how the overall changes will enhance fairness and transparency. • Insufficient checks and balances in the making of justices examination orders. • Majority of individuals placed on emergency examination orders have no underlying mental illness. There may be unintended consequences for the mental health service as the default health care option for assessment of an "impaired" individual given the statistics on underlying mental illness. • Treatment criteria not unequivocally based on a person's lack of capacity to consent to treatment. We acknowledge that the inclusion of "unequivocal" consent provisions may improve individual rights.	**Documents leading to involuntary treatment** 1.1 The documents required under the Act that may lead to involuntary treatment be as follows: • an involuntary examination authority (replacing the justices examination order) • a recommendation for involuntary assessment • an involuntary treatment order. **Involuntary examination authority** 1.2 A person applying for an involuntary examination authority be required to seek advice from a doctor or authorised mental health practitioner prior to seeking the authority on: • the behaviour and other factors that make the person believe the other person may have a mental illness to the extent that involuntary treatment may be warranted • treatment and care options for the person • how the person may be encouraged to seek voluntary treatment and care • the treatment criteria. This seems reasonable but we question how this will operate in practice to ensure commensurate resources are available - e.g. additional triage lines and personnel, up-skilling GPs, additional funding for the Mental Health Nurse Incentive Program (MHNIP) in primary care, otherwise an unintended consequence may be reduced access for someone who requires involuntary assessment and treatment . 1.3 The applicant be required to document this advice in the application for an authority if it is proceeded with. 1.4 Applications must be made to a magistrate or a category of specially authorised and trained justices of the peace. 1.5 The magistrate or authorised justice of the peace must obtain oral or written advice from a doctor or authorised mental health practitioner before issuing an authority, including on whether the stated behaviour and other factors may or may not indicate a mental illness to the extent that involuntary treatment may be warranted. 1.6 A magistrate or authorised justice of the peace must only issue an authority if satisfied: • the person appears to have a mental illness • the person appears to lack the capacity to consent to be treated • attempts at encouraging the person to be treated voluntarily have not succeeded or are not practicable • there is an imminent risk that the person may cause serious harm to himself, herself or someone else, or suffer serious mental or physical deterioration because of the illness if the person does not receive involuntary treatment. Notwithstanding our concerns regarding access and rights, the QNU supports training for authorised JPs and suggest it is offered for

• Treatment criteria do not take a longitudinal approach to diagnosis. The QNU acknowledges this may be the case currently but there is a possibility this may infringe on individual rights where resourcing and risk averse approaches see a person maintained on involuntary treatment for extended periods. See 1.19 for further comments. **More information** Background paper 1— Involuntary examinations and assessments.	magistrates issuing the authority and that they contact the Medical Officer/Health Professional prior to issuing the order 1.7 The Act to include statutory protections and a clear outline of powers that may be exercised under an involuntary examination authority. 1.8 A person for whom an involuntary examination authority is made be able to apply to the Director of Mental Health for a review of the making, and implementation, of the authority. The process and time frames must be specified – it should not take 60 days for response to the individual. 1.9 The Director of Mental Health be required to prepare a report within 60 days of receiving an application on the actions, if any, that should be taken as a result of the application. **Emergency transport, examination, assessment and treatment** Transport under the provisions of another Act are acceptable but need to consider the likely unintended consequence of the MHS as the default health care option for assessment of an "impaired" individual given the statistics on underlying mental illness. 1.10 1.10 A police officer may take into consideration advice received from a health practitioner in forming a view about whether there is an imminent risk of injury to a person for the purpose of section 609 of the Police Powers and Responsibilities Act 2000. 1.11 Emergency transport provisions be placed in an Act other than mental health legislation to apply where a police officer or ambulance officer reasonably believes: • a person appears to have a serious mental impairment as a result of the effects of drugs or alcohol The new Act needs to clearly define 'mental impairment'. If involuntary treatment proceeds it may improve access for persons with impairment related to drugs and/or alcohol intoxication, but it shifts the responsibility for transporting persons who are ostensibly not suffering from mental illness rather 'impairment' to mental health services. This may impact on the individual e.g. stigma etc. The actions that need to be taken following transport should be stated to uphold the rights of the individual with "impairment". The QNU also has safety and workload/resource concerns for members particularly those working in community mental health settings and emergency departments . • there is an imminent risk of the person causing harm to himself or herself, and • the person requires urgent treatment or care for the mental impairment or • a person appears to have a mental illness • there is an imminent risk of the person causing harm to himself, herself or someone else, and • an examination of the person may result in a recommendation for assessment being made for the person, or • the person requires urgent treatment and care for the mental illness. We suggest this should read 'apparent' mental illness 1.12 Where these criteria apply, a police officer or ambulance officer may detain and transport a person to a place where the person may receive treatment and care for the condition, including a public sector hospital, the person's home or another place.

	It is hard to envisage when the person's home would be appropriate in emergent circumstances. 1.13 Where a person brought to a hospital under the emergency transport provisions appears to have a mental illness, the person may be detained for six hours to allow an examination under the Act to be undertaken; this period may be extended for a further six hours by an authorised doctor if an examination is not possible within the initial six hours. We see there is a danger that such an assessment will be immediately directed to a MHS rather than a health service that would undertake a comprehensive review of the person to exclude organic conditions that may mimic intoxication or acute mental illness. 1.14 The fact and time of the person's admission for assessment for a mental illness be documented by the police officer or ambulance officer in a notice to verify the commencement of the period of detention. We recommend that the notice be in a standard form. **Request for assessment** 1.15 The requirement for a 'request for assessment' be discontinued. This was a consumer driven initiative in the last review (around. 2000) to ensure treatment was not commenced until a decision was made that the person was indeed suffering from a mental illness and not an organic condition or just intoxication. This was to facilitate the opportunity to participate willingly once an initial period of intoxication or an acute episode had passed. **Assessment criteria** 1.16 The assessment criteria be discontinued, with the legislation instead requiring a doctor or authorised mental health practitioner to make a recommendation for assessment based on whether an authorised doctor may reasonably form the view that the treatment criteria apply to the person. We note that the treatment criteria are fairly close to the previous assessment criteria. However, we are concerned by the omission of the additional step in the process, not the application of the criteria that we feel may lead to unintended consequences for the person involved.
Question: Will the recommendations provide for fairer, simpler and more transparent processes leading to involuntary treatment? The QNU is not convinced that the proposed measures will improve transparency and fairness for mental health consumers.	
Issues identified	**Review recommendations**

	Treatment criteria
	1.17 The treatment criteria be as follows:
	• the person has a mental illness
	• the person lacks the capacity to consent to be treated for the illness
	• because of the person's illness, the absence of involuntary treatment (or continued involuntary treatment) is likely to result in:
	  • imminent serious harm to the person or someone else, or
	  • the person suffering serious mental or physical deterioration.
	1.18 A person has capacity to consent to treatment, if the person is able to:
	• understand the nature and purpose of the treatment
	• understand the benefits and risks of the treatment, and alternatives to the treatment
	• understand the consequences of not receiving the treatment

	• assess the advantages and disadvantages of the treatment in order to arrive at a decision, and • communicate the decision. 1.19 An authorised psychiatrist may maintain a person on an involuntary treatment order, notwithstanding that a person appears to have capacity to consent, if the psychiatrist reasonably believes that revoking the order is likely to result in the person: • causing harm to himself, herself or someone else, or • suffering serious mental or physical deterioration. The QNU acknowledges that this may be the case currently but there may be a danger to an individual's rights in the application where resourcing and risk averse approaches see a person maintained on involuntary treatment for extended periods. We are concerned there is a subtle overall shift to more restrictive practices. The new Act needs to balance the individual's access to least restrictive care with public safety, the safety of our members, other mental health staff and other patients. **Making of involuntary treatment order** 1.20 An authorised doctor may not make both a recommendation for assessment and an involuntary treatment order for the same person in the same examination and assessment process, unless the doctor is located in a regional, rural or remote area designated by the Director of Mental Health. This may be seen as too inflexible although we acknowledge the difficulties in rural and remote centres. We suggest the legislation could still state that 'an authorised doctor may not make both …', but include reference to the exceptional circumstances in policy rather than address the practicalities in legislation as this is a workforce issue.

2. Individuals held in custody

Issues identified	Review recommendations
• Too many documents leading to involuntary treatment for individuals in custody. The proposed revision of the involuntary treatment process addresses the concerns about "too many documents" . We refer to our previous comments regarding individual rights and involuntary assessment. Prison MH Services are an extension of community services for the purposes of ongoing MH care. Prison MH services are available to work with offenders who do not require inpatient care or who voluntarily accept "outpatient/community" treatment. The current provisions ensure that involuntary treatment for mental illness can only take place in an AMHS - not in prison. This should not change – as it safeguards individual rights regarding involuntary treatment and evidence-based practice in MH care. An acceptable alternative may be equipping Qld prisons with contemporary MH facilities inside the prison but the new Act would need to recognise such facilities as AMHSs and an entire new service with inpatient staff would be required. • Very difficult to understand classified	**Transfer of individuals to an authorised mental health service for assessment** 2.1 A person in custody may be transferred to an authorised mental health service for assessment under the proposed generic assessment documents (recommendation 1.1), while continuing the requirements: • for a custodian's transfer authority (in an approved form), including the information on the person held in custody, and • for the agreement, in writing, from the authorised mental health service to the transfer of the person. **Transfer of individuals to an authorised mental health service by consent** 2.2 A person in custody may be transferred to an authorised mental health service for treatment and care if: • a doctor or authorised mental health practitioner believes the transfer is necessary to provide treatment and care to the person for the person's mental illness • the person consents to be transferred to the service • the custodian agrees to the transfer in a custodian's transfer authority, and • the authorised mental health service agrees, in writing, to the transfer. **Transfer of individuals who are already on a forensic order or involuntary** **treatment order to an authorised mental health service** 2.3 A person in custody who is already on an involuntary treatment order or a forensic order may be transferred to an authorised mental health service for treatment and care if: • a doctor or authorised mental health practitioner believes the transfer is necessary to provide treatment and care to the person for the person's mental illness • the custodian agrees to the transfer in a custodian's transfer authority, and • the authorised mental health service agrees, in writing, to the transfer. **Capacity of authorised mental health services to take classified patients** 2.4 A doctor or authorised mental health practitioner who made a recommendation for assessment of a person in custody must notify the Director of Mental Health if an authorised mental health service does not agree to the transfer of the person within 72 hours. 2.5 The Director of Mental Health to then take reasonable steps to arrange for the person to be admitted to an appropriate authorised mental health service, with the Director of Mental Health retaining the power to direct an authorised mental health service to admit a person if required. Our concern here is for the safety of staff and other patients. It has been our experience that when a local AMHS does not have the capability to manage the prisoner, staff injuries have resulted, despite staff and QNU objections. Transfer to medium and high secure facilities does not proceed readily. The DMH should not be able to order an AMHS where acceptance of the prisoner has been declined. Access to secure facilities should be a priority. If necessary, further beds should be opened to ensure that offenders, particularly

patient provisions. These is a complex issue but it relates as much to the processes of the justice system such as bail and stages of legal proceedings as it does to the Mental Health Act provisions. • Unacceptable delays in acutely unwell individuals in prisons being transferred to an authorised mental health service. Administration of medication during transfer must be undertaken under appropriate health practitioner authorization and supervision/escort to the MH service. A NP in a prison MH could prescribe and 'endorse' escort. Involvement of QAS is dependent on the interdepartmental protocol for transfer, if medications are administered. **More information** Background paper 2—Individuals held in custody.	those assessed with potential for or history of actual violence are managed in an appropriate environment, for safety of other patients and staff and are not subject of undue delays in accessing inpatient MH care.

Question:

Will the recommendations provide for fairer, simpler and more transparent processes leading to involuntary treatment for persons in custody?

Our concerns for this recommendation relate primarily to the safety of staff, our members and other patients of the AMHS to which the mentally ill prisoner /offender is transferred.

Issues identified	Review recommendations
	Admission of individuals to an authorised mental health service 2.6 For all individuals transferred to an authorised mental health service, an authorised doctor must decide if it is necessary for the person to remain in the authorised mental health service to provide treatment and care for the patient or, if this is not required, return the patient to custody. In reality, this process is often subject to delays due to the workload of the Medical Officer (MO). A Nurse Practitioner (NP) or Authorised Mental Health Practitioner (AHMP) could perform such an assessment. **Admission of individuals who are already on an involuntary treatment order or forensic order** 2.7 On admission of a patient who is already on an involuntary treatment order or forensic order: • a community category of an involuntary treatment order or forensic order for the patient is to automatically change to an in-patient category

	• any limited community treatment approved by an authorised doctor for the patient is revoked, and • an authorised doctor must review the patient's treatment needs, document the changed treatment, and talk to the patient about the treatment. **Treatment and care of classified patients** 2.8 The regular assessments of a patient under the Act (see recommendation 5.3) must, for a classified patient, include an assessment of whether the person can be appropriately treated and cared for in custody, rather than in the authorised mental health service. **Ceasing to be a classified patient** 2.9 Clarify that a person ceases to be a classified patient if: • apart from this Act, there is no lawful basis for the person's detention (e.g. the person is granted bail) • the Director of Mental Health decides there is no longer a clinical need for the person to remain in the authorised mental health service and the person leaves the authorised mental health service in lawful custody • for a person who consented to remaining in the authorised mental health service as a classified patient, the person withdraws his or her consent and the person leaves the authorised mental health service in lawful custody • the patient's involuntary treatment order or forensic order is revoked, the person does not consent to remain in the authorised mental health service, and the person leaves the service in lawful custody, or • the Mental Health Court makes a decision in relation to a referral for the person. **Return of person to lawful custody** 2.10 Clarify the provisions relating to returning a person to lawful custody by stating that the person must be returned to the custodian from whom the person was initially transferred. **Terminology** 2.11 The term 'classified patient' be replaced with 'restricted community access patient', to better describe this category of patients. This is a rather clumsy term but is perhaps more accurate given prison is described as part of the community for the purpose of access to health care.

