# Review of the *Mental Health Act 2000*

## *Discussion paper*

May 2014

QH233 05/14

**Review of the *Mental Health Act 2000* discussion paper**
Published by the State of Queensland (Queensland Health), May 2014



Mental Health Alcohol and Other Drugs Branch, Health Service and Clinical Innovation Division, Department of Health, GPO Box 48, Brisbane QLD 4001, email MHA.Review@health.qld.gov.au, phone (07) 3328 9674.

An electronic version of this document is available at:
www.health.qld.gov.au/mentalhealth/news/MHA2000-review.asp



QH233 05/14

# Contents

# Introduction

## Background

Mental health disorders have a significant impact on the health and wellbeing of individuals, their families, carers and the community. These disorders are recognised as serious, and are sometimes debilitating. Families, carers, friends and others who support those with mental health disorders are an important part of a patient's recovery.

In Australia, one in five people are affected by a mental health disorder. The Australian Bureau of Statistics estimates the annual cost of mental health disorders in Australia at approximately $20 billion[1].

In Queensland, more than 85,000 people receive services through the public mental health system each year.

More than $1.1 billion is invested each year in providing Queenslanders with public mental health services and support, healthcare facilities and treatment. More than 300,000 Queenslanders receive treatment for mental health disorders in the private sector, which is largely funded by Medicare.

Mental health facilities and services are provided across Queensland, with a number specialising in areas such as children and youth services or complex mental healthcare.

Partnerships with government and non-government agencies, service providers, families and carers all contribute to the care and recovery process.

The majority of people with a mental illness receive treatment and care for their illness voluntarily—however, some individuals are unable to give informed consent to treatment.

To improve and maintain the health and well-being of these individuals, effective legislation is required to safeguard their rights and ensure treatment and care is provided to support their recovery.

In a limited number of cases an individual may be of unsound mind at the time of an unlawful act or be unfit for trial, due to a mental illness. In these circumstances, the legislation is designed to divert those affected by a mental illness from the criminal justice system into appropriate treatment and care to protect the individual and wider community. However, the majority of involuntary patients in mental health facilities are not admitted as a result of committing an unlawful act.

[1] ABS, National Survey of Mental Health and Wellbeing, 2007.

## Review of the *Mental Health Act 2000*

The *Mental Health Act 2000* replaced the *Mental Health Act 1974* to reflect contemporary clinical practices, international, national and state policy directions and broad community expectations.

Key policy issues within the *Mental Health Act 2000* can be conceptualised into two broad content areas, namely:

- policy issues relating to the involuntary assessment and treatment of people with a mental illness, and
- policy issues relating to people with a mental illness who are charged with an offence, including the treatment and care of these people.

In June 2013, the Honourable Lawrence Springborg MP, Minister for Health, announced a review of the *Mental Health Act 2000* to deliver the best possible mental healthcare for Queenslanders.

The review of the Act is being undertaken as part of a number of key reforms being implemented, including the establishment of the Queensland Mental Health Commission (QMHC).

The QMHC was established as an independent statutory body on 1 July 2013 under the *Queensland Mental Health Commission Act 2013*, to reform the mental health and alcohol and drug systems, drive research and innovation, and promote the mental health and wellbeing of all Queenslanders.

Improvements to the *Mental Health Act 2000* are being done in collaboration with a diverse range of key stakeholders including:

- the Queensland Mental Health Commission
- legal and advocacy groups
- those responsible for administering the legislation, including authorised mental health services and the Mental Health Review Tribunal
- government agencies
- peak bodies
- individuals with specific areas of interest such as victims and patients' families and carers
- the general public.

Two rounds of consultation have been included as part of the review of the Act, as it is recognised there is a diverse range of stakeholders to consult with on a complex range of issues.

The first round of consultation was completed in mid-2013. The release of this discussion paper represents the second round of consultation.

Further information about the review, including the terms of reference can be found at www.health.qld.gov.au/mentalhealth/news/MHA2000-review.asp

Further information about the Queensland Mental Health Commission is available at www.qmhc.qld.gov.au

## Objective

Mental health legislation aims to improve and maintain the health and wellbeing of people with a mental illness who do not have the capacity to consent to treatment, and those who have been found to have been of unsound mind at the time of committing an unlawful act.

The proposed changes to the legislation aim to:

- safeguard the rights of people with a mental illness
- promote an individual's recovery and ability to live in the community without the need for involuntary treatment and care
- strengthen the importance of family, carers and other support people to a patient's treatment and recovery
- adversely affect an individual's rights and liberties only if there is no less restrictive way to protect the health and safety of the individual or others
- provide for simpler and fairer processes under the Act.

## First round of consultation

In June 2013, the Terms of Reference for the review were released for feedback on areas of improvement in the Act.

The Terms of Reference recognised that the Act and the way it is administered can have significant effect on individuals, and deals with a complex and sensitive range of issues.

