Queensland Health

Mental Health Act 2000

10-11 annual report

of the Director of Mental Health

Toward Q2 Tomorrow's Queensland

Queensland Government

Communication objective

This annual report aims to:

- describe our performance — by communicating our achievements and performance for 2010–11
- be accountable and transparent — by enabling the Minister for Health, Minister for Disability Services, Mental Health and Aboriginal and Torres Strait Islander Partnerships and Parliament to assess our efficiency and effectiveness
- inform and listen to our clients and stakeholders — by providing an opportunity for members of the public to review our performance and recognise our future priorities.

2010–11 Annual Report of the Director of Mental Health

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Queensland Government

To:
The Honourable Geoff Wilson MP
Minister for Health
and

The Honourable Curtis Pitt
Minister for Disability Services, Mental Health
and Aboriginal and Torres Strait Islander Partnerships

Dear Ministers

It is with much pleasure that I present the Annual Report of the Director of Mental Health for 2010–11.

The report is provided in accordance with Section 494 of the *Mental Health Act 2000* (Qld).

Yours sincerely

Dr Aaron Groves
Director of Mental Health

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Chapter 1

The year in review

Message from the Director of Mental Health

I am pleased to present the 10th Annual Report of the Director of Mental Health.

This report provides an overview of our key achievements in the administration of the *Mental Health Act 2000* (the Act) during 2010–11.

This year saw the passage of the *Forensic Disability Act 2011* (Forensic Disability Act) in May 2011. The Forensic Disability Act implements the final recommendation of the Promoting balance in the forensic mental health system – Final Report – Review of the Queensland Mental Health Act 2000 (the Butler Report). I have reported on implementation of these recommendations in previous reports. In addition there was further development of the statutory compliance and clinical audits and implementation of the Queensland Health Forensic Mental Health Strategic Framework (QHFMHSF).

As the Director of Mental Health, I am also pleased to provide information in this Annual Report on achievements in the broader work of the Mental Health Alcohol and Other Drugs Directorate (MHAODD). In progressing the reform and development of mental health services, this work contributes directly to improving the treatment and care of people under the Mental Health Act and all Queenslanders who live with mental illness.

Finalising implementation of the Butler Report

Following a significant period of reform of the Queensland forensic mental health system, supported by the Government's allocation in 2007–08 of $53.484 million over four years, only one of the 106 recommendations arising from the Butler Report remained outstanding at the beginning of this reporting period. The final recommendation was implemented this year in work undertaken jointly with the Department of Communities through the development and passage of the Forensic Disability Act and associated amendments to the Mental Health Act.

These legislative developments provide a significant step forward in improving services for individuals with intellectual or cognitive disability who are placed on a forensic order by the Mental Health Court. This includes the development of a service framework to support a contemporary model for the delivery of a forensic disability service and regulate the day to day operation of the service from 1 July 2011. Changes to the Mental Health Act enable the Mental Health Court to order that an individual be placed on a forensic order

(Mental Health Court – Disability) and be managed by the forensic disability service or an authorised mental health service (AMHS). The establishment of the new type of order for this cohort will ensure improved service responses to address their specific needs regardless of whether the person is managed by the forensic disability service or an AMHS.

The Mental Health Act was also amended to reflect the distinction made between the involuntary treatment and care of persons with a mental illness and the care of persons with an intellectual or cognitive disability. The care of such persons includes the provision of rehabilitation, habilitation, support and other services.

The appointment of Dr Jeffrey Chan in January 2011 as Chief Practitioner and subsequently as Director of Forensic Disability, has contributed to much stronger relationship between the office of the Director of Mental Health and the Department of Communities. The offices of the Director of Mental Health and the Director of Forensic Disability will continue to work collaboratively to ensure that people with care needs stemming from intellectual or cognitive disabilities have a coordinated response within the State's forensic system.

Queensland mental health natural disaster response

During the summer of 2010-11, Queensland experienced unprecedented devastation as a result of floods and several cyclones, including Cyclone Yasi. Emergency mental health support was provided to those communities hardest hit by the disasters. Skilled mental health clinicians and counsellors from Queensland and interstate were immediately deployed to help communities and individuals meet pressing practical and emotional mental health needs. Team members visited evacuation and recovery centres and provided outreach services, while specialist mental health disaster and counselling teams helped link people with services that could help provide immediate crisis and longer term support, such as Department of Communities, Lifeline and the Red Cross.

In recognition of the significant immediate and long-term mental health needs of Queenslanders following these severe weather events, the Queensland Mental Health Natural Disaster Recovery Plan 2011-2013 was developed to provide a blueprint for government, non-government and community mental health disaster recovery responses. This plan will provide a coordinated and integrated response to mental health needs and support the building of community and individual resilience, and recovery and strengthening of service delivery.

Clinical reform initiative - Working Together to Change

The Working Together to Change initiative was launched in 2010 to enhance the quality and consistency of mental health services in Queensland. I am pleased with the significant progress that has been made under this initiative through the engagement of services in developing and implementing localised strategic plans for reform at three pilot sites in Queensland. To further develop this initiative, considerable work has been undertaken in consultation with key stakeholders to develop a Queensland Mental Health Performance Framework which will ultimately provide services with a rigorous performance and accountability framework to assist in evaluating the effectiveness of their mental health service delivery.

Queensland Plan for Mental Health 2007-2017

The Queensland Plan for Mental Health 2007–17 (QPMH) continues to provide the blueprint for reform of mental health services across Queensland. The QPMH outlines the Queensland Government's commitment to developing a world class mental health system. The recovery-oriented vision for mental health care in Queensland includes developing a system that better responds to demand and implements new and innovative approaches to meet consumer and carer needs.

Continued implementation of the QPMH during this reporting period has resulted in significant developments including increases in mental health staff levels, better inpatient facilities and increased capacity of mental health services. Improved collaborative relationships have been formed between mental health services and community supports which have increased the quality of the mental health system and provided more sustainable and accessible services for consumers.

Aboriginal and Torres Strait Islander Mental Health Hub

The QPMH acknowledges our indigenous heritage in Queensland and the unique contribution of Indigenous people's culture and heritage to our society. It also recognises Indigenous people's distinctive rights to status and culture, self-determination and the land as fundamental to the well-being of Indigenous Queenslanders.

This year has seen the establishment of an Aboriginal and Torres Strait Islander mental health hub within the MHAODD. This hub will ensure specialist leadership and oversight in the delivery of mental health services to Aboriginal and Torres Strait Islander people in Queensland in order to close the gap on indigenous disadvantage and improve mental health and well-being. I look forward to the finalisation of the Queensland Aboriginal and Torres Strait Islander Mental Health Workforce Report in the next reporting period and the further growth and development of this specialist hub.

Alcohol and Other Drugs Treatment Services

In recognition of the close relationship between mental illness and drug and substance use disorders, the planning of alcohol and other drug treatment services was incorporated into the renamed Mental Health Alcohol and Other Drugs Directorate on 1 November 2010. During 2010-11, the MHAODD launched the Queensland Health Dual Diagnosis Clinician Guidelines and the Clinician Tool Kit in March 2011.

Monitoring and auditing statutory compliance

In line with my statutory role under the Act, I am pleased to report that while the statutory audits and investigations found a small number of significant matters of non-compliance during 2010–11, these have been immediately addressed and a follow-up monitoring and review process implemented.

The audits continue to identify many examples of quality service delivery, as well as areas requiring improvements to systems, the development of new policy and the review and refinement of existing policies. My office collaborates with AMHSs to bring these identified enhancements into effect.

Systematic monitoring and auditing of AMHS compliance with the Act has continued during this reporting period. Since the commencement of statutory auditing, all AMHSs, with the exception of Townsville AMHS, have been audited. It is anticipated that Townsville AMHS will be audited in July 2011. Ten AMHSs were audited during 2010–11. I am pleased to be able to report on the many positive outcomes which have resulted from this audit process.

Queensland Health Forensic Mental Health Strategic Framework

In 2010-11, a review of the policy framework of the state forensic mental health services was concluded. The Queensland Health Forensic Mental Health Strategic Framework (QHFMHSF) was developed in partnership with the state Forensic Mental Health Service and the Forensic Mental Health Advisory Group and was launched in March 2011.

The QHFMHSF builds on the significant reforms that have occurred within Queensland's forensic mental health system and the broader mental health system in general over the past years. It articulates principles that underpin the delivery of forensic mental health services and identifies priorities for the continued reform of forensic mental health services under the QPMH.

The year ahead

My office will continue in the coming year with the strategic reforms, positive developments and growth required to provide quality mental health services to the people of Queensland. I look forward to continuing our strong collaboration with consumers, carers, specialist mental health services, primary care services, the non-government sector and other stakeholders in striving for an improved mental health system.

Acknowledgements

I would particularly like to recognise the contribution of the Honourable Justice Philippides and her service on the Mental Health Court since 2006 including as President from 2008 to 2011. Justice Philippides has worked closely with the office of the Director and other parties in ensuring that the rights of forensic patients who suffer from a mental illness are balanced with the safety of the community. In the four and a half years serving the Court, she has witnessed significant changes to the Act through the Butler Report reforms and the manner in which the Court has responded to the intricacies inherent in forensic mental health.

During her time as the first President of the Mental Health Court, some landmark cases have passed before the Bench. These cases have expanded the thresholds of forensic mental health and the legal system in the way that the court manages forensic patients with a sole diagnosis of intellectual disability. She has also overseen other major changes, including the introduction of the permanent appointment of a second judge to the Court which has led to an increase of Mental Health Court sitting days and cases heard. During her term, she also saw changes in the forensic mental health system in the Government's response to the 2006 report by His Honour Justice Brendan Butler, which led to the introduction of a greater recognition of the rights of victims.

I would also like to recognise the contribution of Dianne Pendergast in her role as Adult Guardian from 2006 to 2011. Her collaboration with the office of the Director has been indispensable in addressing situations requiring close attention in order to protect vulnerable people coming under the Act.

Finally, I take this opportunity to commend the many Queensland Health staff who have demonstrated their great professionalism, commitment and enthusiasm in contributing to the ongoing delivery of mental health services in Queensland.

The professionalism and unswerving dedication of all these individuals have played an essential part in the ongoing development of a more responsive mental health system that meets the needs and rights of people who live with a mental illness while balancing those rights with the rights of others.

Dr Aaron Groves
Director of Mental Health

Chapter 2

Key highlights 2010–11

Achievements for 2010–11

Statutory Achievements

- *Forensic Disability Act 2011* developed and introduced through Queensland Parliament jointly with the Department of Communities. Development included consultations with key stakeholders including the Mental Health Court, the Mental Health Review Tribunal, the Honourable Justice Carter QC, His Honour Judge Brendan Butler, the Public Advocate and the Adult Guardian, service providers, advocates, industry groups and other interested stakeholders
- statutory compliance audits conducted at:
  - Royal Brisbane Women's Hospital Authorised Mental Health Service (AMHS)
  - Greenslopes Private Hospital AMHS
  - New Farm Clinic AMHS
  - Wide Bay AMHS
  - Mater Health Services Child and Youth AMHS
  - Royal Children's Hospital AMHS
  - Gold Coast Network AMHS
  - Logan -Beaudesert AMHS
  - The Park - Centre for Mental Health AMHS
  - The Park High Security Program AMHS
  - Bayside AMHS
- post-audit review visits to AMHS commenced to monitor progress in addressing compliance issues and identify improvements following initial audits
- accredited Investigator Training Course Certificate IV in Government Investigation delivered to increase the number of staff accredited to conduct investigations under the *Mental Health Act 2000*.

Other Mental Health Related Achievements

- *Information Sharing Between Mental Health Workers, Consumers, Carers, Family and Significant Others* published
- Alcohol and Other Drugs Treatment Services Unit incorporated into the renamed Mental Health Alcohol and Other Drugs Directorate
- consumer perceptions of care survey conducted in August-September 2010
- Consumer, Carer and Family Participation Framework launched August 2010
- Memorandum of Understanding signed in November 2010 between the Department of Communities (Child Safety, Youth and Families) and Queensland Health (Child and Youth Mental Health Services) regarding services for children and young people under child protection with mental health needs
- Queensland Health Forensic Mental Health Strategic Framework launched in March 2011
- Queensland Health Dual Diagnosis Clinician Guidelines and Clinician Tool Kit launched in March 2011
- inaugural Mental Health First Aid instructor forum held in April 2011
- 98 consumers and carers trained in Mental Health First Aid for Carers
- Queensland Mental Health Natural Disaster Recovery Plan 2011–2013 developed and implementation commenced, including:
  - recruitment of an additional 126 specialist clinical mental health staff to assist Queenslanders who experienced severe psychological trauma as a result of the natural disasters
  - establishment of a Statewide Family Bereavement Service to provide support to families experiencing bereavement as a result of natural disasters.
- specialist Aboriginal and Torres Strait Islander hub established in the Mental Health and Alcohol and Other Drugs Directorate.