3. Assessment of individuals charged with an offence

Issues identified	Review recommendations
• Mandatory psychiatric reports for individuals charged with offences, breach rights and achieve limited benefits. • Inadequate statutory protections for individuals subject to mandatory psychiatric reports. • Mandatory psychiatric reports divert public sector resources from higher value service delivery. Cost shifting may disadvantage the accused person. • 51 per cent of mandatory psychiatric reports reviewed by the Director of Mental Health are for simple offences. **More information** Background paper 3—Assessment of individuals charged with an offence.	**Offences that can be heard summarily** 3.1 Mandatory psychiatric reports for individuals subject to forensic orders or involuntary treatment orders for offences that can be heard summarily be discontinued. **Offences that must be heard on indictment** 3.2 Mandatory psychiatric reports for individuals subject to forensic orders or involuntary treatment orders for offences that must be heard on indictment be discontinued. Individuals charged with indictable/serious offences who may have a defence of unsound mind or unfitness for trial are currently automatically offered a psychiatric report rather than the person or their representative needing to request this report. We are unsure the person or their representative will know how to proceed. This may disadvantage the patient and shift responsibility and costs to the patient/representative for legal advice to make such a request. 3.3 An authorised mental health service be required to prepare a psychiatric report on the request of a person charged with an offence that must be heard on indictment (or other prescribed indictable offences), if the person was on an involuntary treatment order or forensic order at the time of (or since) the alleged offence. 3.4 A request for a psychiatric report may also be made by the person's representative, such as a personal guardian or attorney, if the person is unable to consent. 3.5 The Director of Mental Health to have authority to direct a psychiatric assessment of a person who may have been of unsound mind at the time of an alleged offence or unfit for trial where the alleged offence must be heard on indictment (or other prescribed indictable offences) if the Director believes it is in the public interest. Does this affect the person's interests? 3.6 The Director of Mental Health to have the authority to refer a person to the Mental Health Court where the psychiatric assessment directed by the Director of Mental Health indicates that a person may have been of unsound mind at the time of the alleged offence or unfit for trial. **Rights and protections in psychiatric examinations** 3.7 Where the Director of Mental Health directs a psychiatric assessment, the Act to state that: • the purpose of the assessment is to provide an opinion on fitness for trial and unsoundness of mind at the time of the alleged offence for the purposes of referral to, and consideration by, the Mental Health Court • the person must attend for an interview • if the person has capacity, he or she may nominate another person to attend the interview, including a lawyer • if the person does not have capacity, the authorised mental health service must ensure an independent person attends the interview, such as a personal guardian, attorney or lawyer • the person is not required to answer self-incriminating questions • the psychiatric report is to be provided to the person (unless unsafe to do so) and the person's personal guardian, attorney

	or lawyer, and • the psychiatric report cannot be used for any other purpose without the consent of the person or the person's representative.

Question: Will the recommendations result in a fairer and more cost effective way of assisting individuals who may have a mental health defence?

The new Act needs to ensure those with mental health issues have the same protections as all persons accused in the justice system e.g. support that minor offences are dealt with in a way which does not unduly restrict the individual's movements or access to ongoing community participation if this were the case for anyone else so charged.

This proposal may cost less, but we are concerned about reduced access to a report that may assist in a defence and therefore that it may not be fairer to the individual accused.

4. Orders and other actions following court findings

Issues identified	Review recommendations
• The range of offences for which forensic orders may be made is too broad. • Limited options for the Mental Health Court in actions it can take where a person is found of unsound mind or unfit for trial. • Model of forensic orders does not allow a patient to 'step-down' from a forensic order to a less- intensive order. • Possibility of forensic orders being revoked shortly after being made creates uncertainty. • Individuals found unfit for trial do not get the opportunity for a jury to determine whether the person did the alleged unlawful act. • Magistrates Courts have no express powers to deal with individuals of unsound mind or unfit for trial. • 43 per cent of forensic orders are for offences that must be heard on indictment. **More information** Background paper 4— Orders and other actions following Court findings.	**Principles of unsoundness of mind** 4.1 The Act state the fundamental principle that if a person was of unsound mind at the time of an alleged offence: • the person is not criminally responsible for the offence and is not to be punished for the offence, and • an order of a court as a result of the alleged offence may only infringe on the person's rights and liberty to the extent necessary to protect the community. **Mental Health Court jurisdiction** 4.2 The jurisdiction of the Mental Health Court be to consider offences that must be heard on indictment, other prescribed indictable offences and indictable offences referred from a magistrate. **Mental Health Court actions following a finding of unsoundness of mind or unfitness for trial** 4.3 On a finding of unsoundness of mind or unfitness for trial, the Mental Health Court's options include making an involuntary treatment order that can only be revoked by the Mental Health Review Tribunal. 4.4 An involuntary treatment order that can only be revoked by the Tribunal may be made by the Court if, on an assessment of relevant risks, the Court determines the community cannot be adequately protected by a 'standard' involuntary treatment order or voluntary treatment from: • serious harm to other individuals • serious property damage, or • repeat offending of the type the person was charged with. 4.5 A forensic order may be made by the Court if, on an assessment of relevant risks, the Court determines the community cannot be adequately protected by an involuntary treatment order that can only be revoked by the Tribunal from: • serious harm to other individuals • serious property damage, or • repeat offending of the type the person was charged with. 4.6 In considering these matters, the Court to have regard to: • the patient's current mental state and psychiatric history • the nature of the unlawful act • the patient's social circumstances • the patient's response to treatment and willingness to continue treatment, and • where relevant, the patient's compliance with previous obligations while on limited community treatment or a community category order. 4.7 The assessment of risk in determining the above to be based on generally accepted community standards. 4.8 An involuntary treatment order that can only be revoked by the Mental Health Review Tribunal to otherwise be the same as a 'standard' involuntary treatment order. The QNU seeks clarification of what constitutes "generally accepted

community standards" in regard to

- the patient's current mental state and psychiatric history, the nature of the unlawful act;
- the patient's social circumstances;
- the patient's response to treatment and willingness to continue treatment; and
- where relevant, the patient's compliance with previous obligations while on limited community treatment or a community category order.

This needs a less subjective measure.

Criminal Code and Minister's forensic orders

4.9 Where a court makes an order under the Criminal Code to detain a person as a result of a jury finding of unsoundness or unfitness or, in a Supreme Court or District Court, the prosecution and the defence agree that the accused person is unfit for trial:

- the court order is not to be treated as a forensic order
- if there is a charge before the court that is within the Mental Health Court's jurisdiction (see recommendation 4.2), the judge must refer the person to the Mental Health Court for a determination of any orders, with the monitoring of temporary fitness by the Mental Health Tribunal applying as with other orders, and
- if there is no charge within the Mental Health Court's jurisdiction, the judge has the same powers as a magistrate (see recommendations

4.10 Minister's forensic orders be discontinued.

Conditions attached to forensic orders

4.11 The Mental Health Court be able to attach conditions to forensic orders recommending the authorised mental health service or the forensic disability service consider specific interventions such as drug and alcohol programs or anger management counselling.

4.12 The implementation of this condition, including the patient's willingness to participate in such programs, be considered during Mental Health Review Tribunal reviews.

Duration and revocation of forensic orders

4.13 To provide greater certainty and stability during the early stages of a forensic order, the Mental Health Court have authority to impose a nonrevoke period for a forensic order of up to three years; where the charges are murder or attempted murder, the proposed period to be up to seven years.

4.14 At a Mental Health Review Tribunal review of a forensic order (after any nonrevoke period), the Tribunal may:

- continue the forensic order
- revoke the order and replace it with an involuntary treatment order that can only be revoked by the Tribunal
- revoke the order and replace it with a 'standard' involuntary treatment order, or
- revoke the forensic order.

4.15 An involuntary treatment order that can only be revoked by the Tribunal to otherwise be the same as a 'standard' involuntary treatment order.

Question:
Will the recommendations improve the system for dealing with individuals found of unsound mind or unfit for trial?
We note that these provisions are not that different to current forensic orders which continue for long periods to monitor patients who have committed offences and include 'compliance ' conditions. Our concern is the balance between the MH consumer's right to least restrictive care and measures which protect our members and the broader community.
Overall the revisions offer a more stringent court process for serious offences and reduce forensic orders for minor offences. This may deliver fewer restrictions on a MH consumer who commits minor offences.

Issues identified	Review recommmendations
	4.16 The Tribunal must revoke a forensic order and replace it with an involuntary treatment order that can only be revoked by the Tribunal if, on an assessment of relevant risks, the Tribunal determines the community can be adequately protected by the involuntary treatment order from: • serious harm to other individuals • serious property damage, or • repeat offending of the type that was the basis for the order. 4.17 The Tribunal must revoke a forensic order (subject to recommendation and make a 'standard' involuntary treatment order or make no other order if, on an assessment of relevant risks, the Tribunal determines the community no longer requires protection from: • serious harm to other individuals • serious property damage, or • repeat offending of the type that was the basis for the order. 4.18 The Tribunal must revoke an involuntary treatment order that can only be revoked by the Tribunal and make a 'standard' involuntary treatment order or make no other order if, on an assessment of relevant risks, the Tribunal determines the community no longer requires protection from: • serious harm to other individuals • serious property damage, or • repeat offending of the type that was the basis for the order. 4.19 In considering these matters, the Tribunal to have regard to: • the patient's current mental state and psychiatric history • the nature of the unlawful act and the time since the unlawful act • the patient's social circumstances • the patient's response to treatment and willingness to continue treatment, and • where relevant, the patient's compliance with previous obligations while on limited community treatment or a community category order. 4.20 The assessment of risk in determining the above to be based on generally accepted community standards. **Special hearings following finding of unfitness for trial** 4.21 Where the Mental Health Court makes a forensic order or an involuntary treatment order following a finding of permanent unfitness for trial or where a finding of temporary unfitness extends over 12 months, a lawyer representing the accused, in consultation with a substitute decision-maker, may elect to have a special hearing heard by the District Court or the Mental

	Health Court sitting as a judge alone. 4.22 The purpose of a special hearing be to determine on the available evidence whether the accused person did the act that constituted the offence: • if the finding is no, the accused person is discharged and the relevant order is revoked • if the finding is yes, the order is confirmed.
Issues identified	**Review recommendations**
	4.23 For the purpose of the special hearing, the accused's lawyer must act in the best interests of the accused, and the court may make any adjustments to normal trial processes that are appropriate in the circumstances. **Magistrates Court powers on finding of unsoundness of mind or unfitness for trial** 4.24 Where a magistrate is satisfied a person is likely to be, or appears, unfit for trial or of unsound mind due to a mental illness, the magistrate may: • discharge the person unconditionally, or • discharge the person and order an involuntary treatment order with a non-revoke period of up to six months for summary offences and up to 12 months for indictable offences. 4.25 However, if the magistrate believes the person might become fit for trial within six months, the magistrate may adjourn the charge and make a nonrevokable involuntary treatment order; if the person is still unfit for trial at the end of six months, the magistrate must act as above (recommendation 4.24). 4.26 In making an involuntary treatment order with a non-revoke period, the magistrate must be satisfied the community cannot be adequately protected by voluntary treatment or a 'standard' involuntary treatment order from harm, property damage or repeat offending of the type the person was charged with. 4.27 An involuntary treatment order with a non-revoke period otherwise to be the same as a 'standard' involuntary treatment order, and automatically becomes a 'standard' involuntary treatment order at the end of the nonrevoke period. 4.28 Where a magistrate is satisfied a person is likely to be, or appears, unfit for rial or of unsound mind due to an intellectual disability, the magistrate: • must discharge the person unconditionally, and • may refer the person to the Department of Communities, Child Safety and Disability Services to consider whether appropriate care can be provided to the person. 4.29 Where a magistrate is satisfied a person charged with an indictable offence is unfit for trial or of unsound mind due to a mental illness or intellectual disability, the magistrate may refer the matter to the Director of Mental Health or the Director of Forensic Disability to assess whether the matter should be referred to the Mental Health Court. **Evaluation** 4.30 An independent evaluation of the revised arrangements for

	the Magistrates Court powers be undertaken after three years. **Special notification forensic patients** 4.31 The category of 'special notification forensic patients' be discontinued. If a forensic order is not to be replaced by an involuntary treatment order that can only be revoked by the Tribunal, the revocation of the order to be subject to an independent second psychiatrist's opinion. **Review of forensic orders** 4.32 To align with the Criminal Code any 'mental disease or natural mental infirmity' that resulted in a forensic order or involuntary treatment order being made by the Mental Health Court be taken into account when the Mental Health Review Tribunal is considering whether to: • revoke the order, or • order or approve community treatment.