During the two-month initial consultation period, meetings and workshops were held with key stakeholders including:

- users of mental health services, their families and carers
- peak bodies (e.g. mental health professional organisations, Queensland Voice, Carers Queensland)
- non-government and private sector agencies that deliver services to people with a mental illness
- legal agencies (e.g. Legal Aid Queensland, Aboriginal and Torres Strait Islander Legal Service, Queensland Law Society)
- authorised mental health services
- victims of crime
- government agencies (e.g. the Department of Justice and Attorney-General, the Adult Guardian, the Public Advocate, the Director of Public Prosecutions)
- the Director of Mental Health and the Director of Forensic Disability
- the Mental Health Court
- the Mental Health Commissioner
- the Mental Health Review Tribunal.

The first round of public consultation was highly successful with approximately 100 written submissions being received.

More than 200 recommendations have been developed in response to issues raised during the initial consultation to improve mental health legislation in Queensland.

Although it was not originally anticipated that a rewrite of the legislation would be required, due to the significant response to the initial consultation, the *Mental Health Act 2000* will need to be repealed and replaced to implement the extensive changes recommended.

## Second round of consultation

All individuals and organisations are welcome to contribute their ideas, thoughts and suggestions to the second round of consultation on the review of the Act. All individuals and organisations can respond to the questions posed in this discussion paper, comment on the details of the recommendations, or offer new ideas or alternative solutions for the proposed legislation.

Workshops and meetings with key stakeholders will take place with the release of this discussion paper.

All interest groups, organisations and individuals who made submissions to the initial consultation or who expressed an interest in being consulted on the review are being advised of the availability of this discussion paper.

Please note the recommendations do not represent government policy, which will be determined after analysis of feedback received.

Additional information on the recommendations can be found in background papers available on the Queensland Health website: www.health.qld.gov.au/mentalhealth/news/MHA2000-review.asp

The background papers deal with the following issues:

1. Involuntary examinations and assessments
2. Individuals held in custody
3. Assessment of individuals charged with an offence
4. Orders and other actions following court findings
5. Treatment and care of involuntary patients
6. Treatment in the community
7. Support for involuntary patients
8. Support for victims
9. Mental Health Review Tribunal
10. Interstate transfers
11. Forensic disability
12. Guardianship and attorneys
13. Restraint and seclusion
14. Regulated treatments
15. Transport issues
16. Regional, rural and remote issues
17. Indigenous and multicultural issues
18. Children and adolescents
19. Streamlined processes
20. Other legal issues
21. Other issues
22. Impact of proposals.

# Consultation process

## Process

Your feedback is welcome on any or all of the recommendations included in this discussion paper, as well as any additional suggestions or ideas you may have.

You do not need to provide feedback on every recommendation. If you do not support a recommendation, please feel free to offer an alternative suggestion.

Your response to the recommendations should be made in writing. Please provide a reference to the recommendation number in your feedback and comments (e.g. 1.1, 13.4).

In addition to the recommendations in this discussion paper, you are invited to include feedback on the impact of the recommendations on stakeholder groups, as outlined in background paper 22.

## Who can make submissions

The Queensland Government encourages any individual or organisation to make a submission.

Your submission should indicate whether you are responding to the discussion paper as an individual or as an organisation.

## How will submissions be treated

Submissions will not be made publicly available. However, submissions may be subject to disclosure under the *Right to Information Act 2009*.

## How and when to respond

Please send your submission by email or letter to:

Mental Health Act Review
Department of Health
PO Box 2368
Fortitude Valley BC QLD 4006
MHA.Review@health.qld.gov.au

**Closing date for submissions:**
**Friday, 25 July 2014**

# Recommendations

## 1. Involuntary examinations and assessments

| Issues identified | Review recommendations |
|---|---|
| • Too many documents leading to involuntary treatment.<br>• Insufficient checks and balances in the making of justices examination orders.<br>• Majority of individuals placed on emergency examination orders have no underlying mental illness.<br>• Treatment criteria not unequivocally based on a person's lack of capacity to consent to treatment.<br>• Treatment criteria do not take a longitudinal approach to diagnosis.<br><br>**More information**<br>Background paper 1—Involuntary examinations and assessments. | **Documents leading to involuntary treatment**<br>1.1 The documents required under the Act that may lead to involuntary treatment be as follows:<br>• an involuntary examination authority (replacing the justices examination order)<br>• a recommendation for involuntary assessment<br>• an involuntary treatment order.<br>**Involuntary examination authority**<br>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:<br>• 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<br>• treatment and care options for the person<br>• how the person may be encouraged to seek voluntary treatment and care<br>• the treatment criteria.<br>1.3 The applicant be required to document this advice in the application for an authority if it is proceeded with.<br>1.4 Applications must be made to a magistrate or a category of specially authorised and trained justices of the peace.<br>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.<br>1.6 A magistrate or authorised justice of the peace must only issue an authority if satisfied:<br>• the person appears to have a mental illness<br>• the person appears to lack the capacity to consent to be treated<br>• attempts at encouraging the person to be treated voluntarily have not succeeded or are not practicable<br>• 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.<br>1.7 The Act to include statutory protections and a clear outline of powers that may be exercised under an involuntary examination authority.<br>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.<br>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. |

| Issues identified | Review recommendations |
|---|---|
| | **Emergency transport, examination, assessment and treatment**<br>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*.<br>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:<br>• a person appears to have a serious mental impairment as a result of the effects of drugs or alcohol<br>• there is an imminent risk of the person causing harm to himself or herself, and<br>• the person requires urgent treatment or care for the mental impairment<br>or<br>• a person appears to have a mental illness<br>• there is an imminent risk of the person causing harm to himself, herself or someone else, and<br>• an examination of the person may result in a recommendation for assessment being made for the person,<br>or<br>• the person requires urgent treatment and care for the mental illness.<br>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.<br>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.<br>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.<br>**Request for assessment**<br>1.15 The requirement for a 'request for assessment' be discontinued.<br>**Assessment criteria**<br>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. |