Chapter 3

Strategic directions for mental health

Our Context

The Fourth National Mental Health Plan 2009–2014

The Fourth National Mental Health Plan 2009–2014 (NMHP) commits the Queensland Government along with the Commonwealth and other State governments to a series of actions designed to build an accountable and transparent mental health system throughout Australia. Following the launch of the NMHP, the Queensland Government took responsibility for the development of an action plan detailing the strategic implementation of five of the 34 key actions agreed to under the NMHP. Draft action plans for the five key areas were submitted to the National Mental Health Standing Committee (NMHSC) in August 2010.

The NMHSC comprises representation from all Australian mental health jurisdictions and reports to the Australian Health Ministers' Advisory Council. It has the key role of overseeing and monitoring the implementation of the NMHP and the Council of Australian Government's (COAG) National Action Plan on Mental Health. Following consideration of the draft action plans, an implementation strategy for the NMHP was agreed to at the Australian Health Ministers' Conference in December 2010 and provides a high level document articulating the process for developing detailed implementation of each action.

National Standards for Mental Health Services 2010

The revised National Standards for Mental Health Services (NSMHS) were launched in September 2010. Following this release, the Mental Health Alcohol and Other Drugs Directorate (MHAODD) has led the local implementation of the revised NSMHS. Adoption of the NSMHS will lead to contemporary clinical practice and provide guidance for continuous quality improvement in mental health services in Queensland.

A range of activities have been undertaken to promote the NSMHS including:

- delivery of presentations to mental health services, non-government organisations and consumer and carer organisations on the NSMHS and the National Recovery Principles
- ongoing development of resources, including initiating the creation of an e-learning tool linked to the NSMHS.

National Drug Strategy 2010–2015

The National Drug Strategy 2010–2015 (NDS) was launched in March 2011. This strategy aims to provide a coordinated national approach to build safe and healthy communities by minimising alcohol, tobacco and other drug related health, social and economic harms among individuals, families and communities.

Following the reforms to Ministerial Councils agreed upon by COAG on 13 February 2011, the management of the NDS was transferred to the Intergovernmental Committee on Drugs (IGCD) where Queensland Health is represented by the MHAODD.

Four standing committees have been developed by the IGCD to support the development of work under the NDS in the following areas:

- alcohol
- tobacco
- illicit drugs
- pharmaceutical drugs misuse.

Working groups were also established in the last reporting period to develop the work of the NDS with the following focus:

- research and data strategy
- workforce development
- Aboriginal and Torres Strait Islander peoples drug strategy.

As part of the development of the NDS, the Queensland Government, as represented by the Executive-Director of the MHAODD, was appointed Chair of the National Research and Data Strategy Working Group, with other nominated representatives of Queensland Health and the Queensland Police Service actively participating on the other IGCD working groups and standing committees.

Queensland Plan for Mental Health 2007–2017

In June 2008, the Queensland Government announced a 10-year plan to reform and develop the mental health system—the Queensland Plan for Mental Health 2007–2017 (QPMH). This plan reflects the Government's commitment to providing a world-class mental health system that delivers world-class results for all Queenslanders which will guide the reform and development of mental health care in Queensland.

As a whole-of-government strategy, the QPMH provides a framework for the reform of mental health services in Queensland. Initiatives in the QPMH are grouped under five priorities aligning with the national commitment under the COAG National Action Plan on Mental Health 2006–2011 and the NMHP.

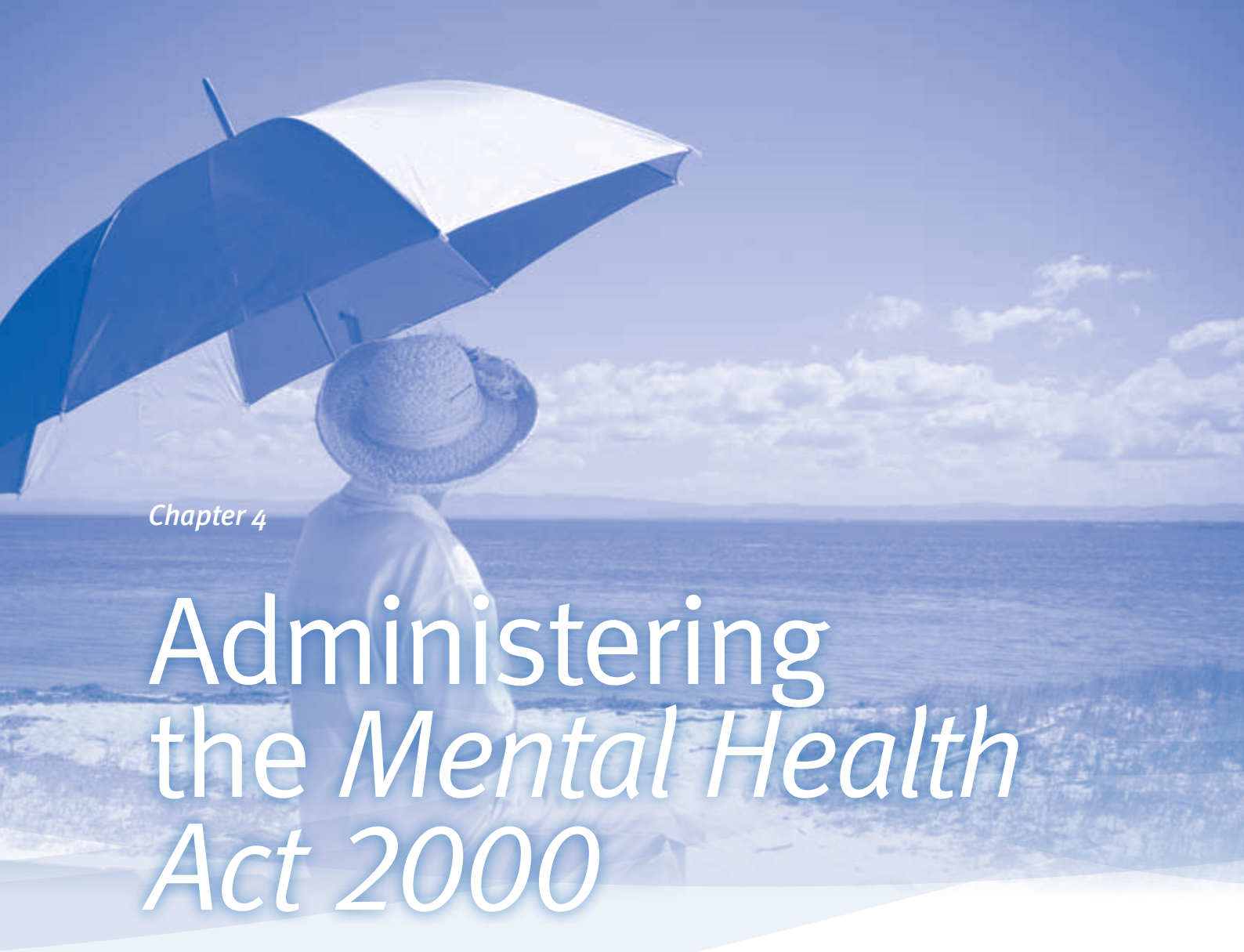
The QPMH outlines a vision for mental health care and positions mental health services to better respond to demand. The aim of the QPMH is to implement new and innovative approaches to meet consumer and carer needs in a system that promotes mental wellbeing, reduces the impact of mental illness and builds the capacity of people affected by mental illness to lead fulfilling lives. The plan will be complemented by a soon to be released mental health community services plan, which will be a companion document to the QPMH. It is intended that this plan will reflect the Government's commitment to strengthen the community mental health sector under Priority area 3 and will build on the achievements to date, to assist and support people with mental illness to live full and meaningful lives in the community.

Queensland Mental Health Natural Disaster Recovery Plan 2011-2013

Following the unprecedented natural disasters experienced in Queensland in 2011, the Queensland Mental Health Natural Disaster Recovery Plan 2011-2013 (MHNDRP) was developed in partnership with the Department of Communities, the non-government sector, local government and other State and Commonwealth agencies.

The World Health Organisation has estimated that in the 12 months after an emergency, the prevalence of severe mental disorders such as post traumatic stress disorder, psychosis and severe depression increase by one per cent and mild or moderate mental disorders increase in prevalence by between five and ten per cent. As such, a significant increase in the demand for public mental health services in Queensland has been predicted for the 12 to 24 months following these disasters.

The MHNDRP is part of the joint initiative by the Australian and Queensland governments under the National Disaster Relief and Recovery Arrangements. It provides for government, non-government and community mental health responses, including a comprehensive range of integrated community-based services to help build resilience and empower and support individuals and communities to come to terms with and recover from these disasters.



Chapter 4

Administering the *Mental Health Act 2000*

Reporting on our statutory role

Most people with a mental illness are able to make decisions about their treatment. However, there are times when the nature of mental illness renders a person unable to have full insight into their treatment needs. In these cases, involuntary treatment may be warranted. *The Mental Health Act 2000* (the Act) provides the legislative framework for the involuntary assessment, treatment and protection of people with a mental illness, safeguarding their rights and freedoms, as balanced with the rights of others.

One of the fundamental human rights principles underpinning the Act is that a person's liberty and rights should only be adversely affected if there is no less restrictive way to protect their health and safety or to protect others. Therefore involuntary provisions can be applied only if a person is believed to represent a risk to their own safety or that of others, or is likely to suffer serious mental or physical deterioration due to a mental illness.

This chapter details the involuntary provisions and related legislative processes that were applied between 1 July 2010 and 30 June 2011. Data on these activities was recorded in the Consumer Integrated Mental Health Application (CIMHA), together with records maintained by the office of the Director of Mental Health (the Director).

Involuntary assessment

The Act allows for the involuntary assessment of people who may require treatment for a mental illness. Two separate forms must be completed, each declared by a different individual, to initiate involuntary assessments. Together, these forms are known as the 'assessment documents'.

The first of these assessment documents is a request for assessment. This form must be completed by an adult (usually a family member, friend or health professional) who, having observed the person in the preceding three days, believes the person requires involuntary assessment. The second document is a recommendation for assessment. This form is

completed by a doctor or authorised mental health practitioner (AMHP) who believes, after having examined the person in the preceding three days, the assessment criteria provided in the Act apply to the person. A recommendation for assessment remains in force for seven days after it is made.

Together these assessment documents authorise an AMHP or ambulance officer to take the person to an authorised mental health service (AMHS). For the purposes of assessment, a public hospital can be considered an AMHS where no other AMHS is readily available. On arrival at the AMHS, the person becomes an involuntary patient where they may be detained for an initial period of 24 hours. If the assessment cannot be conducted during the initial 24 hours by an authorised doctor (AD), the assessment period can be extended by 24 hours. However, the total assessment period must not exceed 72 hours. During the assessment period, an AD must assess the patient to determine whether the treatment criteria as listed in Section 14 of the Act apply. If satisfied that the treatment criteria apply, the AD may make an involuntary treatment order (ITO) for the patient.

Table 1 sets out details of the involuntary assessment activity at each AMHS in 2010–11.

Table 1 Involuntary assessment: involuntary processes commenced with assessment documents 2010–11

Authorised mental health service*	Assessed on assessment documents only	ITO made as a result of involuntary assessment		ITO not made before end of assessment period		Pre-existing involuntary status	
Bayside	164	109	66%	55	34%	0	0%
Belmont Private	70	67	96%	3	4%	0	0%
Cairns	536	281	52%	245	46%	10	2%
Central Queensland	154	88	57%	65	42%	1	1%
Fraser Coast	126	68	54%	57	45%	1	1%
Gold Coast	852	490	58%	360	42%	2	0%
Greenslopes Private	3	2	67%	1	33%	0	0%
Logan Beaudesert	478	271	57%	204	43%	3	1%
Mackay	259	118	46%	137	53%	4	2%
Mater	41	20	49%	20	49%	1	2%
New Farm Clinic	45	34	76%	11	24%	0	0%
Princess Alexandra	854	546	64%	298	35%	10	1%
Redcliffe Caboolture	337	200	59%	133	39%	4	1%
RBWH	1207	643	53%	547	45%	17	1%
Royal Children's	11	5	45%	6	55%	0	0%
Sunshine Coast	348	254	73%	93	27%	1	0%
The Park	10	5	50%	5	50%	0	0%
The Park - High Security	6	6	100%		0%	0	0%
The Prince Charles	358	222	62%	132	37%	4	1%
Toowong Private	39	35	90%	4	10%	0	0%
Toowoomba	319	198	62%	121	38%	0	0%
Townsville	283	124	44%	159	56%	0	0%
West Moreton	250	167	67%	82	33%	1	0%
Wide Bay	92	51	55%	41	45%	0	0%
Total	**6842**	**4004**	**59%**	**2779**	**41%**	**59**	**0.9%**

* See Appendix 4 for full AMHS title

A total of 6842 involuntary assessments were conducted following a request and recommendation during the 2010–11 reporting period, representing a 1.8 per cent increase from the previous year. Of these assessments, 4004 (59 per cent) resulted in an ITO being made, and 2779 (41 per cent) did not result in an ITO being made before the end of the assessment period.