5. Treatment and care of involuntary patients

Issues identified	Review recommendations
• Purpose and benefit of 'treatment plans' is not sufficiently clear. • Statutory requirements for the treatment and care of involuntary patients do not adequately align with good clinical practice. • Patients cannot have an independent review of treatment being provided. • Patients receive inadequate information on their treatment in the community **More information** Background paper 5—Treatment and care of involuntary patients.	**Separate treatment and care provisions in the Act** 5.1 The provisions related to the treatment and care of involuntary patients be placed in one part of the proposed legislation. **Provision of treatment and care** 5.2 On admission of an involuntary patient, an authorised doctor must decide and record in appropriate clinical records, the proposed treatment and care to be provided to the patient. 5.3 The authorised doctor to ensure the treatment and care provided to a patient continues to be appropriate to the patient's needs including, for example, by regularly reviewing the patient's needs. 5.4 An authorised doctor must decide and review a patient's treatment and care in consultation with the patient and, as far as practicable, family, carers and other support persons. 5.5 The administrator of each authorised mental health service be required to: • take reasonable steps to ensure that involuntary patients receive appropriate treatment and care for their mental illness and for other illnesses or conditions, and • ensure the systems for recording treatment and care (proposed and provided) can be audited. **Regular assessments** 5.6 In relation to regular assessments of involuntary patients: • clarify that the purpose of an assessment is to determine whether the treatment criteria continue to apply to the patient, and • state that if, after an assessment, the authorised doctor decides the treatment criteria continue to apply to the patient, the doctor must also decide, and document, when the next assessment is to occur. **Other assessments** 5.7 An authorised doctor to assess a patient against the treatment criteria if, at any time, the doctor reasonably believes the treatment criteria may no longer apply to the patient. **Review of treatment** 5.8 A patient or the patient's representative (e.g. family, carer or other support person) be able to apply to the Mental Health Review Tribunal for a review of the patient's treatment or care after having sought a review of the patient's treatment and care from the administrator of the authorised mental health service. The provisions related to frivolous or vexatious applications to apply to these applications. 5.9 The Tribunal have the authority to direct the authorised mental health service to review the patient's treatment or care and report back to the Tribunal if needed, noting that the Tribunal will not have the authority to direct treatment.

Question:
Will the recommendations provide better statutory protections for involuntary patients that are consistent with good clinical practice?
The recommendation does not appear to offer better protections per se - these seem to be consistent with the current Involuntary Treatment Order (ITO) and treatment plan provisions.
Such a revision may strengthen the links to evidence-based treatment planning and patient engagement , however the individual AMHS/HHS retains authority to determine the most appropriate way to record the

plan (hard copy /electronic, the format, inclusion of risk assessment etc). This does not seem to adequately address the apparent confusion stakeholders have reported about what constitutes a treatment plan or how it is communicated and documented. It appears to relate more to red tape reduction. The QNU seeks: • clear articulation in the interests of patient outcomes; • a standardised format for documentation, content and risk assessment guidelines e.g. a Director of Mental Health (DMH) policy, that addresses the necessary protections for the patient and public .	
	Treatment in the community 5.10 Prior to an involuntary patient leaving an authorised mental health service on a community category or limited community treatment for overnight or longer, the authorised doctor must: • decide and document the treatment and care to be provided to the patient in the community in consultation with the patient and, as far as practicable, family, carers and other support persons • decide and document a statement about the patient's obligations while in the community, including scheduled health appointments • provide to the patient a summary of the treatment and care to be provided in the community and the statement about the patient's obligations • discuss with the patient and, as far as practicable, family, carers and other support persons, the treatment and care to be provided, and the patient's obligations under the statement. 5.11 The above requirements in relation to the statement about the patient's obligations while in the community also to apply where an involuntary patient leaves an authorised mental health service on unescorted day leave. **Director of Mental Health policies** 5.12 The Director of Mental Health to continue to have the authority to establish policies and practice guidelines about the treatment and care of involuntary patients, including the way in which treatment and care is provided and recorded. 5.13 Require all policies and practice guidelines issued by the Director of Mental Health to be published on the internet.

6. Treatment in the community

Issues identified	Review recommendations
• Purpose of 'limited community treatment' is not sufficiently clear • Inconsistencies and inadequate transparency in the way the Act deals with treatment in the community • Criteria for community treatment not sufficiently clear or consistent • Monitoring conditions do not apply to all involuntary patients, and safeguards could be strengthened • Inadequate clarity about how community treatment applies to individuals in custody Further information Background paper 6—Treatment in the community.	**Limited community treatment—involuntary treatment orders and forensic orders** 6.1 Consistent with the least restrictive principle, the purpose of limited community treatment be to support the recovery of involuntary patients by transitioning patients to living back in the community, with appropriate treatment and care. **Forensic orders—limited community treatment and community category** 6.2 The use of limited community treatment for forensic patients align with its use for patients on involuntary treatment orders by limiting the maximum period to seven days. 6.3 A community category of forensic order be established for forensic patients living continuously in the community, with the same criteria applying for a patient going into the community on limited community treatment or a community category. **Forensic orders—criteria for limited community treatment or community category** 6.4 The Mental Health Court and Mental Health Review Tribunal may only approve or order limited community treatment or a community category for a forensic patient if, on an assessment of relevant risks, the Court or Tribunal determines the community will be adequately protected from: • serious harm to other people • serious property damage, or • repeat offending of the type that was the basis for the order. 6.5 In considering these matters, the Court and Tribunal to have regard to: • the patient's current mental state and psychiatric history • the nature of the unlawful act and the time since the unlawful act • the patient's social circumstances • the patient's response to treatment or care and willingness to continue treatment or care, and • where relevant, the patient's compliance with previous obligations while on limited community treatment or a community category order. 6.6 The assessment of risk in deciding the above to be based on generally accepted community standards. 6.7 The above criteria may be met by limiting the level of community access or by placing conditions on the patient's order. 6.8 The Mental Health Court or Tribunal, in deciding whether to approve limited community treatment or a community category order may take into account the assessment of risks that must be made by the authorised doctor in authorising limited community treatment or a community category order. 6.9 An authorised doctor to consider the same criteria (recommendations 6.4 to 6.7) in approving limited community treatment or a community category order.
Question: **Will the recommendations provide for more transparent, consistent approaches to treatment in the community?**	

Classified patients – limited community treatment

6.6 The criteria and other matters for approving limited community treatment for forensic patients also apply to the Director of Mental Health in approving limited community treatment for classified patients.

Involuntary treatment orders – criteria for limited community treatment and community category

6.7 Clarify that a patient should only be placed on an in-patient involuntary treatment order, and continue to be on that order, if the authorised doctor believes the patient's treatment and care needs, and the safety and wellbeing of the patient and others cannot be reasonably met if the patient was on a community category order, having regard to:

- the patient's current mental state and psychiatric history
- the patient's social circumstances
- the patient's response to treatment, and
- where relevant, the patient's compliance with previous obligations while on a community category order.

6.8 The same criteria to apply when an authorised doctor is considering whether a person on an in-patient category of an involuntary treatment order should be granted limited community treatment and the nature of the limited community treatment.

Monitoring conditions

6.9 The Director of Mental Health be authorised to apply monitoring conditions to any involuntary patient (i.e. a forensic patient, classified patient, court order patient (under section 273 of the Act), or a patient on an involuntary treatment order) while in the community if:

- there is significant risk that the patient would not return to the authorised mental health service as required, or
  The QNU opposes the use of obvious monitoring devices, such as an ankle bracelet, that is commonly used for tracking offenders, as it contributes to marginalisation and stigma. We believe that other, less obvious GPS devices should be considered. Further, the need for a monitoring device should be linked to the clinically assessed risk in addition to the potential for patients to abscond.
- the patient has not complied with previous obligations while in the community and this non-compliance has resulted in a significant risk of harm to the patient or others.

6.10 The Mental Health Review Tribunal review the imposition of monitoring conditions on a patient within 21 days of the decision to apply the conditions.

6.11 The ability for patients to review the imposition of monitoring conditions include classified patients and court order patients (under section 273 of the Act).

6.12 Clarify that the general powers for the Mental Health Court and the Mental Health Review Tribunal to apply conditions to patients accessing limited community treatment may include monitoring conditions.

Community treatment and care for patients in custody

6.13 The category of a patient's involuntary order (in-patient or community) and any authority for limited community treatment approved or ordered by the Mental Health Court or the Mental Health Review Tribunal be unaffected by the person being detained in custody under another Act (e.g. being detained in a corrective services facility).

6.14 The person's custodial status under another Act to take precedence

	over any order, approval, authority or other right for the person to be in the community under an involuntary order for the period that the custodial status is in force. This does not apply when the classified patient provisions apply or where a patient is subject to specific court orders under the Act which authorise the patient's detention in an authorised mental health service. 6.15 Decisions about a person's rights to be in the community under an involuntary order to be based on the criteria stated in the Act and not on the fact of the person's custodial status under another Act.

7. Support for involuntary patients

Issues identified	Review recommendations
• Act does not give adequate recognition to the role of family, carers and other support persons. • 'Allied person' model has proved to be ineffective. • Involuntary patients would benefit from having access to an independent person to advise of patients' rights and obligations. • Rights of patients at Tribunal hearings could be improved. **More information** Background paper 7—Support for involuntary patients.	**Principles** 7.1 The principles in the Act strengthen the importance of family, carers and other support persons to a patient's treatment and recovery, based on relevant principles in the Australian Mental Health Statement of Rights and Responsibilities as follows: Family, carers and other support people have the right to: • contact the patient while the patient is undergoing treatment • participate in treatment decisions and decisions about ongoing care • seek and receive additional information about the patient's support, care, treatment, rehabilitation and recovery • be consulted by the treating team about treatment approaches being considered for the patient • arrange other support services for the patient, such as respite care, counselling and community care, and • be provided with any information that the patient requests they should receive. To ensure that these rights are used constructively, the family, carers and other support persons to have the responsibility to: • respect the humanity and dignity of the patient • consider the opinions and skills of professional and other staff who provide assessment, individualised care planning, support, care, treatment, recovery and rehabilitation services to patients, and • cooperate, as far as is possible, with reasonable programs of assessment, individualised care planning, support, care, treatment, recovery and rehabilitation. 7.2 The principles in the Act emphasise the importance of recovery-oriented services and the reduction of stigma associated with mental illness. **Allied persons** 7.3 The 'allied persons' model in the Act be discontinued. **Right to visit** 7.4 The Act include an express statement that involuntary patients in authorised mental health services have a right to: • be visited by family, carers and other support persons at any reasonable time, unless the person is expressly excluded under the Act, and • send and receive correspondence, phone calls and electronic messages from individuals, unless contact with the person is expressly excluded under the Act.

Question:
Will the recommendations improve the support provided to involuntary patients?
We support the proposed principles of recovery-oriented services and reduction of stigma. However, we urge caution at the idea of shifting too far from a clinician's advocacy responsibilities inherent as health professionals in this approach e.g. Codes of Ethics etc.
This approach may need a small team of persons to offer the range of advocacy services described.
If an AMHS is the employer, the 'allied person model' may face recruitment or budget pressures. In our view, at this stage, there are too many variables and unanswered questions in this section for us to lend

support beyond the general underlying principles.	
	Patient information 7.5 The Act note that, under the Hospital and Health Boards Act 2011, family, carers and other support persons may be provided information about a patient's treatment and care if the information is for the purpose of treatment and care, or if the person has sufficient personal interest in the patient's health and welfare. **Independent patient companion** 7.6 Require each authorised mental health service to employ or engage (e.g. from a non-government organisation) a person or persons as an 'Independent Patient Companion', who is to report directly to the administrator of the authorised mental health service and not be part of the treating team. 7.7 The role of the Independent Patient Companion be to: • advise involuntary patients, family, carers and other support persons of the patient's rights and obligations under the Act • assist involuntary patients, family, carers and other support persons to constructively engage with the treating team about the patient's treatment and care • advise patients, family, carers and other support persons of upcoming Mental Health Review Tribunal proceedings, the patient's rights at Tribunal proceedings, and engaging an advocate or legal representative for a hearing • attend Tribunal hearings as an advocate or support person, if requested by the patient • actively identify if the patient has a personal guardian or attorney and, if one exists, work co-operatively with the guardian or attorney to further the patient's interests, and • advise patients, where appropriate, of the benefits of having an advance health directive or enduring power of attorney to address future times when the patient does not have capacity. **Attendance at Mental Health Review Tribunal hearings** 7.8 Provide that at a Mental Health Review Tribunal hearing a patient: • may be represented by a lawyer or other person (e.g. an advocate) unless excluded by the Tribunal, and • may be accompanied by a support person at the hearing, unless excluded by the Tribunal.