**Question:**

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

| Issues identified | Review recommendations |
|---|---|
| | **Treatment criteria**<br>1.17 The treatment criteria be as follows:<br>• the person has a mental illness<br>• the person lacks the capacity to consent to be treated for the illness<br>• because of the person's illness, the absence of involuntary treatment (or continued involuntary treatment) is likely to result in:<br>▪ imminent serious harm to the person or someone else, or<br>▪ the person suffering serious mental or physical deterioration.<br>1.18 A person has capacity to consent to treatment, if the person is able to:<br>• understand the nature and purpose of the treatment<br>• understand the benefits and risks of the treatment, and alternatives to the treatment<br>• understand the consequences of not receiving the treatment<br>• assess the advantages and disadvantages of the treatment in order to arrive at a decision, and<br>• communicate the decision.<br>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:<br>• causing harm to himself, herself or someone else, or<br>• suffering serious mental or physical deterioration.<br>**Making of involuntary treatment order**<br>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. |

# 2. Individuals held in custody

| Issues indentified | Review recommendations |
|---|---|
| • Too many documents leading to involuntary treatment for individuals in custody.<br>• Very difficult to understand classified patient provisions.<br>• Unacceptable delays in acutely unwell individuals in prisons being transferred to an authorised mental health service.<br><br>**More information**<br>Background paper 2—Individuals held in custody. | **Transfer of individuals to an authorised mental health service for assessment**<br>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:<br>• for a custodian's transfer authority (in an approved form), including the information on the person held in custody, and<br>• for the agreement, in writing, from the authorised mental health service to the transfer of the person.<br>**Transfer of individuals to an authorised mental health service by consent**<br>2.2 A person in custody may be transferred to an authorised mental health service for treatment and care if:<br>• 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<br>• the person consents to be transferred to the service<br>• the custodian agrees to the transfer in a custodian's transfer authority, and<br>• the authorised mental health service agrees, in writing, to the transfer.<br>**Transfer of individuals who are already on a forensic order or involuntary treatment order to an authorised mental health service**<br>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:<br>• 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<br>• the custodian agrees to the transfer in a custodian's transfer authority, and<br>• the authorised mental health service agrees, in writing, to the transfer.<br>**Capacity of authorised mental health services to take classified patients**<br>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.<br>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. |

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

| Issues indentified | Review recommendations |
|---|---|
| | **Admission of individuals to an authorised mental health service**<br>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.<br>**Admission of individuals who are already on an involuntary treatment order or forensic order**<br>2.7 On admission of a patient who is already on an involuntary treatment order or forensic order:<br>• a community category of an involuntary treatment order or forensic order for the patient is to automatically change to an in-patient category<br>• any limited community treatment approved by an authorised doctor for the patient is revoked, and<br>• an authorised doctor must review the patient's treatment needs, document the changed treatment, and talk to the patient about the treatment.<br>**Treatment and care of classified patients**<br>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.<br>**Ceasing to be a classified patient**<br>2.9 Clarify that a person ceases to be a classified patient if:<br>• apart from this Act, there is no lawful basis for the person's detention (e.g. the person is granted bail)<br>• 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<br>• 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<br>• 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<br>• the Mental Health Court makes a decision in relation to a referral for the person.<br>**Return of person to lawful custody**<br>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.<br>**Terminology**<br>2.11 The term 'classified patient' be replaced with 'restricted community access patient', to better describe this category of patients. |

# 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.<br>• Inadequate statutory protections for individuals subject to mandatory psychiatric reports.<br>• Mandatory psychiatric reports divert public sector resources from higher value service delivery.<br>• 51 per cent of mandatory psychiatric reports reviewed by the Director of Mental Health are for simple offences.<br><br>**More information**<br>Background paper 3—Assessment of individuals charged with an offence. | **Offences that can be heard summarily**<br>3.1 Mandatory psychiatric reports for individuals subject to forensic orders or involuntary treatment orders for offences that can be heard summarily be discontinued.<br>**Offences that must be heard on indictment**<br>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.<br>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.<br>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.<br>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.<br>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.<br>**Rights and protections in psychiatric examinations**<br>3.7 Where the Director of Mental Health directs a psychiatric assessment, the Act to state that:<br>• 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<br>• the person must attend for an interview<br>• if the person has capacity, he or she may nominate another person to attend the interview, including a lawyer<br>• 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<br>• the person is not required to answer self-incriminating questions<br>• 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<br>• 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?