As demonstrated by the data, it is evident that there are circumstances where assessment documents do not result in an ITO. Not everyone who is subject to an involuntary assessment meets the criteria for involuntary treatment. Further, during the assessment process a person may choose to receive treatment voluntarily which means, at that point, the person does not require treatment under the Act.

Also, the data in Table 1 does not include instances where involuntary assessment was preceded by other processes such as an emergency examination order (EEO) or justices examination order (JEO). Data relating to involuntary assessment following an EEO or JEO is provided in the next section of this report, under processes leading to involuntary assessment.

As can be seen from the data, there are some situations where a person is already subject to involuntary provisions under the Act when an assessment is conducted. This situation commonly occurs where the person is already receiving treatment through an AMHS and subsequently becomes subject to involuntary assessment at another AMHS. In 2010–11, 59 instances of this kind occurred, representing less than one per cent of the total assessments made based on assessment documents only.

Graph 1 represents all assessments made on assessment documents per year over a five-year period and demonstrates a 15 per cent increase in involuntary assessments from 2006–07 to 2010–11. This increase may be attributed to the impact of significant mental health reforms over the past five years and a greater awareness of mental illness and assistance available within the general community.

Graph 1 Number of individuals assessed on assessment documents over a five-year reporting period

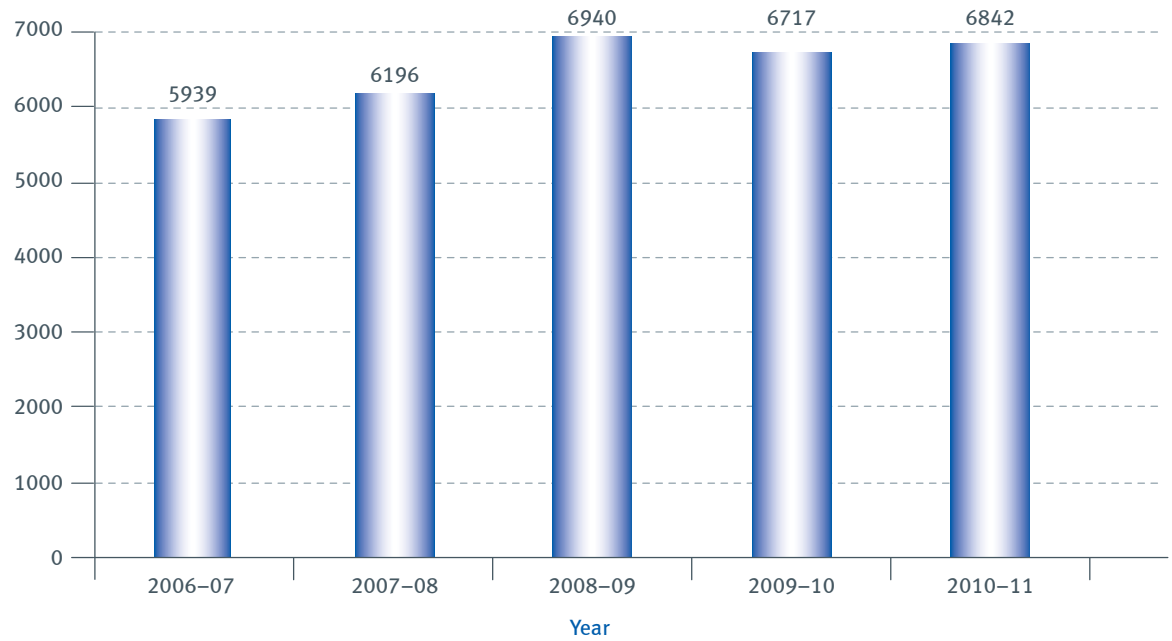
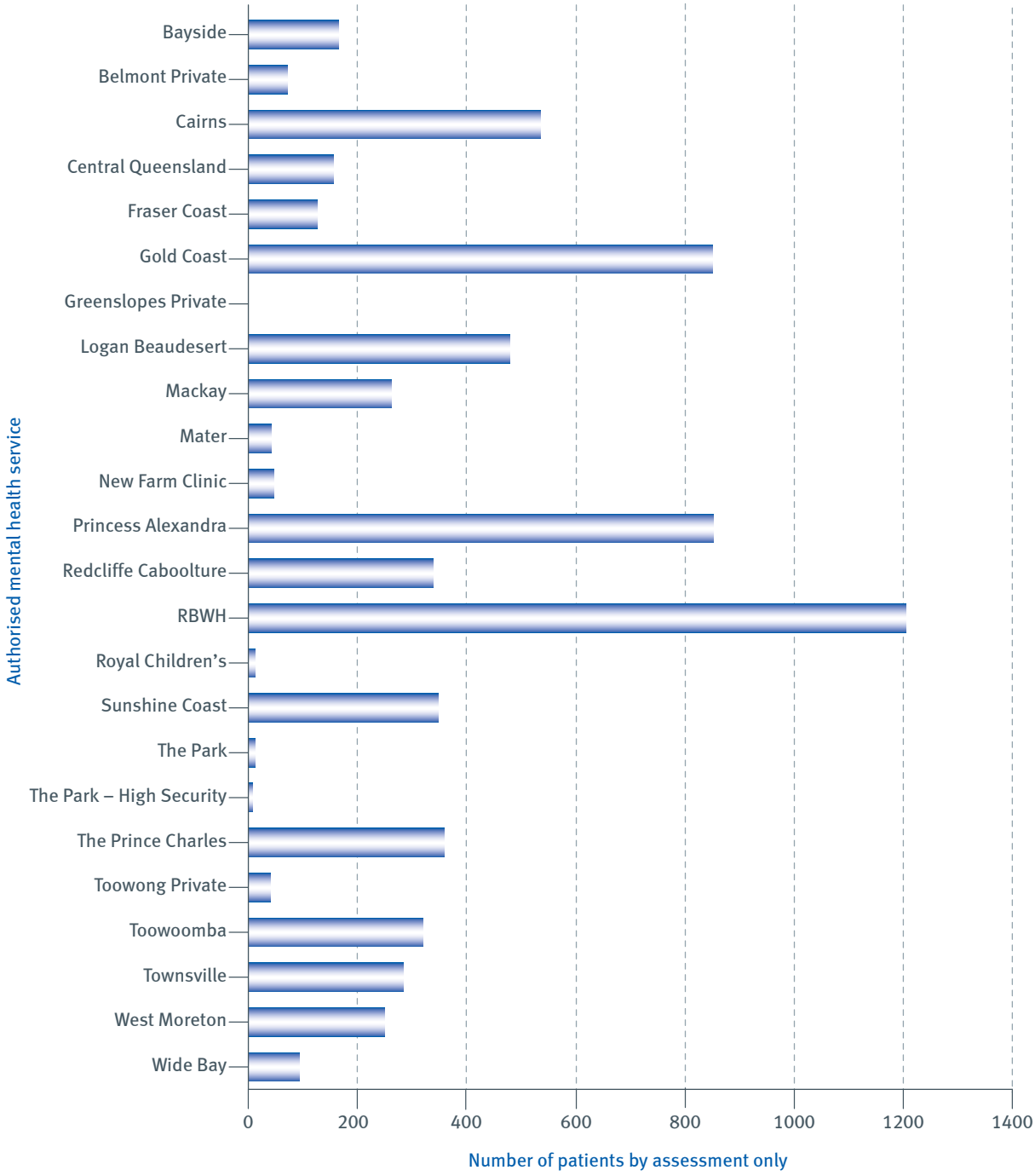


Figure 1 is a graphical representation of the number of patients assessed on assessment documents at each AMHS in the reporting period.

Figure 1 Total number of patients assessed on assessment documents only by authorised mental health service



Processes leading to involuntary assessment

There are times when the involuntary assessment process cannot be applied. For example, a situation of immediate concern may arise where a person is believed to be a risk to their own safety or that of others due to a mental illness and the person does not have an existing relationship with an AMHS. In these circumstances, consideration may be given to initiating assessment through a JEO or an EEO.

Justices examination orders

A member of the community who believes a person requires involuntary assessment may apply for a JEO. The application must detail the grounds for seeking the order and be sworn under oath. A Magistrate or Justice of the Peace (JP) may make the order if they reasonably believe that the person subject to the application has a mental illness and the order is necessary to ensure the person is examined by a doctor or AMHP. If a JEO is made, then the order must be sent to the administrator of the relevant AMHS and is valid for seven days only.

On receiving the order, the administrator must arrange for a doctor or an AMHP to examine the person. The doctor or AMHP then attends the person's residence or another place nominated in the order to examine the person to determine whether involuntary assessment is warranted. If it is decided a recommendation for assessment should be made for the person, the person must be taken to an AMHS to be assessed.

Table 2 demonstrates that 825 (95 per cent) of the 865 JEOs made in 2010–11 were authorised by a JP. However, most Magistrates Courts have one or more staff members who are qualified as a JP. Therefore, it is likely that an unrecorded number of JEO applicants who attended a Magistrates Court to have the order approved would have had the order signed by a JP employed by the court, rather than a Magistrate.

Table 2 Justices examination orders according to AMHSs 2010–11

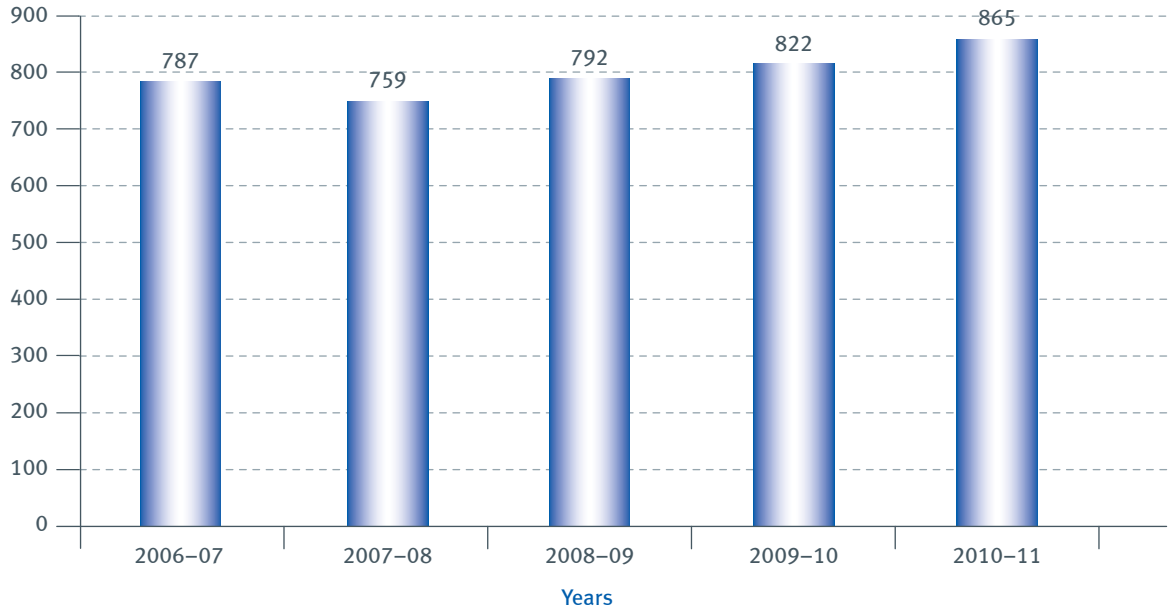
Authorised mental health service*	Total	Justice of the Peace	Magistrate
Bayside	41	41	0
Belmont Private	0	0	0
Cairns	77	42	35
Central Queensland	52	52	0
Fraser Coast	46	46	0
Gold Coast	49	49	0
Greenslopes Private	0	0	0
Logan Beaudesert	82	81	1
Mackay	50	50	0
Mater	4	4	0
New Farm Clinic	1	1	0
Princess Alexandra	95	93	2
Redcliffe Caboolture	47	47	0
RBWH	26	26	0
Royal Children's	7	7	0
Sunshine Coast	36	36	0
The Park	0	0	0
The Park - High Security	0	0	0
The Prince Charles	65	65	0
Toowong Private	0	0	0
Toowoomba	60	59	1
Townsville	46	46	0
West Moreton	60	59	1
Wide Bay	21	21	0
Total	**865**	**825**	**40**

* See Appendix 4 for full AMHS title

A total of 865 JEOs were made during 2010–11. This represents a slight increase from the 2009–10 reporting period when the total was 822 and a gradual increase (10 per cent) over the five years from 2006–07 to 2010–11.