8. Support for Victims

Issues identified	Review recommendations
• Act does not include principles for supporting victims of unlawful acts. • Statutory barriers exist to providing information to identify individuals who may be victims. • Purpose of victim submissions, and the need to re-submit submissions, could be clarified. • Inadequate information is provided under forensic information orders. **More information** Background paper 8–Support for victims.	**Recognition of victims in the principles of the Act** 8.1 The Act to include a statement of principles in relation to victims, to provide guidance to those administering the Act, namely that a person involved in the administration of this Act is to: • recognise with compassion the physical, psychological and emotional harm caused to a victim by an unlawful act of another person • recognise the benefits to a victim of being advised in a timely way of the proceedings against the person under the Act • recognise the benefits to a victim of being given the opportunity to express his or her views on the impact of the unlawful act to decision making entities under the Act • recognise the benefits to a victim of a timely completion of proceedings against the person • recognise the benefits to a victim of being advised in a timely way of decisions to allow the person to go into the community, and • recognise the benefits of counselling, advice on the nature of proceedings under the Act and other support services to a victim's recovery from the harm caused by the unlawful act. In these principles, a reference to an unlawful act includes an alleged unlawful act. **Identifying and providing services to victims** 8.2 Enable the Department of Health, a Hospital and Health Service, the Queensland Police Service, the Department of Justice and Attorney-General and the Director of Public Prosecutions to use and disclose information to: • assist the identification of a person who may be a victim, or • to provide information and assistance to a person who may be, or is, a victim. 8.3 The Act to state that this provision to over-ride any confidentiality or privacy duties under the Hospital and Health Boards Act 2011, the Information Privacy Act 2009 or any other Act. **Victim submissions** 8.4 Clarify that victim submissions to the Mental Health Court and the Mental Health Review Tribunal are of the nature of victim impact statements equivalent to victim impact statements made under the Victims of Crimes Assistance Act 2009. 8.5 Victim submissions to remain confidential unless otherwise requested by the victim.
Question: Will the recommendations improve support for victims of unlawful acts? The QNU supports changes that offer assistance to victims and place fewer hurdles in the process to access information.	
	Re-submission of victim submissions 8.6 The initial victim submission to the Mental Health Court or the Mental Health Review Tribunal to be automatically read into subsequent Tribunal proceedings on each occasion unless the victim wishes to make a new submission. **Notice of hearing for revocation of forensic order** 8.7 Require the Mental Health Review Tribunal to notify a victim of an

	application to revoke a forensic order. **Forensic information orders** 8.8 The Mental Health Review Tribunal to provide a victim who has a forensic information order with a statement of reasons and a summary of the risk assessment that led to a decision for a forensic patient to be granted access to the community or for the revocation of a forensic order. 8.9 Forensic information orders require a victim to also be notified of: • the outcome of a Mental Health Review Tribunal review of fitness for trial, and • the fact that an appeal has been lodged in the Mental Health Court in relation to the forensic order and the outcomes of the appeal. 8.10 The Director of Mental Health to approve forensic information orders instead of the Mental Health Review Tribunal. 8.11 Classified patient information orders be streamlined by replacing orders with the ability for the Department of Health and the Queensland Health Victim Support Service to disclose relevant information to a victim. **Non-contact with victims** 8.12 Continue the ability for the Mental Health Court and the Mental Health Review Tribunal to impose 'non-contact' conditions on limited community treatment. 8.13 The ability to make a 'non-contact order' when the Court or Tribunal has decided that the person does not represent a risk to the community be discontinued. 8.14 The Act give legal authority for an authorised mental health service to prevent an in-patient from attempting to contact a person by phone, email, mail or other means if requested by the person.

9. Mental Health Review Tribunal

Issues identified	Review recommendations
• Low level of legal representation for patients at Tribunal hearings. • Act not sufficiently clear on the purpose of Tribunal hearings, decisions that can be made, and criteria for decisions. • Limited ability for patients to present evidence at Tribunal hearings. • Opportunities exist to improve the cost effectiveness of Tribunal proceedings. • In 2012-13, 11,978 matters were listed for hearing by the Tribunal. **More information** Background paper 9—Mental Health Review Tribunal.	**Deputy President** 9.1 Provide for the position of Deputy President of the Tribunal, to have the same minimum qualifications as the President and who would act as President in the President's absence. **Legal representation** 9.2 Patients to have legal representation at Tribunal hearings, without cost to the patient, for: • hearings involving minors • fitness for trial reviews, and • reviews where the State is legally represented by the Attorney-General. **Tribunal hearings – purpose, applications and decisions** 9.3 The Act clearly state the following: • how Tribunal hearings are initiated (including who may make an application and what can be applied for) • the purpose of each type of hearing • the decision the Tribunal may make at a hearing, and • the criteria for the decisions. **Statement of reasons** 9.4 A function of the Tribunal include publishing de-identified decisions and statements of reasons for Tribunal decisions that may be of precedential value. **Evidence** 9.5 The Tribunal allow individuals to provide evidence at a hearing where requested by a patient or other party. **Time-frames for review of involuntary treatment orders** 9.6 Reviews of involuntary treatment orders by the Mental Health Review Tribunal be conducted 12 monthly, while retaining the initial six week review and the right of a patient, or the patient's representative, to apply for a review at any time. **Missing persons** 9.7 Reviews of forensic patients be suspended if the patient is absent without permission. 9.8 The Tribunal be able to revoke a forensic order if a patient is absent without permission for over five years and the available information indicates that the person is unlikely to return to the State or is presumed to have died.
Question: Will the recommendations provide for fairer more cost-effective Tribunal proceedings? As the patient will lose access to an automatic 6 month review presumably to 'reduce red tape', we believe the costs (including long term social costs) will be transferred on to other sections of the community or the individual. Again we see that short term efficiency may not produce long term, evidence-based gains.	
	Hearings by teleconferencing or on the papers 9.9 The Tribunal be able to conduct hearings by remote conferencing, including video-conferencing, teleconferencing or another form of communication that allows a person to take part in discussions as they happen. 9.10 The Tribunal be able to conduct a review hearing of an involuntary treatment order entirely on the basis of documents, without the patient, the patient's representative or the treating team appearing at

	the hearing if the patient or the patient's representative does not wish to attend a hearing. **Detention of minors in high security facilities** The legislative requirement for the Tribunal to review young patients detained in high security units be discontinued. Even though the DMH may approve the admission of minors, given the vulnerability of youth in the criminal justice system, a Tribunal review offers an additional safeguard. This process is not used often and we believe that a decision to abolish it should be based on evidence of its efficacy, not just to conform with the 'red tape reduction' philosophy that seems to run through the recommendations.

10. Interstate transfers

Issues identified	Review recommendations
• Provisions of the Act in relation to interstate transfers are largely ineffective. • Purpose and benefit of the 'move' provisions in the Act are not clear. **More information** Background paper 10—Interstate transfers.	**Interstate transfers—Ministerial agreements** 10.1 The requirement for Ministerial agreements with other States for the interstate transfer of involuntary patients be discontinued. **Transfer of patients on forensic orders** 10.2 The transfer of forensic patients out of Queensland to take place as follows: • a patient or representative to apply to the Director of Mental Health to transfer to a mental health service interstate, providing information on why the transfer would be in the patient's interests and the willingness of the interstate service to receive the patient • the Director of Mental Health may approve the application if: o the transfer is in the patient's interests, for example, to be in closer proximity to family and support persons who would assist the patient's recovery o suitable treatment and care is available for the person at the destination mental health service, and o the person in the destination jurisdiction that is legally authorised to agree to the transfer agrees to the transfer • the forensic order is suspended when the patient leaves the State, and • the Mental Health Review Tribunal is advised of the transfer. The forensic order is suspended when the patient leaves the State, and the Mental Health Review Tribunal is advised of the transfer. 10.3 If a patient is transferred interstate and the patient returns to Queensland within three years, the forensic order in Queensland is automatically reinstated.
Question: Will the recommendations provide effective arrangements for the interstate transfer of patients? This would need more extensive and rigorous evaluation.	
	10.4 The transfer of patients who are on the equivalent of a forensic order in another State into Queensland to take place as follows: • a request for a transfer to be made to the Mental Health Review Tribunal by the patient or the patient's representative • in making the application, the patient or the patient's representative is to provide information on why the transfer would be in the patient's interests (e.g. closer proximity to family and support persons who would assist the patient's recovery) • the Tribunal may approve a transfer into Queensland of an equivalent forensic patient if: o the transfer is in the patient's interests, for example, to be in closer proximity to family and support persons who would assist the patient's recovery o suitable treatment and care is available for the person at an authorised mental health service o the person in the destination jurisdiction that is legally authorised to agree to the transfer agrees to the transfer, and

	○ the forensic order will adequately protect the community from serious harm to other people, serious property damage or repeat offending of the type that was the basis for the equivalent order interstate • the Tribunal decides the category of order and any conditions, having regard to the equivalent order and conditions that applied interstate, and • the forensic order is effective immediately the patient enters Queensland. **Transfer of patients on involuntary treatment orders** 10.5 The transfer of patients on involuntary treatment orders (or equivalent interstate) into, and out of, Queensland to be approved by the administrator of the authorised mental health service. **Transfer of patients living in the community** 10.6 The requirement that interstate patients on an involuntary order must be 'detained' before being transferred into Queensland be discontinued. **Move provisions** 10.7 The provisions in the Act related to the 'move' of involuntary patients be discontinued.

11. Forensic disability

Issues identified	Review recommendations
• Inadequate clarity in the Mental Health Court making forensic orders for individuals with a dual diagnosis. • Management of forensic orders (disability) and the care of individuals on forensic orders (disability) are not adequately aligned. **More information** Background paper 11—Forensic disability.	**Forensic orders for individuals with dual diagnosis** 11.1 The Mental Health Court be able to make a 'standard' forensic order for a person with a dual diagnosis (i.e. mental illness and intellectual disability) if the Court believes the person requires involuntary treatment and care for a mental illness as well as care for the intellectual disability. 11.2 The Mental Health Review Tribunal be given authority in a review of a person with a dual diagnosis to amend a 'standard' forensic order to a forensic order (disability) if the person no longer requires involuntary treatment for the mental illness. **Management of forensic orders (disability)** 11.3 The legislative, administrative and operational arrangements for the management of forensic orders and the care of a person on a forensic order (disability) be aligned. **Clinicians assisting the Mental Health Court** 11.4 For proceedings for a person with an intellectual disability, the Mental Health Court may be assisted by a person with expertise in the care of people with an intellectual disability, such as a forensic psychologist. **Co-existing application of an involuntary treatment order and a forensic order (disability)** 11.5 Ensure that an involuntary treatment order and a forensic order (disability) can co-exist for a person, regardless of which order is made first.

Question:
Will the recommendations improve the arrangements for individuals on forensic orders (disability)?
On the face of it this revision seems to enhance the distinction between the mental health needs and disability needs of an individual. This may prove a welcome revision if it alters the approach reported by MH nurses that MH is often considered the service of last resort (e.g. consumer with behavioural problems, disability and a history of offending), as MH is not resourced to meet the full range of specific 'disability' needs.
The technical changes should mean that a person can be on a Forensic Disability Order and ITO concurrently and therefore receive involuntary treatment for mental illness as well as disability care. This would be a benefit.

12. Guardianship and attorneys

Issues identified	Review recommendations
• Relationship between mental health legislation and guardianship legislation could be clarified in one area. **More information** Background paper 12—Guardianship and attorneys.	12.1 Clarify that the emergency transport and examination provisions in the proposed mental health legislation do not affect the operation of the *Guardianship and Administration Act 2000*, particularly section 63 (Urgent Health Care).

Question:
Will the recommendations clarify the relationship between mental health legislation and guardianship legislation in emergencies?

These procedures seem to clarify the relationship.