# 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.<br>• Limited options for the Mental Health Court in actions it can take where a person is found of unsound mind or unfit for trial.<br>• Model of forensic orders does not allow a patient to 'step-down' from a forensic order to a less-intensive order.<br>• Possibility of forensic orders being revoked shortly after being made creates uncertainty.<br>• Individuals found unfit for trial do not get the opportunity for a jury to determine whether the person did the alleged unlawful act.<br>• Magistrates Courts have no express powers to deal with individuals of unsound mind or unfit for trial.<br>• 43 per cent of forensic orders are for offences that must be heard on indictment.<br><br>**More information**<br>Background paper 4—Orders and other actions following Court findings. | **Principles of unsoundness of mind**<br>4.1 The Act state the fundamental principle that if a person was of unsound mind at the time of an alleged offence:<br>• the person is not criminally responsible for the offence and is not to be punished for the offence, and<br>• 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.<br>**Mental Health Court jurisdiction**<br>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.<br>**Mental Health Court actions following a finding of unsoundness of mind or unfitness for trial**<br>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.<br>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:<br>• serious harm to other individuals<br>• serious property damage, or<br>• repeat offending of the type the person was charged with.<br>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:<br>• serious harm to other individuals<br>• serious property damage, or<br>• repeat offending of the type the person was charged with.<br>4.6 In considering these matters, the Court to have regard to:<br>• the patient's current mental state and psychiatric history<br>• the nature of the unlawful act<br>• the patient's social circumstances<br>• the patient's response to treatment and willingness to continue treatment, and<br>• where relevant, the patient's compliance with previous obligations while on limited community treatment or a community category order.<br>4.7 The assessment of risk in determining the above to be based on generally accepted community standards.<br>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. |

| Issues identified | Review recommendations |
|---|---|
| | **Criminal Code and Minister's forensic orders**<br>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:<br>• the court order is not to be treated as a forensic order<br>• 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<br>• if there is no charge within the Mental Health Court's jurisdiction, the judge has the same powers as a magistrate (see recommendations 4.24–4.29).<br>4.10 Minister's forensic orders be discontinued.<br>**Conditions attached to forensic orders**<br>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.<br>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.<br>**Duration and revocation of forensic orders**<br>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 non-revoke 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.<br>4.14 At a Mental Health Review Tribunal review of a forensic order (after any non-revoke period), the Tribunal may:<br>• continue the forensic order<br>• revoke the order and replace it with an involuntary treatment order that can only be revoked by the Tribunal<br>• revoke the order and replace it with a 'standard' involuntary treatment order, or<br>• revoke the forensic order.<br>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?

| Issues identified | Review recommendations |
|---|---|
| | 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:<br>• serious harm to other individuals<br>• serious property damage, or<br>• repeat offending of the type that was the basis for the order.<br>4.17 The Tribunal must revoke a forensic order (subject to recommendation 4.31) 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:<br>• serious harm to other individuals<br>• serious property damage, or<br>• repeat offending of the type that was the basis for the order.<br>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:<br>• serious harm to other individuals<br>• serious property damage, or<br>• repeat offending of the type that was the basis for the order.<br>4.19 In considering these matters, the Tribunal to have regard to:<br>• the patient's current mental state and psychiatric history<br>• the nature of the unlawful act and the time since the unlawful act<br>• the patient's social circumstances<br>• the patient's response to treatment and willingness to continue treatment, and<br>• where relevant, the patient's compliance with previous obligations while on limited community treatment or a community category order.<br>4.20 The assessment of risk in determining the above to be based on generally accepted community standards.<br>**Special hearings following finding of unfitness for trial**<br>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.<br>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:<br>• if the finding is no, the accused person is discharged and the relevant order is revoked<br>• if the finding is yes, the order is confirmed. |

| Issue 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.<br>**Magistrates Court powers on finding of unsoundness of mind or unfitness for trial**<br>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:<br>• discharge the person unconditionally, or<br>• 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.<br>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 non-revokable 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).<br>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.<br>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 non-revoke period.<br>4.28 Where a magistrate is satisfied a person is likely to be, or appears, unfit for trial or of unsound mind due to an intellectual disability, the magistrate:<br>• must discharge the person unconditionally, and<br>• 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.<br>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. |

| Issue identified | Review recommendations |
|---|---|
| | **Evaluation**<br>4.30 An independent evaluation of the revised arrangements for the Magistrates Court powers be undertaken after three years.<br>**Special notification forensic patients**<br>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.<br>**Review of forensic orders**<br>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:<br>• revoke the order, or<br>• 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.<br>• Statutory requirements for the treatment and care of involuntary patients do not adequately align with good clinical practice.<br>• Patients cannot have an independent review of treatment being provided.<br>• Patients receive inadequate information on their treatment in the community<br><br>**More information**<br>Background paper 5—Treatment and care of involuntary patients. | **Separate treatment and care provisions in the Act**<br>5.1 The provisions related to the treatment and care of involuntary patients be placed in one part of the proposed legislation.<br>**Provision of treatment and care**<br>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.<br>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.<br>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.<br>5.5 The administrator of each authorised mental health service be required to:<br>• take reasonable steps to ensure that involuntary patients receive appropriate treatment and care for their mental illness and for other illnesses or conditions, and<br>• ensure the systems for recording treatment and care (proposed and provided) can be audited.<br>**Regular assessments**<br>5.6 In relation to regular assessments of involuntary patients:<br>• clarify that the purpose of an assessment is to determine whether the treatment criteria continue to apply to the patient, and<br>• 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.<br>**Other assessments**<br>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.<br>**Review of treatment**<br>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.<br>The provisions related to frivolous or vexatious applications to apply to these applications.<br>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?