The number of JEOs made per year over a five-year reporting period is shown in Graph 2.

Graph 2 Justices examination orders made over a five-year reporting period



After an AD or AMHP has carried out an assessment pursuant to a JEO, they may issue assessment documents if they are satisfied that all the criteria for involuntary assessment detailed in Section 13 of the Act are met.

Of the JEOs made in 2010–11, 529 (61 per cent) ended with no assessment documents being made. This figure is slightly higher than the 2009–10 reporting period figure of 462 (56 per cent).

Table 3 illustrates the outcomes of JEOs made in the reporting period.

Table 3 Justices examination orders and outcomes 2010–11

Authorised mental health service*	Total	Assessment documents not made		Assessment documents made				JEO ended before examination		Pre-existing involuntary status	
				ITO made as a result of involuntary assessment		ITO not made as a result of involuntary assessment					
Bayside	41	30	73%	9	22%	0	0%	2	5%	0	0%
Belmont Private	0	0	0%	0	0%	0	0%	0	0%	0	0%
Cairns	77	39	51%	16	21%	6	8%	16	21%	0	0%
Central Queensland	52	37	71%	8	15%	1	2%	5	10%	1	2%
Fraser Coast	46	30	65%	9	20%	3	7%	4	9%	0	0%
Gold Coast	49	27	55%	13	27%	2	4%	7	14%	0	0%
Greenslopes Private	0	0	0%	0	0%	0	0%	0	0%	0	0%
Logan Beaudesert	82	55	67%	12	15%	3	4%	9	11%	3	4%
Mackay	50	35	70%	8	16%	1	2%	3	6%	3	6%
Mater	4	3	75%	1	25%	0	0%	0	0%	0	0%
New Farm Clinic	1	1	100%	0	0%	0	0%	0	0%	0	0%
Princess Alexandra	95	39	41%	46	48%	4	4%	6	6%	0	0%
Redcliffe Caboolture	47	28	60%	15	32%	3	6%	1	2%	0	0%
RBWH	26	7	27%	18	69%	1	4%	0	0%	0	0%
Royal Children's	7	6	86%	0	0%	0	0%	1	14%	0	0%
Sunshine Coast	36	26	72%	6	17%	2	6%	2	6%	0	0%
The Park	0	0	0%	0	0%	0	0%	0	0%	0	0%
The Park - High Security	0	0	0%	0	0%	0	0%	0	0%	0	0%
The Prince Charles	65	44	68%	15	23%	5	8%	1	2%	0	0%
Toowong Private	0	0	0%	0	0%	0	0%	0	0%	0	0%
Toowoomba	60	36	60%	13	22%	2	3%	9	15%	0	0%
Townsville	46	33	72%	9	20%	2	4%	2	4%	0	0%
West Moreton	60	38	63%	10	17%	3	5%	6	10%	3	5%
Wide Bay	21	15	71%	3	14%	0	0%	2	10%	1	5%
Total	**865**	**529**	**61%**	**211**	**24%**	**38**	**4%**	**76**	**9%**	**11**	**1%**

* See Appendix 4 for full AMHS title

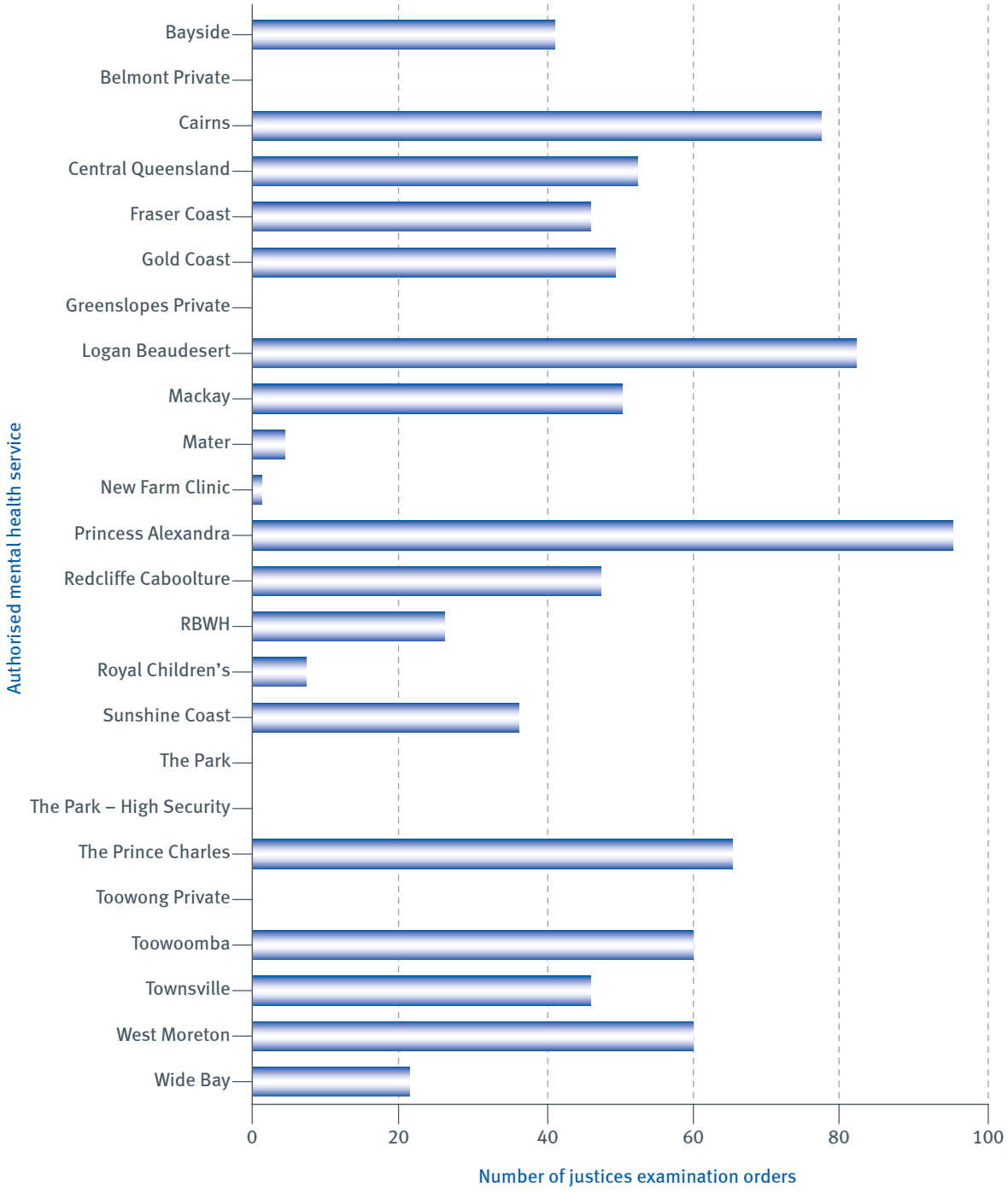
In 2010–11, 211 (24 per cent) of JEOs issued resulted in an ITO being made after assessment. Of the total number of JEOs that progressed to involuntary assessment, 38 (four per cent) did not result in an ITO being made, including some instances where the person had a pre-existing involuntary status (that is, an ITO or forensic order).

In some instances, a JEO expires prior to an examination being conducted. This may occur when the person is unable to be found, or they voluntarily attend an AMHS within the seven-day period covered by the order. In 2010–11, 76 (nine per cent) of all JEOs ended before an examination being conducted.

In 2010–11, 11 cases (one per cent) resulted in a JEO being made for a person who was already subject to the involuntary provisions of the Act.

Figure 2 shows the number of justices examination orders made at each AMHS in the reporting period.

Figure 2 Total number of justices examination orders by authorised mental health service 2010–11



Case study: justices examination order

Chrissie is currently residing in the community at her home. Earlier in the year there was an incident at Chrissie's work and after this she has been become increasingly withdrawn and socially isolated. Chrissie has a history of depression which is managed by her general practitioner with medication. However, Chrissie has stopped taking this medication and instead she has resorted to using alcohol and illicit drugs.

Petrina, Chrissie's best friend is concerned for her safety and feels that Chrissie needs a mental health review. Petrina encourages Chrissie to seek help from her general practitioner, however she refuses. Chrissie is no longer attending work and her employer is threatening to sack her if she does not turn up to work. Petrina holds grave concerns for Chrissie's ability to look after herself and is unsure what to do.

A Mental Health Act liaison officer (MHALO) in the office of the Director of Mental Health receives a call on the 1800 number from Petrina. The MHALO briefly explains the options available under the *Mental Health Act 2000* (the Act) and connects Petrina with a local mental health crisis assessment team. The crisis assessment team talks to Petrina about the application processes for a justices examination order (JEO), which will allow her to request an assessment of Chrissie by a qualified health practitioner.

Petrina downloads the JEO application form from the internet, completes the relevant sections and takes an oath confirming the application before the local Magistrate. The local Magistrate reviews the application and believes that there is sufficient information provided by Petrina to justify that Chrissie has a mental illness and should be examined by a doctor or authorised mental health practitioner (AMHP). The Magistrate makes a JEO and the Registrar of the Magistrates Court arranges for it to be faxed to the nearest authorised mental health service (AMHS). An AMHP and a health practitioner from the AMHS assess Chrissie in her home and talk to her about her mental health. The AMHP assesses that Chrissie has a mental illness which has developed to a point where she is unable to seek assistance for her mental illness by herself and that she requires involuntary assessment in the AMHS under the Act.

Chrissie is taken by the AMHP to the AMHS where she is assessed and admitted as an inpatient. Once Chrissie's mental illness has stabilised, the mental health team are able to assist Chrissie in moving back home. They refer her to a service specialising in drug and alcohol issues to help with her substance abuse and other problems underlying her illness. They also help Petrina to make contact with a support group for carers of people with a mental illness.

Knowing someone who unreasonably refuses or lacks capacity to seek assistance for a mental illness can be stressful for friends and families. The JEO process enables an involuntary assessment of a person who is reasonably believed to have a mental illness, while safeguarding their rights.

Emergency examination orders

An EEO may be made by a police officer, ambulance officer, or psychiatrist if they believe that a person represents an imminent risk of significant physical harm to either themselves or another person.

A police officer, ambulance officer, or psychiatrist may take the person to an AMHS for examination. On arrival at the AMHS, the person can be detained for up to six hours for the purpose of being examined by a doctor or AMHP. A doctor or AMHP at the AMHS examines the person to determine whether they meet the criteria for involuntary assessment.

Table 4 sets out the details of EEOs made in 2010–11.