13. Restraint and Seclusion

Issues identified	Review recommendations
• Act to support the reduction in the use of seclusion and mechanical restraint. • Safeguards in the use of mechanical restraint could be strengthened. • Consistency, clarity and effectiveness of restraint and seclusion provisions could be improved. **More information** Background paper 13—Restraint and seclusion.	**Extension of mechanical restraint and seclusion** 13.1 Clarify that the authorisation of seclusion or mechanical restraint for three hours may be re-authorised if the criteria continue to apply, noting that the Director of Mental Health must approve the use of mechanical restraint (see recommendation 13.9). We ask whether there is an evidence base for this 3 hour stipulation. 13.2 The use of seclusion and mechanical restraint in the high security unit may be used for a particular patient for periods longer than three hours without a re-authorisation if the Director of Mental Health has approved a management plan for the patient. 13.3 A management plan must include strategies to reduce seclusion or mechanical restraint for the patient and must be reviewed monthly. **Exceptions to the mechanical restraint offence and offences under other laws** 13.4 Clarify that the mechanical restraint offence does not prevent the use of a mechanical restraint if the use is lawful under another law (e.g. the use of hand-cuffs by the police if the use is authorised under the Police Powers and Responsibilities Act 2000). 13.5 Clarify that a person does not commit an offence under another law (e.g. the Criminal Code) if the person uses a mechanical restraint in accordance with the Act. We welcome this provision in light of recent events when authorities arbitrarily locked all MH acute adult inpatient units (discussed more fully in our covering submission). **Exceptions to the seclusion offence and offences under other laws** 13.6 Clarify that the seclusion offence does not prevent the use of seclusion if it is lawful under another law. 13.7 Clarify that a person does not commit an offence under another law (e.g. the Criminal Code) if the person uses seclusion in accordance with the Act. **Approval of mechanical restraint and seclusion** 13.8 Mechanical restraints only to be used in a high security unit or another authorised mental health service approved by the Director of Mental Health. 13.9 Mechanical restraints only to be used with the prior written approval of the Director of Mental Health. 13.10 The Director of Mental Health can direct that seclusion not be used in a particular authorised mental health service or not be used for a particular patient. Here, we are concerned about appropriate workplace heath and safety measures to prevent violence. We need further detail on matters such as: • how this decision is made; • whether there is stakeholder/clinician consultation; • what workplace health and safety measures to prevent violence will be instigated; • how long the direction not to use seclusion will endure? Require the Director of Mental Health to issue binding policies on the use of mechanical restraint and seclusion to minimise its use and impact on patients.

	These policies need to mitigate the risk of violence to mental health staff and other patients while recognising the rights of the patient.
Question: Will the recommendations strengthen the safeguards and effectiveness of the restraint and seclusion provisions? Again, we seek balance in providing safety for the individual while protecting their individual rights as well as those of staff, other patients, family, carers and the community. We recognise that this is not easily struck and therefore urge caution and the use of evidence to support changes in this area.	
	Notification of mechanical restraint and seclusion 13.11 Require the notification to the Director of Mental Health on the use of mechanical restraint or seclusion to be done in the way, and within the time, directed by the Director, on a general basis or for particular authorised mental health services. **Definition of mechanical restraint** 13.12 The definition of 'mechanical restraint' be revised to "any device or apparatus used to prevent the free movement of a person's body or a limb". **Offence of mechanical restraint** 13.13 The mechanical restraint offence state that it is an offence for a person to apply a mechanical restraint to an involuntary patient in an authorised mental health service, unless the restraint is of a type approved by the Director of Mental Health and in accordance with the Act. These provisions enhance clarity. **Definition of seclusion** 13.14 The definition of 'seclusion' be revised so that it does not apply if the person consents (e.g. for the person's privacy). We find it difficult to envisage why privacy would require locking - contemporary units should offer privacy for individuals. If this relates to the patient's mental state e.g. fear etc, then a clinically appropriate intervention such as the allocation of a nurse to undertake close observations must be the first consideration. 13.15 Define 'overnight' (which is excluded from the definition of seclusion in a high security unit) as being a period of no more than 10 hours between 8:00 pm and 8:00 am as determined by the administrator of the authorised mental health service. Even though this definition only applies in medium and high security units, this does not abrogate the HHS's responsibility to proved adequate numbers of appropriately qualified and experienced staff - i.e. the numbers and skill mix of staff must be available to manage acute patients 'overnight' consistent with workload models and risk assessment including OVRAT. If the definition is included it should be clear that it applies to medium and high secure facilities ONLY. **Release from seclusion** 13.16 A senior registered nurse who placed a patient in seclusion in urgent circumstances be able to release the person from seclusion if satisfied the patient's seclusion is no longer necessary, while retaining the requirement for the patient to be examined by a doctor as soon as practicable. We agree with NaMOQ's suggestion that the provisions must reflect the current nomenclature for 'a senior registered nurse' which is a 'nurse in charge of ward or unit'. Subsequent returns to seclusion need to be available otherwise there is a risk to others, particularly if the MO is not close by and available for timely review. This requires balancing MO availability

	with the patient's immediate needs. **Basis for authorising the use of a mechanical restraint and seclusion** 13.1 Enable the authorisation of the use of mechanical restraint to be on the same basis as the authorisation of seclusion (i.e. necessary to protect the patient or other people from imminent physical harm, and there is not less restrictive way of ensuring the safety of the patient or others).

14. Regulated treatments

Issues identified	Review recommendations
• Act to have adequate safeguards for the use of ECT and psychosurgery. • Terminology related to regulated treatments not contemporary. • Time-frames for hearings could be expedited. **More information** Background paper 14—Regulated treatments.	**Psychosurgery** 14.1 The term 'psychosurgery' be replaced with 'neurosurgery for psychiatric conditions' and be defined as follows: • Neurosurgery for psychiatric conditions' means a neurological procedure to treat or ameliorate symptoms of a psychiatric condition. • To remove doubt, neurosurgery for psychiatric conditions does not include neurosurgery for treating epilepsy, Parkinson's disease, Gilles de la Tourette syndrome or another neurological disorder. 14.2 Non-ablative procedures (such as deep brain stimulation) be excluded from the definition of 'neurosurgery for psychiatrist conditions', with the protections under the Guardianship and Administration Act 2000 being retained. **Electroconvulsive therapy** 14.3 The definition of electroconvulsive therapy (ECT) clearly link the procedure with the treatment of mental illness by including 'for the purpose of treatment of mental illness' in the definition. 14.4 The two-day timeframe for notices of hearings about ECT applications may be waived by the patient or the patient's representative. 14.5 The seven-day timeframe for notices of hearings of appeals to the Mental Health Court about ECT applications may be waived by the patient or the patient's representative. 14.6 Where an existing application for ECT has been made to the Mental Health Review Tribunal, the psychiatrist be required to notify the Tribunal if emergency ECT is undertaken, rather than requiring a new application to be made.

Question:
Will the recommendations improve the effectiveness of the provisions related to regulated treatments?

Whilst we acknowledge there is greater evidence of the benefits and acceptance of this type of treatment e.g. RANZCP position, we suggest caution in this area. We believe these treatments should be used only as a last resort and on the basis of evidence.

If a decision is taken to remove the requirement for the "tribunal" which is advised by health professionals to approve this type of procedure, we acknowledge that the *Guardianship and Administration Act 2000* provides for this type of special health care under particular circumstances. We accept that this coupled with stringent safeguards around informed consent and Advanced Health Directives would likely serve to offer the necessary protections.

Similarly with ECT. We support maintaining it as a regulated treatment and the refined definition. There is some evidence of red tape reduction re a second application in emergent circumstances but it may be redundant given the circumstances in which it applies. The concessions around waiving timeframes to proceed (in emergent situations) must be balanced with the intent of informed decision making and/or the existence of an Advanced Health Directive indicating the individual's wants /wishes, where available. There is potential for improvements in these treatments, but the QNU suggests we proceed with caution.

15. Transport issues

Issues identified	Review recommendations
• Powers to transport involuntary patients are inconsistent and inadequate. • Police may receive inadequate information to effectively respond to requests to return patients. • Act does not require individuals who are involuntarily transported from the community to be returned in all instances. • Circumstances where a person may be detained and transported to an authorised mental health service are not sufficiently clear. **More information** Background paper 15—Transport issues.	**Inconsistent transport powers** 15.1 The Act include one set of provisions that consistently authorises the transport of individuals to, from, and within authorised mental health services, who is authorised to transport individuals, the use of reasonable force, and the authority to use medication if required. We have concerns about administering medication during transport and capacity for clinical handover (we refer here to the Background Paper 15, p 2. Transport by Family). These transport powers are not consistent with national safety and quality practice standards. Again we point out that the 'red tape reduction' mantra needs to take into account proper operational procedures including adequate numbers of nursing and clinical support staff. As previously discussed, medication must only be administered by a qualified licensed clinician such as a doctor or NP. This is not a procedure that can be delegated to un authorised or unqualified workers. **Police assistance** 15.2 Where an authorised mental health service is seeking police assistance to transport a person to the service, the service is to advise police of the reason the person requires transportation, the reason that police assistance is required, and risk information about the person. 15.3 When requested by an authorised mental health service, police to provide assistance, of the nature and in the time that is reasonable in the circumstances, having regard to the reason the person is to be transported, and the risk information provided by the service. This must be a joint decision otherwise the balance of decision making power sits with QPS officers. **Use of mechanical restraint** 15.4 The use of mechanical restraint be permitted when transporting high security patients, if clinically required, to ensure the safety of the patient or others, in accordance with policies issued by the Director of Mental Health. **Appearances before court** 15.5 Clarify the arrangements for a patient to appear before a court via video link from an authorised mental health service, including the power to detain a patient if the patient's status under the Act changes as a result of court proceedings via video-link.
Question: Will the recommendations provide for clear, consistent powers to transport individuals? The powers are clear, but we disagree with the provisions around medication administration and the decision making process when seeking police assistance.	

	Review recommendations

Issues identified	
	Returning individuals to relevant place 15.6 The circumstances where the administrator of an authorised mental health service be required to ensure that a person is reasonably returned to a place in the community be expanded to include all situations where a person has been taken to an authorised mental health service under an involuntary process of the Act. **Authority to return patients** 15.7 The Act to clearly state the circumstances where a person can be detained and returned involuntarily to an authorised mental health service, namely: • a person absconds while being lawfully detained under the Act • a person on limited community treatment absconds from escorted leave, does not attend for treatment as required, or does not return to the service as required • a person on a community category order does not attend for treatment as required • a person on a temporary absence absconds or does not return to the service as required • a person who is not in an authorised mental health service is placed on an involuntary treatment order, forensic order, or court order as an in-patient, or • a person for whom limited community treatment is revoked or suspended, a community category order is changed to an in-patient order, or a temporary absence is revoked. **Entry of places and warrants** 15.8 Clarify that a warrant is not required if a classified patient, forensic patient, or a person detained under a court order under the Act is required to return to an authorised mental health service, due to the operation of section 21 of the *Police Powers and Responsibilities Act 2000.* We need further explanations of the benefit of such a provision. It would seem to us that Queensland Police may be more comfortable to act if working under the *Police Powers and Responsibilities Act 2000.*

16. Regional, rural and remote issues

Issues identified	Review recommendations
• Increased flexibility under the Act could improve the provision of services in regional, rural and remote areas of Queensland. **More information** Background paper 16—Regional, rural and remote issues.	6.1 The Director of Mental Health have the authority to approve authorised mental health services with conditions or limitations to enable small rural or remote health facilities to provide a limited range of in-patient treatment for involuntary patients. 6.2 The restrictions on the use of audio-visual facilities for assessments be discontinued, with it being at the discretion of the relevant clinician to determine whether the use of audio-visual facilities is appropriate in each case. 6.3 For regional, rural and remote areas designated by the Director of Mental Health, a second assessment (to confirm or revoke an involuntary treatment order) be required in seven days rather than three days if the patient is being detained as an in-patient in an authorised mental health service, and 14 days if the patient is placed on a community category order. 6.4 Clarify that community treatment may be provided at any clinically- appropriate place determined by the relevant clinician, such as an authorised mental health service, a community mental health service, a primary healthcare centre or another place, such as a person's home. 6.5 The administrator of an authorised mental health service in a regional, rural or remote area designated by the Director of Mental Health may extend the time period for an assessment of a person for an additional 72 hours if it is necessary to enable transportation of the person to a suitable place for the assessment. The extension of time should only occur once.

Will the recommendations increase the flexibility of service provision in regional, rural and remote areas?

Possibly but consumers' rights/safeguards and access should not depend on where the individual resides. Codifying these provisions in legislation is dangerous as it may limit further efforts to address the inequity.

17. Indigenous and multicultural issues

Issues identified	Review recommendations
• The Act should give recognition to providing services to Aboriginal people, Torres Strait Islander people and people from culturally and linguistically diverse backgrounds. **More information** Background paper 17— Indigenous and multicultural issues.	.1 The following two principles be included in the Act: • the cultural, communication, and other unique contexts and needs of Aboriginal people, Torres Strait Islander people and people from culturally and linguistically diverse backgrounds must be recognised and taken into account, and • to the extent that is practicable and appropriate to do so, services provided to Aboriginal people and Torres Strait Islander people are to have regard to the person's cultural and spiritual beliefs and practices, and the views of families and significant members of the person's community.

on: Will the recommendations adequately recognise the needs of Aboriginal people, Torres Strait Islander people and people from culturally and linguistically diverse backgrounds?

U recognises and supports culturally safe practice by all nurses and midwives. This is a legislative

18. Children and adolescents

Issues identified	Review recommendations
• Consent to treatment by minors, and by a minor's parents or guardians, could be clarified in legislation. • There would be benefit in having an expert in child psychiatry participating in Tribunal hearings for minors. **More information** Background paper 18—Children and adolescents.	**Consistent use of terminology** 18.1 The term 'minor' replace the terms child, young person and young patient, with a minor meaning a person under the age of 18 years. **Children within adult facilities** 18.2 The Act include a principle that, wherever practicable, minors should be held separately from adults in in-patient facilities. **Capacity to consent** 18.3 For the purposes of the Act, a minor be presumed to have capacity to consent to treatment if the minor has the maturity and intelligence to fully understand the decisions being made. 18.4 Clarify that the Act does not affect the common law in relation to parents or guardians consenting to a minor's treatment, noting that this would not prevent a doctor proceeding under the Act if the parents or guardians did not agree to treatment and the doctor believed the treatment was in the minor's best interests. **Composition of Mental Health Review Tribunals** 18.5 For hearings pertaining to minors where a psychiatrist is required to be on the Tribunal, the psychiatrist is to have expertise in child psychiatry.