| Issues identified | Review recommendations |
|---|---|
| | **Treatment in the community**<br>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:<br>• 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<br>• decide and document a statement about the patient's obligations while in the community, including scheduled health appointments<br>• 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<br>• 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.<br>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.<br>**Director of Mental Health policies**<br>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.<br>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<br>• Inconsistencies and inadequate transparency in the way the Act deals with treatment in the community<br>• Criteria for community treatment not sufficiently clear or consistent<br>• Monitoring conditions do not apply to all involuntary patients, and safeguards could be strengthened<br>• Inadequate clarity about how community treatment applies to individuals in custody<br><br>**Further information**<br>Background paper 6—Treatment in the community. | **Limited community treatment—involuntary treatment orders and forensic orders**<br>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.<br>**Forensic orders—limited community treatment and community category**<br>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.<br>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.<br>**Forensic orders—criteria for limited community treatment or community category**<br>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:<br>• serious harm to other people<br>• serious property damage, or<br>• repeat offending of the type that was the basis for the order.<br>6.5 In considering these matters, the Court and Tribunal to have regard to:<br>• the patient's current mental state and psychiatric history<br>• the nature of the unlawful act and the time since the unlawful act<br>• the patient's social circumstances<br>• the patient's response to treatment or care and willingness to continue treatment or care, and<br>• where relevant, the patient's compliance with previous obligations while on limited community treatment or a community category order.<br>6.6 The assessment of risk in deciding the above to be based on generally accepted community standards.<br>6.7 The above criteria may be met by limiting the level of community access or by placing conditions on the patient's order.<br>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.<br>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?

| Issues identified | Review recommendations |
|---|---|
| | **Classified patients – limited community treatment**<br>6.10 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.<br>**Involuntary treatment orders – criteria for limited community treatment and community category**<br>6.11 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 well-being of the patient and others cannot be reasonably met if the patient was on a community category order, having regard to:<br>• the patient's current mental state and psychiatric history<br>• the patient's social circumstances<br>• the patient's response to treatment, and<br>• where relevant, the patient's compliance with previous obligations while on a community category order.<br>6.12 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.<br>**Monitoring conditions**<br>6.13 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:<br>• there is significant risk that the patient would not return to the authorised mental health service as required, or<br>• 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.<br>6.14 The Mental Health Review Tribunal review the imposition of monitoring conditions on a patient within 21 days of the decision to apply the conditions.<br>6.15 The ability for patients to review the imposition of monitoring conditions include classified patients and court order patients (under section 273 of the Act).<br>6.16 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. |

| Issues identified | Review recommendations |
|---|---|
| | **Community treatment and care for patients in custody**<br>6.17 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).<br>6.18 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.<br>6.19 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.<br>• 'Allied person' model has proved to be ineffective.<br>• Involuntary patients would benefit from having access to an independent person to advise of patients' rights and obligations.<br>• Rights of patients at Tribunal hearings could be improved.<br><br>**More information**<br>Background paper 7—Support for involuntary patients. | **Principles**<br>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:<br>Family, carers and other support people have the right to:<br>• contact the patient while the patient is undergoing treatment<br>• participate in treatment decisions and decisions about ongoing care<br>• seek and receive additional information about the patient's support, care, treatment, rehabilitation and recovery<br>• be consulted by the treating team about treatment approaches being considered for the patient<br>• arrange other support services for the patient, such as respite care, counselling and community care, and<br>• be provided with any information that the patient requests they should receive.<br>To ensure that these rights are used constructively, the family, carers and other support persons to have the responsibility to:<br>• respect the humanity and dignity of the patient<br>• 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<br>• cooperate, as far as is possible, with reasonable programs of assessment, individualised care planning, support, care, treatment, recovery and rehabilitation.<br>7.2 The principles in the Act emphasise the importance of recovery-oriented services and the reduction of stigma associated with mental illness.<br>**Allied persons**<br>7.3 The 'allied persons' model in the Act be discontinued.<br>**Right to visit**<br>7.4 The Act include an express statement that involuntary patients in authorised mental health services have a right to:<br>• be visited by family, carers and other support persons at any reasonable time, unless the person is expressly excluded under the Act, and<br>• 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?