Table 4 Emergency examination orders made 2010–11

Authorised Mental Health Service*	Total	Ambulance officer		Police officer		Psychiatrist	
Bayside	555	319	57%	235	42%	1	0%
Belmont Private	1	1	100%	0	0%	0	0%
Cairns	456	109	24%	347	76%	0	0%
Central Queensland	406	202	50%	203	50%	1	0%
Fraser Coast	102	39	38%	63	62%	0	0%
Gold Coast	836	256	31%	579	69%	1	0%
Greenslopes Private	0	0	0%	0	0%	0	0%
Logan Beaudesert	402	190	47%	212	53%	0	0%
Mackay	220	95	43%	125	57%	0	0%
Mater	163	64	39%	98	60%	1	1%
New Farm Clinic	0	0	0%	0	0%	0	0%
Princess Alexandra	941	477	51%	461	49%	3	0%
Redcliffe Caboolture	736	434	59%	302	41%	0	0%
RBWH	911	527	58%	381	42%	3	0%
Royal Children's	7	3	43%	4	57%	0	0%
Sunshine Coast	312	121	39%	190	61%	1	0%
The Park	0	0	0%	0	0%	0	0%
The Park - High Security	0	0	0%	0	0%	0	0%
The Prince Charles	697	363	52%	333	48%	1	0%
Toowong Private	0	0	0%	0	0%	0	0%
Toowoomba	569	175	31%	393	69%	1	0%
Townsville	803	265	33%	538	67%	0	0%
West Moreton	436	138	32%	297	68%	1	0%
Wide Bay	133	42	32%	91	68%	0	0%
Total	**8686**	**3820**	**44%**	**4852**	**56%**	**14**	**0.2%**

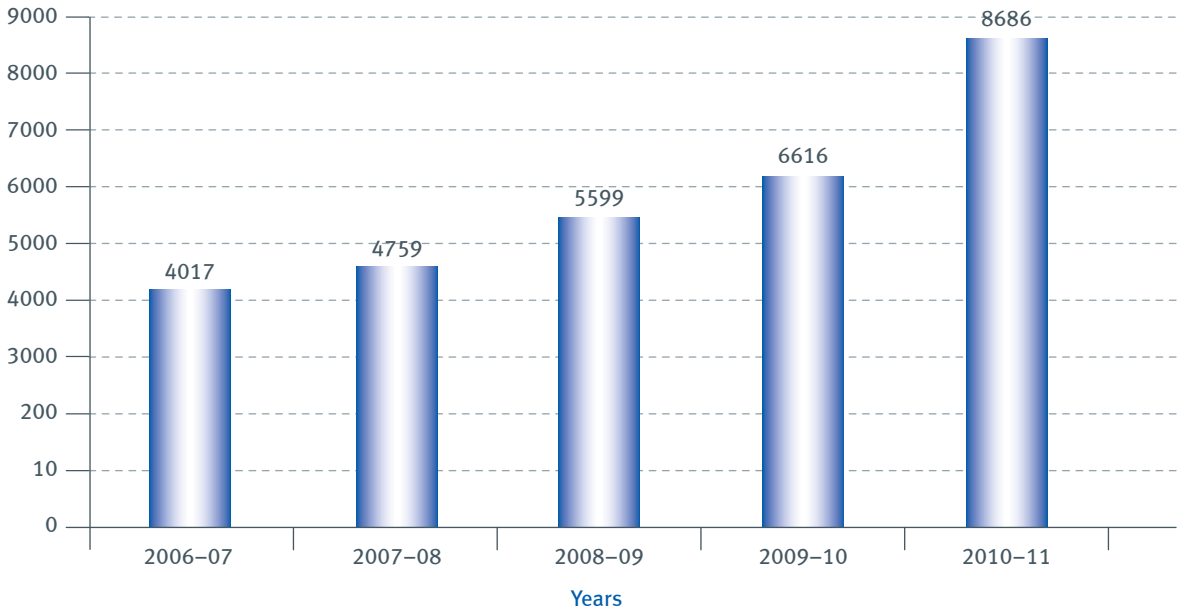
* See Appendix 4 for full AMHS title

As can be seen from Table 4, a total of 8686 EEOs were made during the reporting year, which represents a 31 per cent increase from 2009–10, when the total was 6616.

Police officers made 4852 (56 per cent) of the total number of EEOs in 2010–11. This figure represents a slight proportional decrease (6 per cent) from the total number of EEOs made by police officers in the 2009-10 reporting period. There has been an increase in EEOs made by ambulance officers proportional to the total over recent years. In 2006–07, only 21 per cent of the total number of EEOs were made by ambulance officers, compared to 44 per cent of the total (3820) in 2010–11. Psychiatrists made less than one per cent of the EEOs in 2010–11. This figure is comparable to 2009–10 results.

Graph 3 represents the total number of EEOs made per year over a five-year reporting period.

Graph 3 Emergency examination orders made over a five-year reporting period

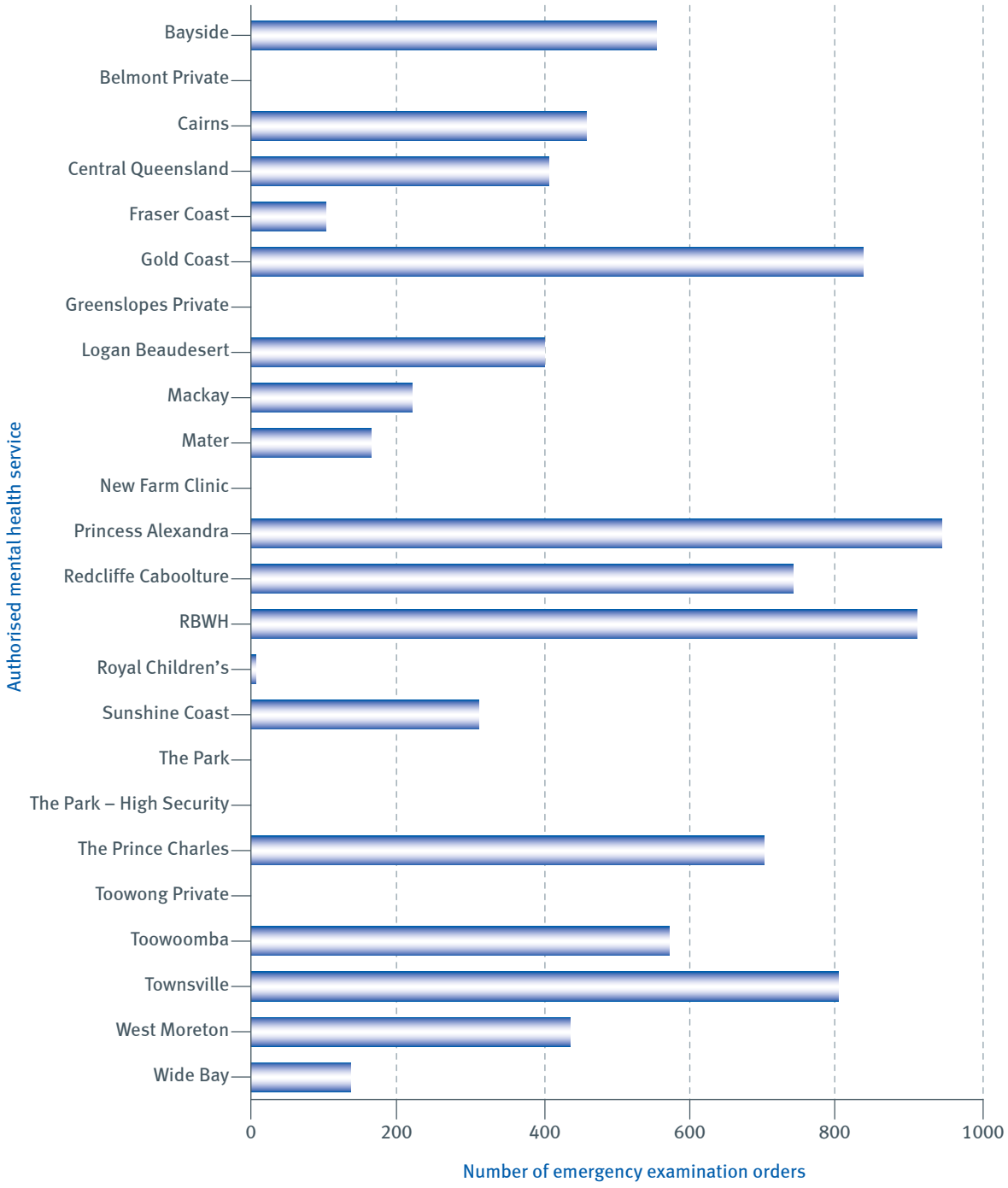


The number of EEOs has increased significantly over the past five reporting periods with a 116 per cent increase from 2006–07. This increase may be attributed to increased collaboration between police, ambulance and mental health services in responding to crisis situations when it is believed the person has a mental illness and there is an imminent risk to their health and safety or that of others.

The total number of EEOs represents 53 percent of all involuntary examination and assessment activity in the reporting period compared to 46 per cent in the previous reporting year.

Figure 3 is a graphical representation of the number of EEOs made at each AMHS in the reporting period.

Figure 3 Total number of emergency examination orders made by authorised mental health service 2010–11



Of the 8686 EEOs made in the reporting period, 56 per cent (4853) ended without a recommendation for assessment being made. In these cases, the doctor or AMHP determined that the involuntary assessment criteria were not satisfied. This situation may occur where:

- the person consents to treatment
- the doctor or AMHP does not believe the person has a mental illness that meets the criteria for involuntary assessment, or
- it is determined that there are less restrictive ways of ensuring the person receives treatment for their mental illness.

During the reporting period, 3034 EEOs resulted in assessment documents being made and of these, 1089 (13 per cent) resulted in an ITO being made.

A small proportion of EEOs (six per cent) expired before a doctor or AMHP was able to examine the person. As previously noted, the EEO expires six hours after the person arrives at the AMHS. In some instances, the person cannot be examined within this period due to a range of factors including alcohol intoxication or other substance misuse. In three per cent of cases, the person was already subject to the involuntary provisions of the Act.

Table 5 illustrates the various outcomes of the EEOs made in 2010–11.

Table 5 Emergency examination orders and outcomes 2010–11

Authorised mental health service*	Total	Assessment documents not made		Assessment documents made				EEO ended before examination		Pre-existing involuntary status	
				ITO made as a result of involuntary assessment		ITO not made as a result of involuntary assessment					
Bayside	555	428	77%	42	8%	76	14%	2	0%	7	1%
Belmont Private	1	0	0%	0	0%	1	100%	0	0%	0	0%
Cairns	456	165	36%	74	16%	195	43%	9	2%	13	3%
Central Queensland	406	313	77%	13	3%	54	13%	12	3%	14	3%
Fraser Coast	102	58	57%	11	11%	28	27%	2	2%	3	3%
Gold Coast	836	506	61%	134	16%	158	19%	20	2%	18	2%
Greenslopes Private	0	0	0%	0	0%	0	0%	0	0%	0	0%
Logan Beaudesert	402	231	57%	42	10%	62	15%	57	14%	10	2%
Mackay	220	96	44%	31	14%	74	34%	13	6%	6	3%
Mater	163	140	86%	5	3%	18	11%	0	0%	0	0%
New Farm Clinic	0	0	0%	0	0%	0	0%	0	0%	0	0%
Princess Alexandra	941	461	49%	125	13%	126	13%	180	19%	49	5%
Redcliffe Caboolture	736	454	62%	76	10%	108	15%	82	11%	16	2%
RBWH	911	53	6%	229	25%	585	64%	13	1%	31	3%
Royal Children's	7	6	86%	0	0%	1	14%	0	0%	0	0%
Sunshine Coast	312	197	63%	48	15%	36	12%	16	5%	15	5%
The Park	0	0	0%	0	0%	0	0%	0	0%	0	0%
The Park - High Security	0	0	0%	0	0%	0	0%	0	0%	0	0%
The Prince Charles	697	511	73%	59	8%	107	15%	12	2%	8	1%
Toowong Private	0	0	0%	0	0%	0	0%	0	0%	0	0%
Toowoomba	569	333	59%	86	15%	122	21%	8	1%	20	4%
Townsville	803	507	63%	42	5%	119	15%	105	13%	30	4%
West Moreton	436	318	73%	51	12%	54	12%	6	1%	7	2%
Wide Bay	133	76	57%	21	16%	21	16%	12	9%	3	2%
Total	**8686**	**4853**	**56%**	**1089**	**13%**	**1945**	**22%**	**549**	**6%**	**250**	**3%**

* See Appendix 4 for full AMHS title

Case study: emergency examination order

Police officers find John walking through the Queen Street Mall. He appears to be experiencing significant distress, as he seems disoriented and incoherent and is abusing passers-by. A number of shop owners have contacted the police about John, with concerns about his inappropriate behaviour outside their stores and its impact on customers.

After talking briefly to John, the police officers are concerned that he may pose an imminent threat of physical harm to himself or others. The police officers decide to take him to an authorised mental health service (AMHS) for assessment under an emergency examination order (EEO).

The EEO allows a police officer, ambulance officer or a psychiatrist to take a person to an AMHS for examination in emergency situations if they reasonably believe:

- the person has a mental illness
- because of the person's illness, there is an imminent risk of significant physical harm being sustained by the person or someone else
- applying for a justices examination order (JEO) would cause a dangerous delay and increase the risk of harm.

After John is brought to the hospital, an authorised doctor (AD) or authorised mental health practitioner (AMHP) must review him within six hours of the order being made. The AD assesses John and decides that he needs to be treated as an inpatient. John does not consent to a further assessment period and so an AD and an AMHP complete a recommendation and request for assessment.

An EEO allows for a person with a mental illness to receive a prompt assessment when they are at significant risk of physical harm to themself or someone else.

Classified patient admissions

The Act contains provisions that allow for the involuntary assessment of a person detained in custody or appearing before a court. A person becomes a classified patient if they are brought to an AMHS from court or custody. The classified patient provisions provide for secure management of the person while they receive assessment and/or treatment.

Three documents must be completed to allow a classified patient to be admitted to an AMHS:

- a recommendation for assessment
- an agreement for assessment
- either a court assessment order, or a custodian's assessment authority.