: Willtherecommendationsadequately recognise minors?

The recommendations may provide clarification of the definition of a 'minor' and thus reduce confusion.

The legislation does not appear to assist in dealing with the complexity of applying the "Gillick test" (see note below) and issues of consent for behavioural interventions. We welcome the DMH developing an 'enforceable' policy in consultation with stakeholders and clinicians. This policy would apply across all HHS settings in the public sector and the private sector.

The matter of 'locked time out' versus seclusion raises a concern regarding rights and protections. The QNU favours an approach that offers standard/consistent safeguards so if the new Act *"alllows the flexibility to vary the seclusion arrangements for individuals, including for minors, consistent with the least restrictive principle "* (Background paper 18, p.2) then this would be preferable to authorising locked time out.

Note

The Gillick Test holds that while a minor who has a requisite level of understanding may consent to treatment, this does not amount to a corresponding right to refuse treatment. Hence, an adolescent who is competent according to the principles established by Gillick, will generally lack the capacity to refuse life-saving treatment if his/her parents are prepared to consent to it.
http://www.findlaw.com.au/articles/432/age-of-consent-to-medical-treatment.aspx; *Health care & the Law 0McIllwraith & Madden 4th Edition , pg110, Lawbook Co. Sydney NSW*

19. Streamlined processes

Issues identified	Review recommendations
• Too many forms and other paperwork required in administering the legislation. **More information** Background paper 19—Streamlined processes.	9.1 The requirements to complete forms under the Act be streamlined and clarified to distinguish between: • approved forms • requirements to notify or document a matter in another way (including in electronic form), and • template forms which are discretionary to use. The requirements to be in line with Addendum A of Background Paper 19. The Consumer Integrated Mental Health Application (CIMHA) system has not been reliable and in our experience data entry by our members has not been factored into the Business Planning Framework (BPF) which is currently used to determine nursing hours in inpatient units and in community services. The QNU has seen too much paperwork shift to nurses rather than the appropriate administrative staff. Access to hardware and reliability of software/programs are factors which may impact negatively on nurses' workloads and clinical time. Electronic records require adequate information technology support. We question whether a "discretionary" approach to standardized forms has the potential to enhance and improve outcomes for MH consumers covered by this Act and the accountability of those administering it. 9.2 The powers and responsibilities of authorised positions be modified in line with Addendum B of Background Paper 19. The changes allowing a local Administrator to appoint a health practitioner, rather than the DMH may lead to variable outcomes where the lack of central responsibility and accepted criteria may compromise reliability and validity. Currently s. 508 of the Act provides that *'a person is automatically a health practitioner if the person is a doctor, registered nurse, occupational therapist, psychologist, or a social worker and given the 'powers' - taking patient to AMHS and to take a patient to or from court'.* The proposal to '*streamline provisions - replace with a health service employee (as defined in the Hospitals and Health Service Act 2011) and other persons approved by the AMHS administrator (e.g. a security officer)'* ignores the contemporary recovery and partnership approach to MH care. Such a model seems to favour convenience over clinical need and evidence-based practice. 9.3 The Act to include provisions for authorised persons to investigate offences under the Act. This seems a reasonable addition, however we stress the need for impartiality.

tion:

Will the recommendations streamline processes in administering the legislation?

We welcome moves to reduce paperwork providing the alternative is reliable, properly resourced and easily accessible. Convenience should not usurp sound administration.

20. Other legal issues

Issues identified	Review recommendations
• A number of legal issues could be addressed in the new legislation. **More information** Background paper 20—Other legal issues.	**Presentation of indictment within six months of committal** 20.1 The requirement of the Criminal Code (section 590) to present an indictment within six months of a committal to apply, notwithstanding that proceedings have been suspended under the Act. **ition of 'unfit for trial'** 20.2 Provide that a person is mentally unfit to stand trial on a charge of an offence if the person is mentally impaired to the extent that the person is: • unable to understand, or to respond rationally to, the charge or the allegations on which the charge is based • unable to exercise (or to give rational instructions about the exercise of) procedural rights (such as, for example, the right to challenge jurors) • unable to understand the nature of the proceedings or to follow the evidence or the course of the proceedings, or • unable to endure the person's trial without serious adverse consequences to the person's mental condition. A person is not unfit to stand trial only because he or she is suffering from memory loss. **Intoxication and unsoundness of mind** 20.3 The definition of 'unsound mind' refer directly to sections 27 and 28 of the Criminal Code. The QNU would defer to legal advice on this matter. However we would expect the definition to be consistent with accepted MH research/evidence such that it does not disadvantage the MH consumer who has a defence currently available to them. **Mental Health Court proceedings where the charge is disputed** 20.4 Where there may be a reasonable doubt that a person committed an alleged offence, but not one that affects the expert psychiatric evidence, the Act allow the Mental Health Court to make a determination of unsoundness of mind. Options presented for feedback for how this determination could occur are: • prior to the matters in dispute being referred to a criminal court for decision • after the matters in dispute are referred to a Mental Health Court judge sitting alone for decision (if the judge rejects the other defences), or • after the matters in dispute are referred to a criminal court for decision (if the jury rejects the other defences). **Disputed facts relevant to expert opinion** 20.5 Where there is a dispute of a fact that is material to an expert opinion, the matter in dispute be determined by a Mental Health Court judge sitting alone and then returned to the full Mental Health Court for a determination of unsoundness. **Youth justice officers attending the Mental Health Court** 20.6 The chief executive of the youth justice department be entitled to be heard by the Mental Health Court in a similar way to proceedings before the Childrens Court.

Issues identified	Review recommendations
	Managing capacity, clinical needs and forensic order admissions 20.7 Where a forensic order is made for a patient to be detained to a high security unit, the Mental Health Court must stay the order for a period of up to seven days if requested by the Director of Mental Health to enable the facility to make a place available for the patient. 20.8 The Mental Health Court may refuse to grant a stay, or may grant a stay for a shorter period than requested by the Director of Mental Health, where it is satisfied the person should be urgently admitted to a high security unit for treatment and care. **Admissibility of Mental Health Court decisions in sentencing** 20.9 Clarify that Mental Health Court decisions are admissible in sentencing where there is a trial for an alleged offence after a Mental Health Court finding. **Making of forensic orders on appeals from Mental Health Review Tribunal fitness for trial decisions** 20.10 Allow the Mental Health Court to make a forensic order (or an involuntary treatment order that can only be revoked by the Tribunal) if, on appeal from a Mental Health Review Tribunal decision that a person is fit for trial, the Court decides the person is unfit for trial. **Miscellaneous confidentiality issues** 20.11 Define 'publish', for the purposes of Chapter 14, part 5 (Confidentiality), as including the public dissemination of information, such as distributing information via leaflets in letterboxes, or announcing the information at a meeting. 20.12 Define 'report', for the purposes of Chapter 14, part 5 (Confidentiality), to include any account of all or part of the proceedings. The definitions in 20.11 & 20.12 seem reasonable. 20.13 Allow the provision of confidential information for bona fide research along the lines of the provisions of the Youth Justice Act 1992 (section 297). This appears to uphold the relevant ethical requirements around confidentiality of the information and anonymity of the person. 20.14 Authorise the sharing of information between police, courts, other relevant departments and Queensland Health to facilitate the identification of individuals who may have a defence related to a mental illness or an intellectual disability. We recommend that in the first instance, the police, courts and others should seek consent before sharing information. **Access to health records for private psychiatrist's reports** 20.15 An authorised mental health service to grant access to a patient's medical records to a lawyer or psychiatrist acting for the patient where the patient may have been of unsound mind at the time of an alleged offence or may be unfit for trial, and the patient does not have capacity to give written consent to the access.

ion: Will the recommendations address other relevant legal issues?

We reserve comment until the full legislation is available

21. Other issues

Issues identified	Review recommendations
• Objectives of the Act could be improved. • A number of other issues could be addressed in the new legislation. **More information** Background paper 21— Other issues.	**Objectives of Act** 21.1 The main objectives of the Act be as follows: • to improve and maintain the health and well-being of people with a mental illness who do not have the capacity to consent to treatment This objective is inconsistent with the December, 2013 unilateral decision by the Health Minister to lock acute adult MH inpatient units. We will welcome changes in the new Act that prevent such archaic and poorly informed actions (See part one of our submission for further details). • to enable people to be diverted from the criminal justice system where found to have been of unsound mind at the time of an unlawful act or unfit for trial, and • to protect the community where people diverted from the criminal justice system may be at risk of harming others. These objectives to be achieved in a way that: • safeguards the rights of individuals • affects a person's rights and liberties in an adverse way only if there is no less restrictive way to protect the health and safety of the person or others, and • promotes the person's recovery, and ability to live in the community, without the need for involuntary treatment and care. **Notifications** 21.2 All provisions in the Act where individuals are to be notified of a decision or other event to clearly and consistently state the individuals to be notified, who is responsible for the notification and the time-frame for the notification. 21.3 All notifications should be subject to a qualification that the person does not need to make a notification if it may cause harm to a patient's health or put the safety of any person at risk. **Director of Mental Health annual report** 21.4 The Act to expand on the content and timing of the annual report issued by the Director of Mental Health. 21.5 The annual report to include details of each recommendation to rectify a serious non-compliance under the Act by an authorised mental health service and the actions taken in response. **Terminology** 21.6 The following changes to terminology apply under the Act: • 'senior registered nurse on duty' be replaced with 'registered nurse in charge of the shift' • 'audio visual link' be defined using the definition in the Evidence Act 1977, and • the title 'Director of Mental Health' be replaced with 'Chief Psychiatrist'.

Issue/s	Review recommendations
	Authorised mental health service where treatment and care may be provided 21.7 Ensure that an involuntary patient may be treated or cared for by an authorised mental health service other than the designated service responsible for the person's involuntary status. **Searches** 21.8 The search provisions ensure that non-consensual searches within authorised mental health services only apply to individuals involuntarily detained under the Act. 21.9 The search provisions also apply to public sector health service facilities where a person is admitted under the emergency transport provisions or as a result of the making of a recommendation for assessment. 21.10 A doctor or registered nurse in charge of the shift at an authorised mental health service be authorised to conduct a search of a patient or their possessions if he or she believes a search is reasonably necessary for the patient's or another person's safety. 21.11 Ensure that the provisions that apply for the searches of visitors at the high security unit do not prevent other authorised mental health services undertaking reasonable searches of visitors if the service believes it necessary for the safety and welfare of patients, staff and others at the service. **Terms for assisting psychiatrists** 21.12 Assisting psychiatrists for the Mental Health Court be appointed for a maximum of two consecutive terms. **Automatic cessation of involuntary treatment orders** 21.13 The automatic cessation of an involuntary treatment order after six months of non-contact with an authorised mental health service be discontinued.

Question: Will the recommendations address other relevant issues?

The background papers indicate that searches will be undertaken with consent where possible for involuntary and voluntary patients. The QNU agrees with this approach.

The QNU also concurs that there are limitations in the current Act Under s. 353 that requires ‘‘a search in an AMHS (other than a high security unit) can only be conducted if a doctor or the senior registered nurse on duty reasonably believes a patient in the health service has possession of a harmful thing (as defined).’

Further, we agree with the Background Paper 21 (p.5) that “there are risks associated with waiting for direct evidence to meet this reasonable belief and that although providing for greater clinical discretion to conduct searches may impact on individual rights, the impact is justified to ensure the safe operation of the AMHS”.

Attachment 2

Submission to
The Department of Health

Mental Health Bill 2015

June, 2015

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Introduction

The Queensland Nurses' Union (QNU) thanks the Department of Health for the opportunity to comment on the *Mental Health Bill 2015* (the bill).

Nurses and midwives are the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNU is the principal health union in Queensland covering all categories of workers that make up the nursing and midwifery workforce including registered nurses (RN), registered midwives, enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 52,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

Our submission responds to the key aspects of the Bill outlined in the *Comparison of Key Provisions – Mental Health Bill 2015 and Mental Health Act 2000.* We have also provided specific comments in the attached table.

Additional comments based on the background papers and *Overview of the Mental Health Bill 2015* (Queensland Health, 2015)

Patients' rights

The QNU supports the requirement for the Chief Psychiatrist to prepare a Statement of Rights to be made available to patients and other persons. We note that the statement aims to respect privacy and confidentiality but with specific circumstances permitting sharing and exchange of information in regard to continuing care and /or access to a defence for alleged offences.

