THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Submission to The Health and Community Services Committee

Mental Health Bill 2014

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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.

[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.

The QNU has concerns around the Advanced Health Directive (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;
- 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.*