| Issues identified | Review recommendations |
|---|---|
| | **Patient information**<br>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.<br>**Independent patient companion**<br>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.<br>7.7 The role of the Independent Patient Companion be to:<br>• advise involuntary patients, family, carers and other support persons of the patient's rights and obligations under the Act<br>• assist involuntary patients, family, carers and other support persons to constructively engage with the treating team about the patient's treatment and care<br>• 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<br>• attend Tribunal hearings as an advocate or support person, if requested by the patient<br>• 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<br>• 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.<br>**Attendance at Mental Health Review Tribunal hearings**<br>7.8 Provide that at a Mental Health Review Tribunal hearing a patient:<br>• may be represented by a lawyer or other person (e.g. an advocate) unless excluded by the Tribunal, and<br>• 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.<br>• Statutory barriers exist to providing information to identify individuals who may be victims.<br>• Purpose of victim submissions, and the need to re-submit submissions, could be clarified.<br>• Inadequate information is provided under forensic information orders.<br><br>**More information**<br>Background paper 8– Support for victims. | **Recognition of victims in the principles of the Act**<br>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:<br>• recognise with compassion the physical, psychological and emotional harm caused to a victim by an unlawful act of another person<br>• recognise the benefits to a victim of being advised in a timely way of the proceedings against the person under the Act<br>• 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<br>• recognise the benefits to a victim of a timely completion of proceedings against the person<br>• 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<br>• 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.<br>In these principles, a reference to an unlawful act includes an alleged unlawful act.<br>**Identifying and providing services to victims**<br>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:<br>• assist the identification of a person who may be a victim, or<br>• to provide information and assistance to a person who may be, or is, a victim.<br>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.<br>**Victim submissions**<br>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*.<br>8.5 Victim submissions to remain confidential unless otherwise requested by the victim. |

**Question:**
Will the recommendations improve support for victims of unlawful acts?

| Issues identified | Review recommendations |
|---|---|
| | **Re-submission of victim submissions**<br>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.<br>**Notice of hearing for revocation of forensic order**<br>8.7 Require the Mental Health Review Tribunal to notify a victim of an application to revoke a forensic order.<br>**Forensic information orders**<br>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.<br>8.9 Forensic information orders require a victim to also be notified of:<br>• the outcome of a Mental Health Review Tribunal review of fitness for trial, and<br>• 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.<br>8.10 The Director of Mental Health to approve forensic information orders instead of the Mental Health Review Tribunal.<br>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.<br>**Non-contact with victims**<br>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.<br>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.<br>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.<br>• Act not sufficiently clear on the purpose of Tribunal hearings, decisions that can be made, and criteria for decisions.<br>• Limited ability for patients to present evidence at Tribunal hearings.<br>• Opportunities exist to improve the cost-effectiveness of Tribunal proceedings.<br>• In 2012-13, 11,978 matters were listed for hearing by the Tribunal.<br><br>**More information**<br>Background paper 9—Mental Health Review Tribunal. | **Deputy President**<br>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.<br>**Legal representation**<br>9.2 Patients to have legal representation at Tribunal hearings, without cost to the patient, for:<br>• hearings involving minors<br>• fitness for trial reviews, and<br>• reviews where the State is legally represented by the Attorney-General.<br>**Tribunal hearings – purpose, applications and decisions**<br>9.3 The Act clearly state the following:<br>• how Tribunal hearings are initiated (including who may make an application and what can be applied for)<br>• the purpose of each type of hearing<br>• the decision the Tribunal may make at a hearing, and<br>• the criteria for the decisions.<br>**Statement of reasons**<br>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.<br>**Evidence**<br>9.5 The Tribunal allow individuals to provide evidence at a hearing where requested by a patient or other party.<br>**Time-frames for review of involuntary treatment orders**<br>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.<br>**Missing persons**<br>9.7 Reviews of forensic patients be suspended if the patient is absent without permission.<br>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?

| Issues identified | Review recommendations |
|---|---|
| | **Hearings by teleconferencing or on the papers**<br>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.<br>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.<br>**Detention of minors in high security facilities**<br>9.11 The legislative requirement for the Tribunal to review young patients detained in high security units be discontinued. |

# 10. Interstate transfers

| Issues identified | Review recommendations |
|---|---|
| • Provisions of the Act in relation to interstate transfers are largely ineffective.<br>• Purpose and benefit of the 'move' provisions in the Act are not clear.<br><br>**More information**<br>Background paper 10—Interstate transfers. | **Interstate transfers—Ministerial agreements**<br>10.1 The requirement for Ministerial agreements with other States for the interstate transfer of involuntary patients be discontinued.<br>**Transfer of patients on forensic orders**<br>10.2 The transfer of forensic patients out of Queensland to take place as follows:<br>• 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<br>• the Director of Mental Health may approve the application if:<br>▪ 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<br>▪ suitable treatment and care is available for the person at the destination mental health service, and<br>▪ the person in the destination jurisdiction that is legally authorised to agree to the transfer agrees to the transfer<br>• the forensic order is suspended when the patient leaves the State, and<br>• the Mental Health Review Tribunal is advised of the transfer.<br>The forensic order is suspended when the patient leaves the State, and the Mental Health Review Tribunal is advised of the transfer.<br>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?