Regional and Remote Areas

The QNU welcomes improved access in regional and remote areas of the state including:

- authorising the Chief Psychiatrist to approve specific facilities as an Authorised Mental Health Service (AMHS) with conditions. As outlined in the background papers this would enable, for example, a small rural hospital to provide a limited range of involuntary treatment services as part of a larger AMHS and support care in the local community;

- removal of restrictions on utilising audio-visual facilities (e.g. Telehealth) for examinations and assessments. The QNU acknowledges practitioners may have varying levels of comfort with this technology and it may not be appropriate for all patients or all reviews, but it does address the tyranny of distance in some parts of the state.

Involuntary Treatment

The Bill provides for the use of advance health directives (AHD) and substitute decision-making regimes in relation to the provision of mental health treatment, and requires that the involuntary treatment provisions only be used where there is no less restrictive alternative.

The QNU supports the least restrictive option, however we have concerns around the AHD and substituted decision-making in that:

- clinical staff may be unfamiliar with the AHD and *Guardianship and Administration Act 2000* (GAA) provisions;
- the level of community awareness is unknown in regard to AHD and substituted decision-making so reliance on these processes may be premature and require a strong community awareness campaign;
- the patient rights adviser/s will require legal knowledge or at least a sound understanding of the AHD and GAA and the legal ramifications;
- it is unclear which legislation will prevail in the application of the least restrictive approach for mental health care.

Emergency Examinations

It is also proposed to modify the approach to emergency examination orders (to be re-named 'emergency examination authorities'), which authorise police officers and ambulance officers to transport a person in emergency circumstances to an authorised mental health service or other public sector health service. Under the current Act, these powers are generally used when persons are threatening self-harm. However, in the majority of cases, persons are suffering from the adverse effects of drug or alcohol consumption, rather than from an underlying mental illness.

For this reason, it is proposed to transfer these powers to the *Public Health Act 2005* to enable the powers to be utilised within the broader health system.

The QNU supports an approach that acknowledges the provisions of the *Public Health Act 2005* in respect to persons who are intoxicated and who have solely drug or alcohol misuse issues so they are not subject to the provisions of the *Mental Health Act 2000* by default.

Searches and Security

The QNU notes that the Bill also provides for clearer search powers in AMHSs with appropriate protections for persons being searched. This has potential to enhance the protection of patients, nurses, visitors and others, and assists in fostering security and safety in the facilities of the AMHS.

Matters Affecting Nursing

Mental Health Nurse Practitioners (NPs)

The QNU and the Office of the Chief Nursing and Midwifery Officer made a strong case for Mental Health NPs during initial consultations, yet the Bill fails to recognise the important role they could play in mental health.

Workloads

- There is no impact assessment of the increased workloads that are likely to result for mental health nurses when there is more demand for services and new IT systems.

- The training schedule for the new Act, AHDs and other elements of the transition must be included in the costings and time accounted for in service profiles.

- The CIMHA IT system has not been reliable and data entry has NOT been factored into workload management systems or work days in community services. The QNU has witnessed the shifting of administrative work to nurses without the extra resources to cope with the demand. Appropriate administrative and IT staff are required for electronic records. Access to hardware and reliability of software/programs are factors which may impact negatively on nurses' workloads and clinical time.

Workplace Health and Safety

We have the following safety concerns for staff and other patients around admissions from the watchhouse or prison:

- It has been our experience that when a local AMHS does not have the capability to manage a prisoner, staff injuries have resulted despite QNU objections and those from nurses themselves;
- Transfer from an AMHS to medium and high secure facilities does not always proceed readily;
- The Director, Mental Health should not be able to order an AMHS where acceptance of the prisoner has been declined;
- Access to secure facilities should be a priority. If necessary, further beds should be opened to ensure that offenders, particularly those assessed with potential for or history of actual violence, are managed in an appropriate environment for the safety of other patients and staff and are not subject to undue delays in accessing inpatient mental health care.

References

Australian Nursing and Midwifery Council (2006) *National Competency Standards for the Nurse Practitioner.*

Department of Health (2015) *Mental Health Bill 2015*, Background papers.

Mental Health Bill 2015

Key provisions that are different from the Mental Health Act 2000	QNU Response
Chapter 1 Preliminary	
The objects of the Bill more clearly state the legislative objectives, including distinguishing between the 'civil' and forensic purposes of the Bill. The objects of the Bill are to be achieved in a way that: • safeguards the rights of persons; • ensures the rights and liberties of a person who has a mental illness are adversely affected only to the extent required to protect the person's health and safety or to protect others; and • promotes the recovery of a person who has a mental illness, and the person's ability to live in the community without the need for involuntary treatment and care. The Bill includes principles relating to victims of unlawful acts, to guide persons involved in the administration of the Bill. The meaning of 'involuntary patient' reflects the revised approaches in the Bill, namely persons subject to: • an examination authority (replacing a justices examination order); • a recommendation for assessment; • a treatment authority (replacing an involuntary treatment order); • a forensic order; • a court treatment order (a new order); • a judicial order (replacing various court orders). The meaning of 'treatment criteria' has been updated. The meaning of 'less restrictive way' is	The new objects are enhanced by the distinction between the civil and forensic purposes of the Bill. We also welcome the inclusion of the recognition given to: • the benefits of involving support persons in decisions about a person's treatment and care; • the needs of Aboriginal people and Torres Strait Islander people; • the needs of persons from culturally and linguistically diverse backgrounds; • promoting the best interests of minors; and • recovery-oriented services. The QNU supports culturally safe practice in all settings. The revision of definitions of treatment is less restrictive and adds clarity. The Bill provides for the use of Advance Health Directives (AHD) and substitute decision-making regimes in relation to the provision of mental health treatment, and requires that the involuntary treatment provisions only be used where there is no less restrictive alternative. The QNU supports the least restrictive option the QNU has concerns around the AHD in that: • clinical staff may be unfamiliar with the AHD provisions; • the level of community awareness is unknown so reliance on the AHD may be premature at best; • the patient rights adviser/s will require legal knowledge or at least a sound understanding of the AHD and its legal ramifications.

Key provisions that are different from the Mental Health Act 2000	QNU Response
included in the Bill. This is a key element in determining whether a person is to be placed, and maintained, on a treatment authority. A revised definition of 'capacity to consent to be treated' is included in the Bill.	Greater clarity about which legislation will prevail will be crucial in the application of the least restrictive concept for MH care. **Recommendation** The QNU requests additional staffing and resources to accommodate the increased workload across all services, sectors and categories of patients bearing in mind there are private sector AMHSs at present.
Chapter 2 Treatment authorities on examination and assessment	
A key change in the examination process is the replacement of 'justices examination orders' with the more appropriately managed 'examination authorities', which are made by the Mental Health Review Tribunal. 'Emergency examination orders' are replaced by the emergency transport powers in the *Public Health Act 2005*. These powers apply in emergency situations for persons who appear to have a mental illness, as well as persons who are significantly affected by drugs or alcohol. If a person's treatment needs can be met under an advance health directive or with the consent of a personal guardian or attorney (a 'less restrictive way'), they must be treated that way. There are no longer separate assessment criteria and treatment criteria outlined in the Bill. The Bill instead requires a prima facie case that the treatment criteria may apply for a recommendation for assessment to be made. Requirements are included in the Bill to discuss an assessment, and treatment and care to be provided, with the person and, where practicable, with support persons.	These provisions appear to appropriately safeguard patient rights. The processes for convening the Mental Health Review Tribunal (MHRT) will need to be streamlined to ensure timely access to this option, when/if required.

Key provisions that are different from the Mental Health Act 2000	QNU Response
A treatment authority may be an inpatient category or community category (comparable to the MHA), but the 'default' category is to be community (i.e. the category must be community unless the person's treatment and care cannot be met this way).	
Chapter 3 Persons in Custody	
The Chief Psychiatrist is to be notified if a person is not transferred to an authorised mental health service within 72 hours. This enables the Chief Psychiatrist to take action, as necessary, to ensure the person receives timely treatment.	While it seems to support timely review and treatment for the patient, the QNU has the following safety concerns for staff and other patients around admissions from the watchhouse or prison: • It has been our experience that when a local AMHS does not have the capability to manage the prisoner staff injuries have resulted despite QNU objections and those from nurses themselves; • Transfer from an AMHS to medium and high secure facilities does not always proceed readily; • The Director, Mental Health should not be able to order an AMHS where acceptance of the prisoner has been declined; • Access to secure facilities should be a priority. If necessary further beds should be opened to ensure that offenders, particularly those assessed with potential for or history of actual violence, are managed in an appropriate environment for the safety of other patients and staff and are not subject to undue delays in accessing inpatient mental health care.
Chapter 4 Psychiatrist reports for serious offences	
A person subject to a treatment authority, forensic order or court treatment order may request a psychiatrist report be prepared if they are charged with, or have an outstanding, serious offence. This request may also be made by a representative of the person, for example, a legal representative or nominated	This seems to have addressed our concern that a person who may have a defence will not be automatically referred for a psychiatrist's report, as the other safeguards regarding the patient's access to support persons potentially off-sets the likelihood that the person who is unwell will not be in the position to request a report.

Key provisions that are different from the Mental Health Act 2000	QNU Response
support person. A referral to the Mental Health Court may then be made by the person or the person's lawyer. The Chief Psychiatrist may also direct that a psychiatrist report be prepared in relation to person who has committed a serious offence (regardless of whether the person is also currently subject to an authority or order) if it is in the public interest. A referral to the Mental Health Court may then be made by the Chief Psychiatrist if it is in the public interest. The Bill provides that a serious offence is an indictable offence, other than an offence that must otherwise be heard by a Magistrate under the Criminal Code. This approach replaces the current model whereby a psychiatrist report is mandatorily prepared for an involuntary patient for any offence. Currently, references are made to the Mental Health Court by the Chief Psychiatrist as a result of these reports whether or not the relevant person wishes this to occur.	The matter of cost to the patient has been addressed in the overview document. It seems that the process for arranging the report may be the subject of policy under the authority of the Chief Psychiatrist and our main concern here would be consistency across AMHS and Health and Hospital Services (HHS). Further, the distinction between the types of offences provides that 'simple offences' may be dealt with in the usual way rather than the 'higher bar' that applied to the person with mental illness (PWMI) under the *Mental Health Act 2000*. Magistrates also have capacity to refer for assessment so options exist if the person before the court appears to be unwell for a referral for access to treatment to be made/offered. The Background Papers (Department of Health, 2015) indicate that "this model is intended to be supported by a revised Court Liaison Service, which will utilise clinical assessments to provide advice to Magistrates about persons with a mental illness and other mental conditions that are before the courts". Reference to the Court Liaison Service in regard to this provision seems to imply that AMHS/HHS will not have discretion to provide such a service and we would recommend that consideration is given to the employment of Nurse Practitioners (NP) for this court liaison service. In our previous submission to the Review of the *Mental Health Act 2000*, the QNU strongly advocated for Mental Health NPs. A NP is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The

Key provisions that are different from the Mental Health Act 2000	QNU Response
	NP role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The NP role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The NP's scope of practice is determined by the context in which they are authorised to practice (Australian Nursing and Midwifery Council, 2006). Such roles have existed in Queensland since 2006.
Chapter 5 Mental Health Court References	
The Bill amends the jurisdiction of the Mental Health Court to a 'serious offence', which is an indictable offence, other than an offence that must otherwise be heard by a Magistrate under the Criminal Code. The Bill includes a revised definition of 'unsound mind", reflecting its use under the Criminal Code. Under the Bill, the Mental Health Court may make a less intensive order - a court treatment order. Court treatment orders will 'tie' the person to involuntary treatment without the stringent oversight that applies to persons on forensic orders. Unlike forensic orders, the Court (and the Mental Health Review Tribunal) does not set limits on the extent of community treatment under court treatment orders. As with treatment authorities, this will be the responsibility of authorised doctors in accordance with the criteria established under the Bill. As with treatment authorities, these persons will be placed on a community category, unless it is necessary for the person to be an inpatient. However, like forensic orders, only the	The shift of focus to care and treatment of the individual reflects contemporary mental health care and risk management. The provisions continue to provide for the safety of the community with the Court Treatment Order and the use of the MHRT as the review mechanism. Community safety has been addressed by 'non-revoke' periods for forensic orders which in this case seem to be reserved for the most serious matters. This should potentially provide the balance between least restrictive practice for the patient and safeguarding the community The QNU regards this as a positive and significant safeguard.