When these documents have been completed, an AD must assess the patient within three days of their categorisation as a classified patient. The patient can be treated voluntarily if they consent to treatment, or under an ITO, if the treatment criteria listed in Section 14 of the Act are satisfied.

A person's status as a classified patient ends if there are:

- changes to their treatment needs
- the charges against them are finalised, or
- their custodial requirements cease.

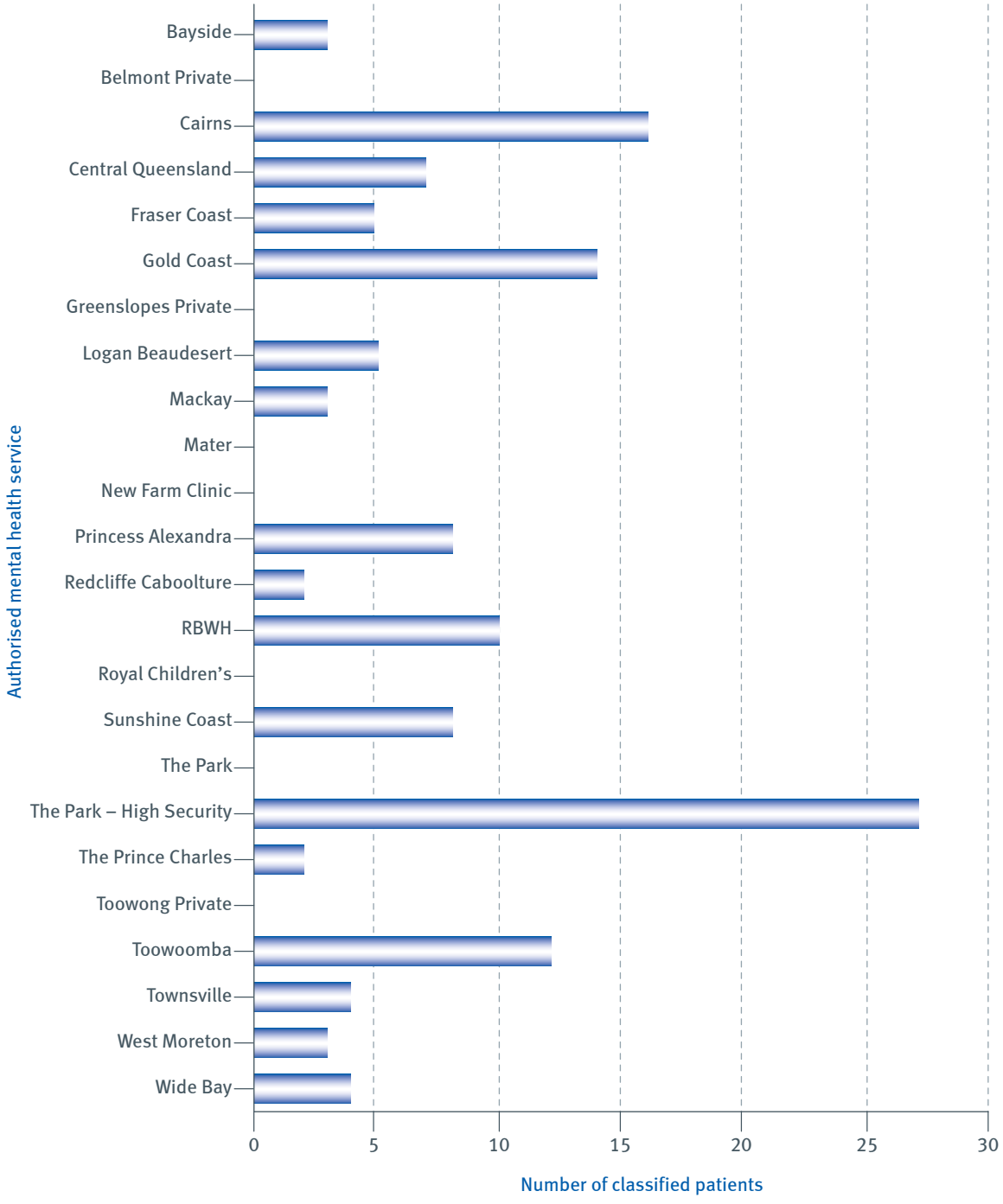
During the reporting period, 133 classified patients were admitted to an AMHS (see Table 6 and Figure 4). Of these, 100 were transferred from a correctional centre; 29 were transferred from a watchhouse; and four were transferred from court. These figures represent an 11 per cent decrease in the number of classified patients since 2009–10, when the total was 150.

Table 6 Classified patient admissions 2010–11

Authorised mental health service *	Total	Court		Watchhouse		Queensland Correctional centres	
Bayside	3	0	0%	0	0%	3	100%
Belmont Private	0	0	0%	0	0%	0	0%
Cairns	16	1	6%	3	19%	12	75%
Central Queensland	7	0	0%	1	14%	6	86%
Fraser Coast	5	0	0%	2	40%	3	60%
Gold Coast	14	0	0%	7	50%	7	50%
Greenslopes Private	0	0	0%	0	0%	0	0%
Logan Beaudesert	5	0	0%	1	20%	4	80%
Mackay	3	0	0%	2	67%	1	33%
Mater	0	0	0%	0	0%	0	0%
New Farm Clinic	0	0	0%	0	0%	0	0%
Princess Alexandra	8	1	12%	0	0%	7	88%
Redcliffe Caboolture	2	0	0%	0	0%	2	100%
RBWH	10	0	0%	1	10%	9	90%
Royal Children's	0	0	0%	0	0%	0	0%
Sunshine Coast	8	0	0%	4	50%	4	50%
The Park	0	0	0%	0	0%	0	0%
The Park - High Security	27	1	4%	0	0%	26	96%
The Prince Charles	2	0	0%	0	0%	2	100%
Toowong Private	0	0	0%	0	0%	0	0%
Toowoomba	12	0	0%	4	33%	8	67%
Townsville	4	1	25%	2	50%	1	25%
West Moreton	3	0	0%	1	33%	2	67%
Wide Bay	4	0	0%	1	25%	3	75%
Totals	**133**	**4**	**3%**	**29**	**22%**	**100**	**75%**

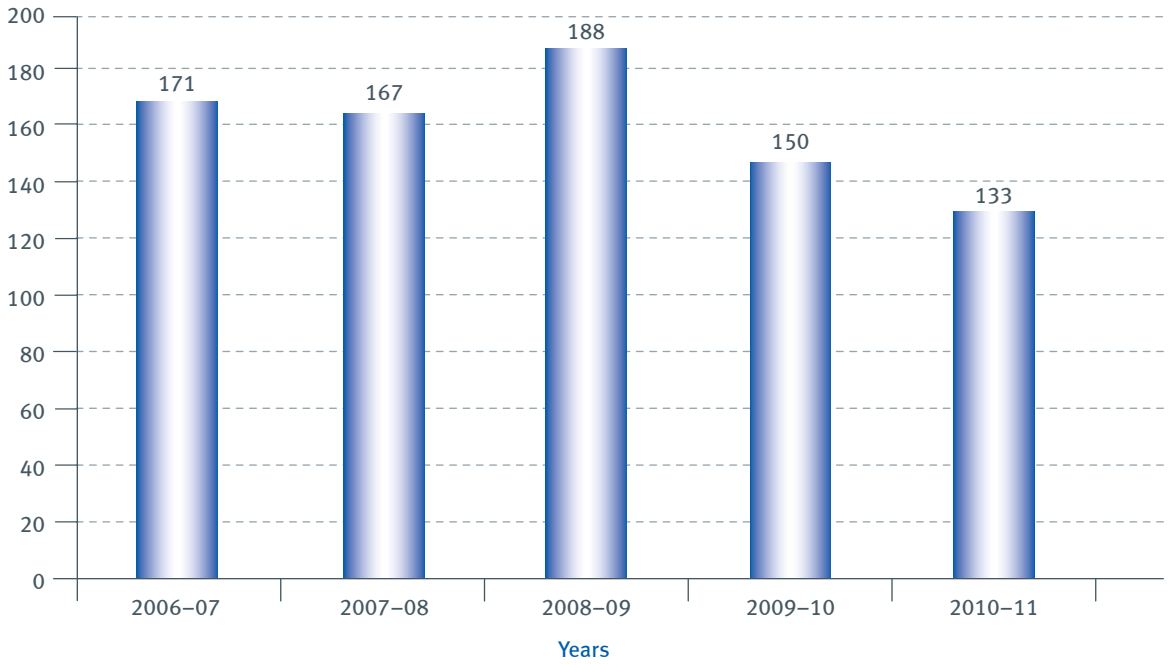
* See Appendix 4 for full AMHS title

Figure 4 Total number of classified patient admissions by authorised mental health service 2010–11



Graph 4 represents the number of classified patient admissions made per year over a five-year reporting period and demonstrates a 22 per cent decrease from 2006–07 to 2010–11.

Graph 4 Classified patient admissions over a five-year reporting period



Case study: classified patient

Patrick is currently a remand prisoner and has been in prison for two months awaiting his court hearing. He was remanded following an incident in the community where he allegedly assaulted and robbed a shop attendant.

Over the past few weeks, prison officers have become concerned about his mental health and have reported these concerns to the Prison Mental Health Service (PMHS). The PMHS is a consultation and liaison clinical service that provides mental health advice, assessments and referral for people with identified mental health needs who are detained in custody. This service can recommend that people with mental health needs are diverted to a mental health service for assessment and/or treatment.

An authorised psychiatrist (AP) and authorised mental health practitioner (AMHP) from the PMHS review Patrick. They determine that he is experiencing a serious mental illness and recommend that he be taken to an authorised mental health service (AMHS), where he can be assessed and treated according to his mental health needs in a secure environment.

The AP completes a recommendation for assessment and organises for Patrick to be admitted to the AMHS closest to his home address. After receipt of an agreement for assessment from the local AMHS, the prison completes a custodian's assessment authority and Patrick is transported by prison officers to the AMHS.

On arrival at the AMHS, Patrick becomes a classified patient and is assessed by an AD. As a classified patient, Patrick is able to receive care for his mental illness and his charges are suspended until his classified patient status ceases.

Patient information orders

People who are victims of an offence committed by a classified patient may apply to the Director to receive certain information about the detention of that classified patient. After reviewing the application the Director may make a classified patient information order (CPIO) which enables information to be provided to the victim. A parallel scheme exists for forensic patients, enabling victims or other interested persons to apply to the Mental Health Review Tribunal (the Tribunal) for a forensic patient information order (FPIO). In the 2011–12 reporting period, amendments made to the Act will enable victims to apply for information orders in relation to forensic disability patients. FPIOs will then be known as forensic information orders (FIO).

The Director administers the victim information registers for classified and forensic patients and is responsible for providing information to registered persons. The system allows victims to receive certain information about a patient's status under the Act which is relevant to their safety and well-being. This includes information about: the patient's absence without approval; transfer to another AMHS; or approval to undertake limited community treatment. In practice, information is provided to holders of information orders through the Queensland Health Victim Support Service (QHVSS). The QHVSS provides support, information and referral for victims of offences by people with a mental illness.

As at 30 June 2011 there were:

- 4 classified patients with CPIOs, and
- 80 forensic patients with FPIOs.

The Director is responsible for determining CPIO applications. In the 2010-11 reporting period, the Director approved 4 CPIOs, which is consistent with the previous period.

The Tribunal is responsible for determining FPIO applications. In the 2010-11 reporting period, the Tribunal approved 18 FPIOs.

Case study: patient information orders

Mark has mild to moderate mental retardation and was diagnosed in 2003 with acute paranoid schizophrenia. Mark's professional carer is James, who works for a charity providing assistance to intellectually disabled people living in the community. Mark has poor impulse control and damages James' work car during an outing. James tells Mark their outing is over and he is taking him home. Mark hits James, rendering him unconscious. James is taken to hospital and dies after failing to regain consciousness. Mark is charged with murder and arrested by the police. While he is in the watchhouse, police become concerned about his mental health. He is taken to an authorised mental health service (AMHS) to be assessed. On arrival, Mark's legal status changes from that of a prisoner to a classified patient. The assessment team at the AMHS decides that he requires in patient treatment to stabilise his mental health. While he is a patient, Mark's murder charge is automatically suspended under the *Mental Health Act 2000* (the Act) and his criminal case remains suspended until his classified patient status ceases. The arresting officer refers James' parents, Susan and Carl, to the Queensland Health Victim Support Service (QHVSS) for support.