| Issues identified | Review recommendations |
|---|---|
| | 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:<br>• a request for a transfer to be made to the Mental Health Review Tribunal by the patient or the patient's representative<br>• 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)<br>• the Tribunal may approve a transfer into Queensland of an equivalent forensic patient if:<br>▪ 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<br>▪ suitable treatment and care is available for the person at an authorised mental health service<br>▪ the person in the destination jurisdiction that is legally authorised to agree to the transfer agrees to the transfer, and<br>▪ 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<br>• the Tribunal decides the category of order and any conditions, having regard to the equivalent order and conditions that applied interstate, and<br>• the forensic order is effective immediately the patient enters Queensland.<br>**Transfer of patients on involuntary treatment orders**<br>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.<br>**Transfer of patients living in the community**<br>10.6 The requirement that interstate patients on an involuntary order must be 'detained' before being transferred into Queensland be discontinued.<br>**Move provisions**<br>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.<br>• Management of forensic orders (disability) and the care of individuals on forensic orders (disability) are not adequately aligned.<br><br>**More information**<br>Background paper 11—Forensic disability. | **Forensic orders for individuals with dual diagnosis**<br>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.<br>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.<br>**Management of forensic orders (disability)**<br>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.<br>**Clinicians assisting the Mental Health Court**<br>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.<br>**Co-existing application of an involuntary treatment order and a forensic order (disability)**<br>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)?

# 12. Guardianship and attorneys

| Issues identified | Review recommendations |
|---|---|
| • Relationship between mental health legislation and guardianship legislation could be clarified in one area.<br><br>**More information**<br>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?

# 13. Restraint and seclusion

| Issues identified | Review recommendations |
|---|---|
| • Act to support the reduction in the use of seclusion and mechanical restraint.<br>• Safeguards in the use of mechanical restraint could be strengthened.<br>• Consistency, clarity and effectiveness of restraint and seclusion provisions could be improved.<br><br>**More information**<br>Background paper 13—Restraint and seclusion. | **Extension of mechanical restraint and seclusion**<br>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).<br>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.<br>13.3 A management plan must include strategies to reduce seclusion or mechanical restraint for the patient and must be reviewed monthly.<br>**Exceptions to the mechanical restraint offence and offences under other laws**<br>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*).<br>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.<br>**Exceptions to the seclusion offence and offences under other laws**<br>13.6 Clarify that the seclusion offence does not prevent the use of seclusion if it is lawful under another law.<br>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.<br>**Approval of mechanical restraint and seclusion**<br>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.<br>13.9 Mechanical restraints only to be used with the prior written approval of the Director of Mental Health.<br>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.<br>13.11 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. |

**Question:**
Will the recommendations strengthen the safeguards and effectiveness of the restraint and seclusion provisions?

| Issues identified | Review recommendations |
|---|---|
| | **Notification of mechanical restraint and seclusion**<br>13.12 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.<br>**Definition of mechanical restraint**<br>13.13 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".<br>**Offence of mechanical restraint**<br>13.14 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.<br>**Definition of seclusion**<br>13.15 The definition of 'seclusion' be revised so that it does not apply if the person consents (e.g. for the person's privacy).<br>13.16 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.<br>**Release from seclusion**<br>13.17 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.<br>**Basis for authorising the use of a mechanical restraint and seclusion**<br>13.18 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.<br>• Terminology related to regulated treatments not contemporary.<br>• Time-frames for hearings could be expedited.<br><br>**More information**<br>Background paper 14—Regulated treatments. | **Psychosurgery**<br>14.1 The term 'psychosurgery' be replaced with 'neurosurgery for psychiatric conditions' and be defined as follows:<br>• Neurosurgery for psychiatric conditions' means a neurological procedure to treat or ameliorate symptoms of a psychiatric condition.<br>• 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.<br>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.<br>**Electroconvulsive therapy**<br>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.<br>14.4 The two-day timeframe for notices of hearings about ECT applications may be waived by the patient or the patient's representative.<br>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.<br>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?

# 15. Transport issues

| Issues identified | Review recommendations |
|---|---|
| • Powers to transport involuntary patients are inconsistent and inadequate.<br>• Police may receive inadequate information to effectively respond to requests to return patients.<br>• Act does not require individuals who are involuntarily transported from the community to be returned in all instances.<br>• Circumstances where a person may be detained and transported to an authorised mental health service are not sufficiently clear.<br><br>**More information**<br>Background paper 15—Transport issues. | **Inconsistent transport powers**<br>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.<br>**Police assistance**<br>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.<br>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.<br>**Use of mechanical restraint**<br>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.<br>**Appearances before court**<br>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?

| Issues identified | Review recommendations |
|---|---|
| | **Returning individuals to relevant place**<br>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.<br>**Authority to return patients**<br>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:<br>• a person absconds while being lawfully detained under the Act<br>• 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<br>• a person on a community category order does not attend for treatment as required<br>• a person on a temporary absence absconds or does not return to the service as required<br>• 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<br>• 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.<br>**Entry of places and warrants**<br>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*. |

# 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.<br><br>**More information**<br>Background paper 16—Regional, rural and remote issues. | 16.1 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.<br>16.2 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.<br>16.3 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.<br>16.4 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.<br>16.5 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. |

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

# 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.<br><br>**More information**<br>Background paper 17—Indigenous and multicultural issues. | 17.1 The following two principles be included in the Act:<br>• 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<br>• 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. |