Key provisions that are different from the Mental Health Act 2000	QNU Response
tribunal may revoke a court treatment order. The criteria for the Mental Health Court to make decisions have been modified and made consistent throughout the Bill. This mainly applies to the making of orders and the extent of treatment in the community. Persons placed on a forensic order may be on: • an inpatient category with no limited community treatment • an inpatient category with limited community treatment, or • a community category. This approach replaces the model under the MHA, which did not have a community category. Under the MHA, 'limited community treatment' is extended to treatment in the community on an ongoing basis. The Bill modifies the approach to Mental Health Court proceedings if there is a fact that is substantially material to the opinion of an expert witness, such as a psychiatrist. Under the Bill, the Mental Health Court can decide the matter in dispute rather than referring the whole proceeding to a criminal court. For serious violent offences (a 'prescribed offence'), the Court can impose a non-revoke period for a forensic order of up to 10 years.	
Chapter 6 Powers of courts during criminal proceedings and related processes	
The Bill provides that a Magistrate may discharge a person charged with an offence if the court is reasonably satisfied, on the balance of probabilities, that the person was of unsound mind when the offence was allegedly committed or appears to be	Magistrates also have capacity to order an assessment so options exist for a referral for access to treatment to be made/offered if the person before the court appears to be unwell. Reference in the overview document to the

Key provisions that are different from the Mental Health Act 2000	QNU Response
unfit for trial. Magistrates may also order that a person before the court be examined by an authorised doctor to decide if a treatment authority should be made for the person or to make recommendations about the person's treatment and care.	Court Liaison Service in regard to this provision seems to imply that AMHS/HHS will not have discretion in relation to the provision of such services. **Recommendation** The QNU again recommends that consideration is given to the NP role for this court liaison service.
Chapter 7 Treatment and care of patients	
The provisions related to the treatment and care of patients replace the disparate and limited provisions in the current Act. Key changes from the MHA include: • stating the relationship between community treatment and a person's custodial status under another Act • stating the responsibility of administrators and authorised doctors for providing treatment and care • replacing the use of 'treatment plans' under the MHA by a statutory obligation to record planned and actual treatment • requiring authorised doctors to have regard to the views of the patient and support persons, and • requiring authorised doctors to document the patient's treatment and care while being treated in the community. An authorised doctor is not required to revoke a treatment authority if the person's capacity to consent to treatment is not stable. The power for the Chief Psychiatrist to require a patient to wear a tracking device has been removed. This power is transferred to the Mental Health Court and the Tribunal. Limited community treatment for classified	These provisions add clarity to the roles. We acknowledge that a record of treatment should form part of the clinical notes but it needs to be located in a consistent and standard part of the file in a standard /format or efficiency to mitigate risk of missing important changes to treatment. Workloads associated with increased administrative tasks need to be monitored so that these responsibilities do not impinge on patient safety. In terms of patient rights revoking a treatment authority offers a safeguard for a PWMI who has a cyclical or labile condition and assists our members in their professional practice and advocacy for ongoing treatment when a PWMI's capacity to consent is variable. The QNU does not support the wearing of tracking devices. In our view, such devices do little to assure safety and do nothing to reduce stigma. Such devices are therefore questionable as 'safeguards'. If these devices are used they must be unobtrusive despite the cost and if lost or damaged supplied without cost to the patient. There are potential workload implications for our members as there is a stipulation for an escort to accompany a patient on the grounds. In terms of contemporary mental

Key provisions that are different from the Mental Health Act 2000	QNU Response
patients and patients subject to judicial orders is limited to on-ground escorted leave. For the performance of electroconvulsive therapy, the approval of the Tribunal is required if the person is a minor. The Bill distinguishes between psychosurgery (where brain tissue is intentionally damaged or removed to treat a mental illness) and non- ablative neurosurgery, such as deep brain stimulation techniques. Under the Bill, psychosurgery is prohibited. Non-ablative neurosurgery can only be performed with the consent of the person and the approval of the Tribunal. The Bill enables a person to appoint a 'nominated support person' to support the person if they become acutely unwell at a future time. This replaces the more limited 'allied person' under the MHA.	health care – partnership in recovery and continuous risk assessment and management this would ideally be a clinician escort as opposed to security personnel. The QNU supports tribunal approval for ECT for minors. This is an important safeguard. The QNU supports the distinction between psychosurgery and non-ablative neurosurgery as this as it appears to be an evidence based safeguard. The QNU supports a 'nominated support person' in principle but we are concerned about the role in practice. For example, we ask • how a single individual could properly fulfil this role? • how the HHS/AMHS will support the position's 'independent' functioning? • how the department will manage potential inconsistencies across the state unless the functions are the subject of 'enforceable' policy under an authority such as the Chief Psychiatrist?
Chapter 8 Use of mechanical restraint, seclusion, physical restraint and other practices	
The offence of using mechanical restraint and seclusion in an authorised mental health service is extended to include voluntary inpatients of an authorised mental health service. All uses of mechanical restraint must be approved by the Chief Psychiatrist. This is a change from the current MHA whereby an authorised doctor may approve the use of restraint, provided the device used in the restraint is approved by the Chief Psychiatrist. The criteria for applying mechanical restraint have been strengthened, and the patient must be continuously observed.	The QNU recognises there is a body of evidence regarding the reduction of restrictive practices in contemporary mental health care, however we point out that workplace health and safety must be taken into account when using mechanical restraints and/or seclusion as a form of confinement. Nurses must not be exposed to violent situations through the use of these measures. Further, we seek clarification on who will undertake this action. Policy development requires comprehensive consultation which respects the exercise of professional judgment for example –

Key provisions that are different from the Mental Health Act 2000	QNU Response
The Chief Psychiatrist may require an approval to be sought be way of a reduction and elimination plan, the purpose of which is to eliminate the use of restraint for the patient. Mechanical restraint must be removed if it is no longer required. The Chief Psychiatrist may give an authorised mental health service written directions about the use of seclusion. This may include that seclusion only be used under an approved reduction and elimination plan. Seclusion may be authorised by the health practitioner in charge of the inpatient unit or an appropriately qualified person authorised by the health practitioner ('Senior registered nurse on duty' under MHA). A timeframe for this authorisation has been included in the Bill and is limited to not more than 1 hour. Seclusion for a patient must end if it is no longer required. Physical restraint must be authorised in accordance with legislative policies set by the Chief Psychiatrist that are binding for authorised mental health services. Legislative polices set by the Chief Psychiatrists regarding the inappropriate use of medication will be binding for authorised mental health services and require medication use for clinical purposes only.	• the current clinical environment and resourcing including skill mix to support less restrictive practice will need a workforce and education plan; • 'protocol'/policy must be evidence based and have scope for application for each individual so there are no unintended consequences arising from blanket adherence to the protocol/policy; • The balance between the safety of staff, other patients and the individual's recovery must be maintained. If the annual report is to include information on compliance with the policies for seclusion, mechanical restraint and use of medications, then the data must be used to as a part of the safety and quality agenda to evaluate the effectiveness of the policies. In summary, the QNU recognises contemporary least restrictive practice but not at the expense of our members' safety or professional judgment.
Chapter 9 Rights of patients and others	
The Bill establishes a stand-alone chapter dealing with the rights of patients and others. The Bill includes the right to be visited by family, carers and other support persons	Overall, we support improvements that recognise and support the rights of PWMI. The QNU supports the patients' rights adviser position in principle but we are concerned about the role in practice. For example, we

Key provisions that are different from the Mental Health Act 2000	QNU Response
and to communicate, in a reasonable way, with other persons. Provisions are included in the Bill in relation to understanding oral information to assist in the treatment and care of a person. The Bill requires explanations to be given to the patient's nominated support person and, where appropriate, other support persons. The provisions in relation to the giving of written notices replace the disparate and inconsistent provisions in the MHA. The Bill requires notices to be given to the patient's nominated support person, personal guardian or attorney. The Bill states that patient, or someone on behalf of the patient, may request a second opinion about the patient's treatment and care. The Bill states a patient's right to privacy. The Bill outlines the rights and responsibilities of family, carers and other support persons. The Bill requires public sector mental health services to appoint or engage patient rights advisers to advise patients and support persons of their rights and responsibilities under the Bill.	ask: • how a single individual could properly fulfil this role; • how the HHS/AMHS will support the position's 'independent' functioning; • how the department will manage potential inconsistencies across the state unless the functions are the subject of 'enforceable' policy under an authority such as the Chief Psychiatrist. In addition, we suggest a team may be a more appropriate approach to meet the patient's needs in large AMHSs
Chapter 10 Chief psychiatrist	
The Bill lists matters for which policies and practice guidelines may be made, and mandates that policies must be made on a range of matters. The Bill also requires policies and practice guidelines to be made publicly available. The ability for the Chief Psychiatrist to undertake investigations is comparable to the MHA.	The QNU welcomes public availability of policies and broad performance indicators in annual reports. Under sections 299, 300 and 301 of the Bill, the Chief Psychiatrist may investigate a matter or direct an inspector to investigate a matter. Following the investigation, the Chief Psychiatrist, or the inspector investigating the matter, must prepare a report on the investigation which may include recommendations relating to the

Key provisions that are different from the Mental Health Act 2000	QNU Response
	improvement of the operation of an AHMS. The QNU seeks clarification on whether these reports and recommendations for improvement be made publically available.
Chapter 11 Authorised mental health services	
The Bill provides that the Chief Psychiatrist may include conditions when declaring an authorised mental health service. This supports service delivery options in, for example, smaller rural or regional hospitals. The appointment of authorised mental health practitioners is to be made by Administrators of authorised mental health services rather than the Chief Psychiatrist (Director of Mental Health under the MHA). The provisions in the Bill related to the transfer of patients replace the disparate provisions in the MHA. The requirement for interstate agreements to be in place for patients to be transferred interstate has been removed. The Bill consistently deals with the transport of persons, including the administration of medication for the purpose of transporting a patient. Chief Psychiatrist approval is required for any use of mechanical restraint while a person is being transported.	The QNU supports the appointment of AMHPs on the understanding that the Chief Psychiatrist develops binding policy regarding the competencies of AMHP and that participation at AMHS remains voluntary – i.e our members retain the choice to undertake this role.
Chapter 12 Mental Health Review reviews and applications	
Additional functions for the Tribunal under the Bill are: • the review of court treatment orders • the hearing of applications for examination authorities • the hearing of applications for the transfer of forensic order and court treatment order patients into and out of Queensland. On a review of a forensic order, the	No further comment.

Key provisions that are different from the Mental Health Act 2000	QNU Response
Tribunal may make a court treatment order. The Tribunal will review a forensic order (Criminal Code) to decide, among other things, whether the order should become a forensic order (mental condition) or a forensic order (disability). For clarity and transparency, the Bill provides clear and consistent criteria for decisions made by the Tribunal. This mainly applies to the continuing or revocation of orders and authorities, and the extent of treatment in the community. The initial review of the making of a treatment authority is to occur within 28 days (currently 6 weeks for involuntary treatment orders). For a person on a treatment authority for 12 months, the Tribunal is to consider whether the person's treatment needs may be met in a less restrictive way with the consent of a personal guardian.	
Chapter 13 Appeals	
	No further comment.
Chapter 14 Monitoring and Enforcement	
The Bill significantly enhances monitoring and enforcement provisions. Currently, the MHA has limited provisions relating to investigative powers that may result in remedial actions rather than prosecutions, and entry to places or warrant provisions that may be enacted in circumstances where involuntary detention is required.	The QNU welcomes provisions which improve legislative oversight and support existing monitoring and compliance mechanisms, however we stress the importance of transparency and the value of public reporting to assure this.
Chapter 15 Offences and Legal Matters	
	No further comment.
Chapter 16 Establishment and administration of Tribunal and court	
Mental Health Review Tribunal	No further comment.

Key provisions that are different from the Mental Health Act 2000	QNU Response
The Bill provides for the appointment of a deputy president. The Bill requires the president to develop competencies for tribunal members. The Bill requires a treating practitioner to give a report about a patient for specified reviews at least 7 days before a hearing. The Bill requires a party to give any document to be relied on at a hearing to the other party at least 3 days before a hearing. The Bill states that the person the subject of a proceeding may be represented by a nominated support person, a lawyer or another person. The Bill states that the person the subject of a proceeding may be accompanied by a nominated support person, family member, carer or other support person. The Bill requires the Tribunal to appoint, at no cost to the person, a lawyer for the following hearings: • if the person is a minor • for a fitness for trial review • for an electroconvulsive therapy treatment application • at a hearing where the Attorney-General is to appear. An adult person may waive this right. For proceedings for a review of a treatment authority where the person does not wish to attend or be represented by another person, the matter may be heard 'on the papers'. <u>Mental Health Court</u> The Mental Health Court may be assisted	

Key provisions that are different from the Mental Health Act 2000	QNU Response
by a person with expertise in the care of persons who have an intellectual disability. Assisting clinicians may be appointed for up to 6 years.	
Chapter 17 Confidentiality	
The Bill enables information to be disclosed for specific purposes, additional to those under the MHA, namely: • to assist in identifying persons who may have a mental health defence • to assist in identifying and offering support to victims • to assist in the preparation of a private psychiatrist report • to provide relevant information to a patient rights adviser • to provide limited information to the victim of a person who is a classified patient (this replaces classified patient information orders under the MHA) • to enable information to be disclosed to a lawyer preparing for a proceeding of the Mental Health Court or the Tribunal • the disclosure of photographs of a person required to return.	The QNU supports the disclosure of information for specific purposes providing this facilitates continuity of care, safe and swift return of absconded patients and access to support to develop a defence.
Chapter 18 General provisions	
A provision in the Bill enables information to be disclosed by QCAT about whether a personal guardian has been appointed for a person.	