A QHVSS coordinator explains the mental health and criminal law systems to Susan and Carl and helps them apply to the Director of Mental Health (the Director) for a classified patient information order (CPIO). Such an order will enable them to receive some information about Mark's detention and treatment regime while in the AMHS. The strict confidentiality requirements attached to an order are also explained and that the CPIO might be revoked if James' parents publicly disclose information about Mark's detention.

Susan and Carl decide that receiving some information and knowing that Mark is detained and receiving treatment might help them come to terms with James' death.

The Director grants Susan and Carl a CPIO after receiving information from Mark's treating psychiatrist that it is unlikely to seriously harm Mark's health, or place him or anyone else at risk should such information be released.

After two months, Mark is transferred from a high security inpatient facility to another AMHS on the basis of a comprehensive assessment of his treatment needs, including a risk assessment. The Director approves limited community treatment (LCT) of escorted leave which will allow Mark to walk in the grounds of the AMHS as long as he is accompanied by two staff members at all times. Mark's psychiatrist authorises this LCT as he considers that it will assist his recovery and is consistent with the risk management approach to his treatment.

The Director provides James' parents with a formal notice advising them of the transfer and details of his LCT. This notice is sent to the QHVSS, which explains in practical terms to Susan and Carl the changes in Mark's detention.

At the same time, Mark's solicitor is of the opinion that the Mental Health Court (the Court) is the appropriate court to decide if Mark's mental illness was a factor in James' murder and refers his case to the Court. Mark's solicitor also successfully applies for bail. Upon his release from the AMHS, Mark's classified status ceases and Susan and Carl's CPIO is revoked. They are extremely upset about the withdrawal of their information order and concerned that Mark may not be convicted of their son's murder. The QHVSS coordinator explains why they are no longer able to receive information about Mark's detention, but offers to accompany them to the Court hearing if they wish to attend. The QHVSS coordinator also helps them to write a submission to the Court.

The Court decides that Mark was of unsound mind at the time of the offence. The QHVSS coordinator then helps Susan and Carl to apply to the Mental Health Review Tribunal (the Tribunal) for a forensic patient information order (FPIO). Their application is allowed and their FPIO allows the Director to provide information about:

- when the Tribunal is going to carry out a review of Mark's forensic order
- if the forensic order is revoked or confirmed by the Tribunal
- if Mark is approved to move out of Queensland
- if Mark is transferred between AMHSs or to a similar interstate service
- if he is given LCT or this is revoked
- LCT conditions relevant to Susan and Carl's safety and well-being
- if Mark is absent without permission or is returned.

Overview of examination and assessment activity

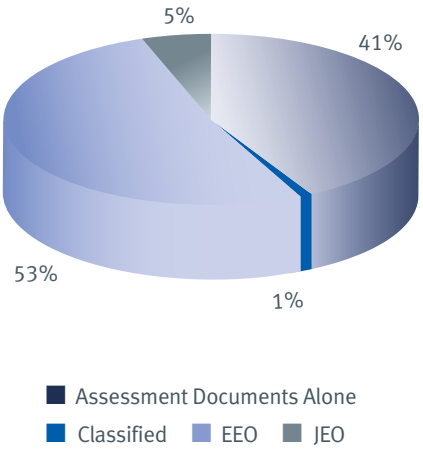
The preceding sections have focused on the involuntary examination and assessment processes under the Act and associated activity during the reporting period of 2010–11.

In summary, there are four avenues to commence the involuntary examination and assessment processes. These are:

- assessment documents alone (request for assessment and recommendation for assessment)
- JEO preceding the assessment documents
- EEO preceding the assessment documents
- the classified patient process for patients in custody or before a court.

Figure 5 below displays the percentage of activity of the four involuntary examination and assessment provisions. These percentages are comparable to those of the previous reporting period.

Figure 5 Breakdown of involuntary examination and assessment processes 2010–11



Involuntary treatment orders

An ITO authorises treatment of a person's mental illness without the person's consent. Under an ITO, a patient can receive treatment as an inpatient or in the community.

The Act allows an AD to make an ITO for a patient who is subject to involuntary assessment, or for a classified patient. In making an ITO, the AD must be satisfied that all six treatment criteria in Section 14 of the Act are met.

As a safeguard, a second examination by a psychiatrist is required if the AD making the ITO is not a psychiatrist, or if the initial examination was conducted by audio-visual link. If a second examination is required, it must be conducted within three days of the first examination. At the second examination, the psychiatrist must either confirm or revoke the ITO, depending on whether the psychiatrist believes that each of the six treatment criteria apply to the patient.

The Act requires that a psychiatrist must regularly review the patient to assess whether the criteria for involuntary treatment continue to apply. If any of the criteria no longer apply, the ITO must be revoked.

Patients subject to an ITO must also be regularly reviewed by the Tribunal. A patient must be reviewed within the first six weeks of making the order and thereafter at intervals of no longer than six months. Patients can also apply for review within these statutory time frames. When reviewing the patient's ITO, the Tribunal must also consider whether the treatment criteria continue to apply and confirm or revoke the order accordingly.

The Act requires that an ITO be revoked when the patient does not receive treatment for six months or when a forensic order is made.

The total number of ITOs and the means by which they are made is set out in Table 7.

A total of 5331 ITOs were made in 2010–11. This represents a slight increase (two per cent) in the total number of ITOs from the 2009–10 reporting period. The majority of ITOs, 5246 (98 per cent), were initiated as inpatient category as opposed to community category. This figure is consistent with figures from the previous reporting period.

Of the 5331 ITOs made, 3732 (70 per cent) required a second examination, of which 2814 (75 per cent) were confirmed and 918 (25 per cent) were revoked.

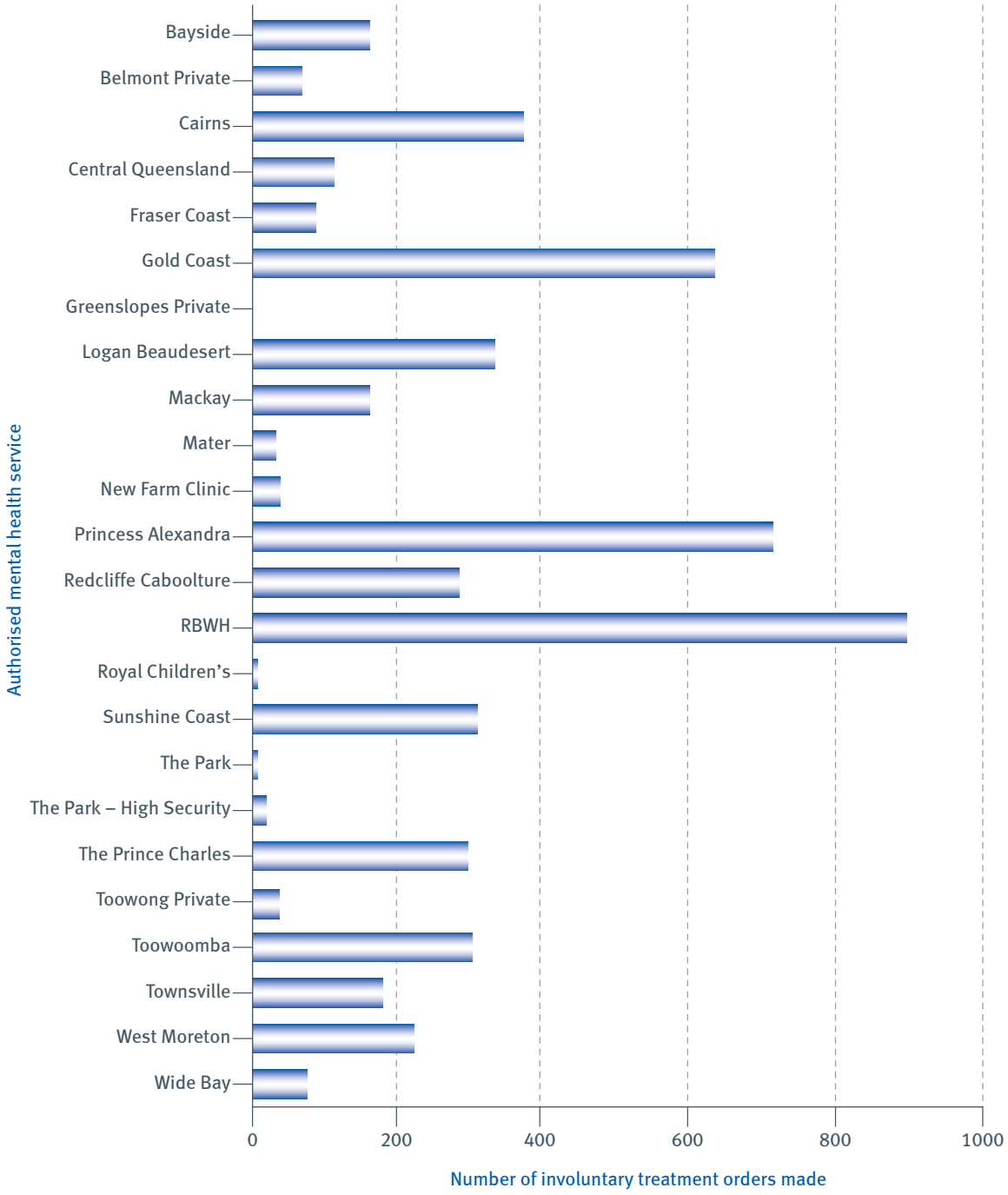
Table 7 Involuntary treatment orders made 2010–11

Authorised mental health service*	Total ITO made	Category of initial order				Second examination required		Second examination details			
		Inpatient		Community				ITO confirmed		ITO not confirmed	
Bayside	160	154	96%	6	4%	96	60%	78	81%	18	19%
Belmont Private	68	68	100%	0	0%	6	9%	6	100%	0	0%
Cairns	370	363	98%	7	2%	216	58%	184	85%	32	15%
Central Queensland	111	108	97%	3	3%	81	73%	69	85%	12	15%
Fraser Coast	89	84	94%	5	6%	54	61%	41	76%	13	24%
Gold Coast	636	627	99%	9	1%	493	78%	386	78%	107	22%
Greenslopes Private	2	2	100%	0	0%	0	0%	0	0%	0	0%
Logan Beaudesert	330	322	98%	8	2%	240	73%	181	75%	59	25%
Mackay	159	155	97%	4	3%	54	34%	38	70%	16	30%
Mater	33	33	100%	0	0%	12	36%	9	75%	3	25%
New Farm Clinic	38	36	95%	2	5%	10	26%	10	100%	0	0%
Princess Alexandra	712	698	98%	14	2%	542	76%	420	77%	122	23%
Redcliffe Caboolture	285	283	99%	2	1%	216	76%	124	57%	92	43%
RBWH	896	893	100%	3	0%	800	89%	554	69%	246	31%
Royal Children's	6	6	100%	0	0%	3	50%	2	67%	1	33%
Sunshine Coast	307	294	96%	13	4%	215	70%	160	74%	55	26%
The Park	5	5	100%	0	0%	2	40%	2	100%	0	0%
The Park - High Security	18	18	100%	0	0%	11	61%	11	100%	0	0%
The Prince Charles	299	295	99%	4	1%	236	79%	178	75%	58	25%
Toowong Private	33	32	97%	1	3%	5	15%	5	100%	0	0%
Toowoomba	302	302	100%	0	0%	174	58%	139	80%	35	20%
Townsville	177	175	99%	2	1%	75	42%	65	87%	10	13%
West Moreton	222	222	100%	0	0%	149	67%	121	81%	28	19%
Wide Bay	73	71	97%	2	3%	42	58%	31	74%	11	26%
Total	**5331**	**5246**	**98%**	**85**	**2%**	**3732**	**70%**	**2814**	**75%**	**918**	**25%**

* See Appendix 4 for full AMHS title

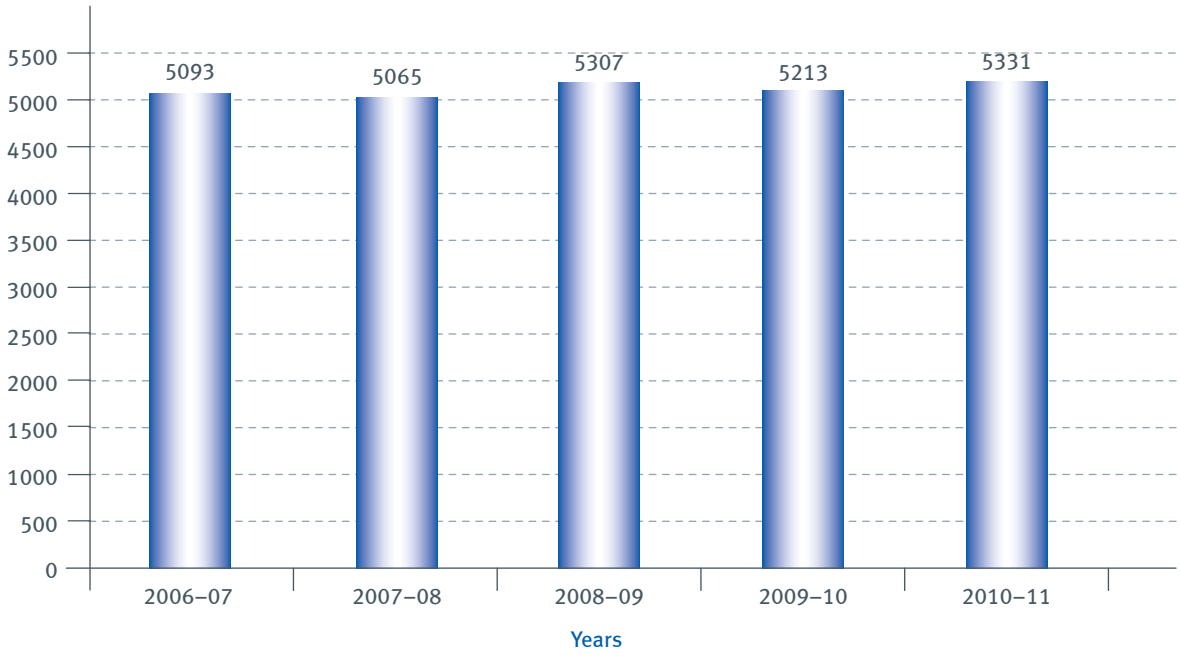
Figure 6 is a graphical representation of the total number of ITOs per AMHS in the reporting period.