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

# 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.<br>• There would be benefit in having an expert in child psychiatry participating in Tribunal hearings for minors.<br><br>**More information**<br>Background paper 18—Children and adolescents. | **Consistent use of terminology**<br>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.<br>**Children within adult facilities**<br>18.2 The Act include a principle that, wherever practicable, minors should be held separately from adults in in-patient facilities.<br>**Capacity to consent**<br>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.<br>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.<br>**Composition of Mental Health Review Tribunals**<br>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. |

**Question:**
Will the recommendations adequately recognise minors?

# 19. Streamlined processes

| Issues identified | Review recommendations |
|---|---|
| • Too many forms and other paperwork required in administering the legislation.<br><br>**More information**<br>Background paper 19—Streamlined processes. | 19.1 The requirements to complete forms under the Act be streamlined and clarified to distinguish between:<br>• approved forms<br>• requirements to notify or document a matter in another way (including in electronic form), and<br>• template forms which are discretionary to use.<br>The requirements to be in line with Addendum A of Background Paper 19.<br><br>19.2 The powers and responsibilities of authorised positions be modified in line with Addendum B of Background Paper 19.<br><br>19.3 The Act to include provisions for authorised persons to investigate offences under the Act. |

**Question:**
Will the recommendations streamline processes in administering the legislation?

# 20. Other legal issues

| Issues identified | Review recommendations |
|---|---|
| • A number of legal issues could be addressed in the new legislation.<br><br>**More information**<br>Background paper 20—Other legal issues. | **Presentation of indictment within six months of committal**<br>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.<br>**Definition of 'unfit for trial'**<br>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:<br>• unable to understand, or to respond rationally to, the charge or the allegations on which the charge is based<br>• unable to exercise (or to give rational instructions about the exercise of) procedural rights (such as, for example, the right to challenge jurors)<br>• unable to understand the nature of the proceedings or to follow the evidence or the course of the proceedings, or<br>• unable to endure the person's trial without serious adverse consequences to the person's mental condition.<br>A person is not unfit to stand trial only because he or she is suffering from memory loss.<br>**Intoxication and unsoundness of mind**<br>20.3 The definition of 'unsound mind' refer directly to sections 27 and 28 of the Criminal Code.<br>**Mental Health Court proceedings where the charge is disputed**<br>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:<br>• prior to the matters in dispute being referred to a criminal court for decision<br>• 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<br>• after the matters in dispute are referred to a criminal court for decision (if the jury rejects the other defences).<br>**Disputed facts relevant to expert opinion**<br>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.<br>**Youth justice officers attending the Mental Health Court**<br>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. |

**Question:**
Will the recommendations address other relevant legal issues?

| Issues identified | Review recommendations |
|---|---|
| | **Managing capacity, clinical needs and forensic order admissions**<br>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.<br>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.<br>**Admissibility of Mental Health Court decisions in sentencing**<br>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.<br>**Making of forensic orders on appeals from Mental Health Review Tribunal fitness for trial decisions**<br>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.<br>**Miscellaneous confidentiality issues**<br>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.<br>20.12 Define 'report', for the purposes of Chapter 14, part 5 (Confidentiality), to include any account of all or part of the proceedings.<br>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).<br>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.<br>**Access to health records for private psychiatrist's reports**<br>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. |

# 21. Other issues

| Issues identified | Review recommendations |
|---|---|
| • Objectives of the Act could be improved.<br>• A number of other issues could be addressed in the new legislation.<br><br>**More information**<br>Background paper 21—Other issues. | **Objectives of Act**<br>21.1 The main objectives of the Act be as follows:<br>• 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<br>• 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<br>• to protect the community where people diverted from the criminal justice system may be at risk of harming others.<br>These objectives to be achieved in a way that:<br>• safeguards the rights of individuals<br>• 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<br>• promotes the person's recovery, and ability to live in the community, without the need for involuntary treatment and care.<br>**Notifications**<br>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.<br>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.<br>**Director of Mental Health annual report**<br>21.4 The Act to expand on the content and timing of the annual report issued by the Director of Mental Health.<br>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.<br>**Terminology**<br>21.6 The following changes to terminology apply under the Act:<br>• 'senior registered nurse on duty' be replaced with 'registered nurse in charge of the shift'<br>• 'audio visual link' be defined using the definition in the *Evidence Act 1977*, and<br>• the title 'Director of Mental Health' be replaced with 'Chief Psychiatrist'. |

**Question:**
Will the recommendations address other relevant issues?

| Issue/s | Review recommendations |
|---|---|
| | **Authorised mental health service where treatment and care may be provided**<br>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.<br>**Searches**<br>21.8 The search provisions ensure that non-consensual searches within authorised mental health services only apply to individuals involuntarily detained under the Act.<br>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.<br>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.<br>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.<br>**Terms for assisting psychiatrists**<br>21.12 Assisting psychiatrists for the Mental Health Court be appointed for a maximum of two consecutive terms.<br>**Automatic cessation of involuntary treatment orders**<br>21.13 The automatic cessation of an involuntary treatment order after six months of non-contact with an authorised mental health service be discontinued. |