Figure 6 Total number of involuntary treatment orders made by authorised mental health service 2010–11



Graph 5 represents the total number of ITOs made per year over the five-year period from 2006–07 to 2010–11.

Graph 5 Involuntary treatment orders made over a five-year reporting period



There are seven situations in which an ITO can be ended. These situations are as follows:

- the ITO was revoked by an AD, the Tribunal or the Court
- the ITO ceased to have effect (as the person did not receive involuntary treatment for a period of at least six months)
- a forensic order was made
- an ITO already exists (the person had been made subject to ITO on a previous occasion and is receiving treatment under that ITO)
- the person is transferred interstate
- the patient is deceased, or
- the ITO is neither revoked nor confirmed in the assessment period.

The number of ITOs ending in the reporting period and the way in which they were ended is detailed in Table 8.

A total of 5128 ITOs ended in the reporting period. Of these, 4665 (91 per cent) were revoked (either by an AD, the Tribunal or through an appeal to the Court). This trend is consistent with previous years.

A total of 61 (one per cent) ITOs ended because the patient did not receive treatment within a six-month period, resulting in the order automatically ceasing to have effect. This outcome is generally the result of a patient being absent without permission (AWOP) for an extended period.

A total of 72 ITOs ended when a forensic order was made by the Court.

A total of 31 patients were already subject to an ITO when a subsequent order was made. This situation can arise from a patient's use of an alias, or if a patient is already receiving treatment at another AMHS.

During the reporting period, 260 (five per cent) ITOs ended because they either did not receive a required second examination, or the ITO was not confirmed or revoked within the maximum period of 72 hours allowed for examination and assessment.

Table 8 Involuntary treatment orders ended 2010–11

Authorised mental health service*	Total	ITO revoked by authorised doctor, the Tribunal or the Court**		ITO ceased to have effect		Forensic Order made		ITO already exists		Transferred Inter-state		Patient deceased		ITO neither revoked or confirmed within the assessment period	
Bayside	162	155	96%	1	1%	2	1%	0	0%	0	0%	0	0%	4	2%
Belmont Private	88	88	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Cairns	345	313	91%	1	0%	9	3%	5	1%	0	0%	4	1%	13	4%
Central Queensland	118	112	95%	1	1%	2	2%	0	0%	0	0%	1	1%	2	2%
Fraser Coast	86	82	95%	0	0%	2	2%	0	0%	0	0%	0	0%	2	2%
Gold Coast	577	517	90%	9	2%	7	1%	1	0%	0	0%	7	1%	36	6%
Greenslopes Private	3	3	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Logan Beaudesert	314	281	89%	0	0%	0	0%	4	1%	0	0%	1	0%	28	9%
Mackay	156	145	93%	4	3%	2	1%	2	1%	0	0%	2	1%	1	1%
Mater	33	29	88%	0	0%	0	0%	0	0%	0	0%	0	0%	4	12%
New Farm Clinic	53	49	92%	0	0%	0	0%	2	4%	0	0%	0	0%	2	4%
Princess Alexandra	702	638	91%	6	1%	9	1%	7	1%	1	0%	1	0%	40	6%
Redcliffe Caboolture	267	241	90%	1	0%	2	1%	4	1%	0	0%	1	0%	18	7%
RBWH	662	584	88%	21	3%	4	1%	5	1%	0	0%	5	1%	43	6%
Royal Children's	10	10	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Sunshine Coast	297	272	92%	6	2%	3	1%	0	0%	0	0%	1	0%	15	5%
The Park	20	16	80%	0	0%	1	5%	2	10%	0	0%	0	0%	1	5%
The Park - High Security	15	9	60%	0	0%	4	27%	0	0%	1	0%	0	0%	1	7%
The Prince Charles	338	299	88%	6	2%	7	2%	2	1%	0	0%	3	1%	21	6%
Toowong Private	49	49	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Toowoomba	300	281	94%	1	0%	6	2%	1	0%	1	0%	1	0%	9	3%
Townsville	188	168	89%	2	1%	6	3%	0	0%	0	0%	2	1%	10	5%
West Moreton	269	253	94%	0	0%	5	2%	1	0%	0	0%	0	0%	10	4%
Wide Bay	76	71	93%	2	3%	1	1%	0	0%	0	0%	2	3%	0	0%
Total	**5128**	**4665**	**91%**	**61**	**1%**	**72**	**1%**	**36**	**1%**	**3**	**0%**	**31**	**1%**	**260**	**5%**

* See Appendix 4 for full AMHS title

** The Tribunal – Mental Health Review Tribunal, The Court – Mental Health Court

A total of 30 patients (one per cent) under an ITO died during the reporting period. Any death of a patient in a mental health service is reviewed by a number of mechanisms. An inpatient death is immediately reported to the Coroner by the treating team. Any suspected suicide or unexplained death of a patient in the community is a reportable death under the *Coroners Act 2003* and is referred to the Coroner by the Queensland Police Service or the treating team. The treating team also reports the death to the Queensland Health Patient Safety and Quality Improvement Centre (PSQIC). A report to the PSQIC is made through a reportable incident brief. The Director is also notified by way of a mortality report form.

Forensic orders

The Act contains provisions for making a forensic order. Forensic orders are usually made by the Court following a finding that the person was of unsound mind or unfit for trial. A person on a forensic order is a forensic patient under the Act.

Activity relating to forensic orders for the reporting period is represented in Table 9. Figure 7 is a graphical representation of the number of forensic orders made in respect of each AMHS in the reporting period. The total number of forensic orders made during 2010–11 was 134, which was 12 more than 2009–10, representing a 10 per cent increase.

However, the number of patients on forensic orders as at 30 June 2011 was 693 which represents an eight per cent increase from the previous year (640).

A special sub-category of forensic order was created in 2008 in line with recommendations of the Butler Report. The special notification forensic patient (SNFP) category refers to patients who have been charged with unlawful homicide, attempted murder, dangerous operation of a motor vehicle involving the death of another person, rape and assault with the intent to commit rape. As at 30 June 2011, there was a total of 133 SNFPs in Queensland compared to 125 in 2009–10, representing a six per cent increase from the previous reporting period.

Amendments to the Mental Health Act in the *Forensic Disability Act 2011* provide that from 1 July 2011, the Court will have the option of making a new type of forensic order for people with an intellectual or cognitive disability. A forensic order (Mental Health Court – Disability) will authorise that an individual be managed by the forensic disability service at Wacol administered by the Department of Communities or an AMHS. A disability forensic order enables a person to receive care appropriate to their individual needs, including rehabilitation, habilitation, support and other services. From the next reporting period, the Director will report on the administration of disability forensic orders as they apply to people in AMHSs.

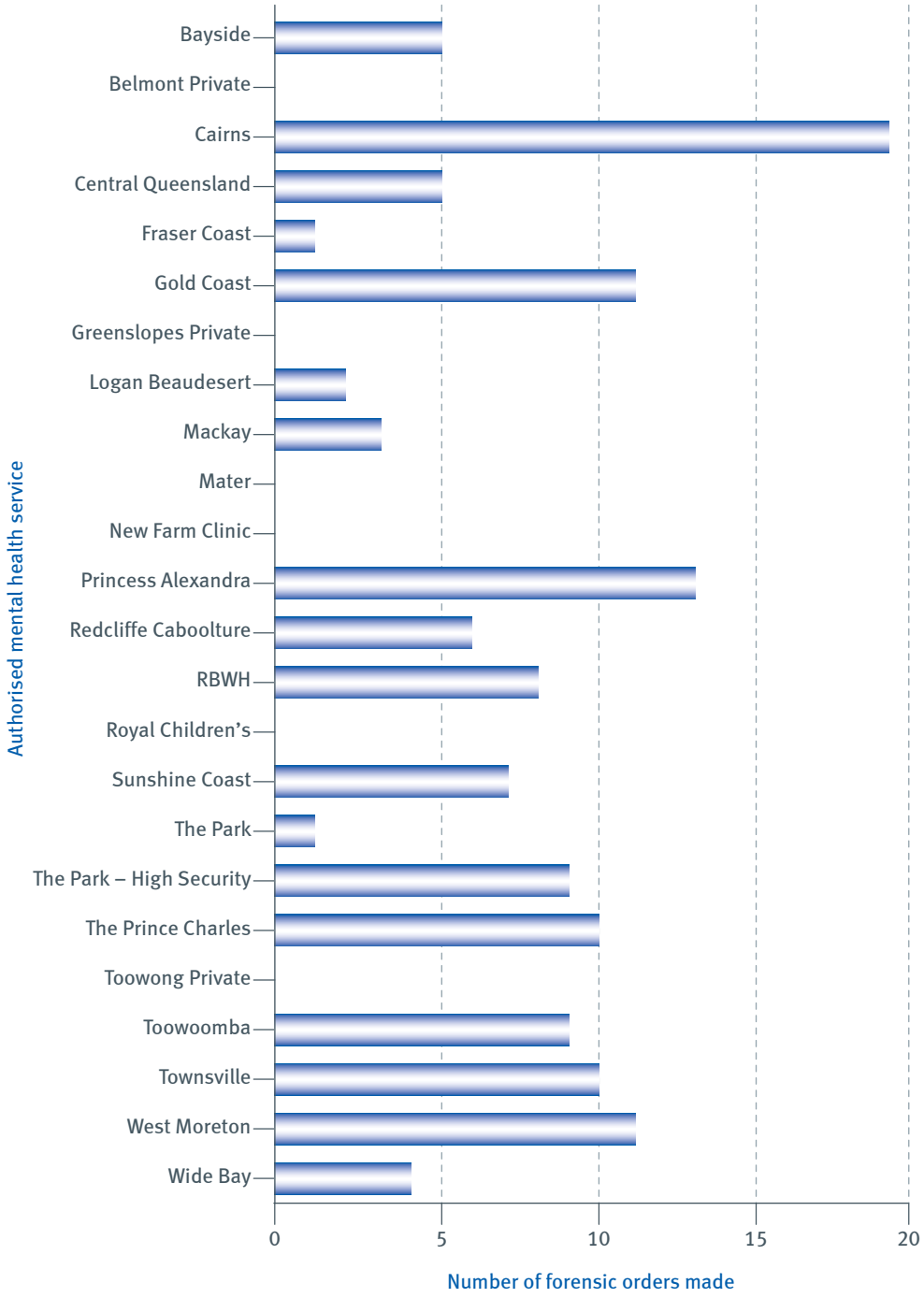
Table 9 Forensic orders made and ended in 2010–11 and number of forensic orders and special notification forensic patients (SNFP) at 30 June 2011

Authorised mental health service*	Forensic orders made	Forensic order ended	Number of patients with forensic orders at 30 June 2011	Number of SNFPs at 30 June 2011**
Bayside	5	2	20	4
Belmont Private	0	0	0	0
Cairns	19	9	41	5
Central Queensland	5	1	23	1
Fraser Coast	1	0	12	0
Gold Coast	11	8	55	10
Greenslopes Private	0	0	0	0
Logan Beaudesert	2	1	42	5
Mackay	3	3	10	2
Mater	0	0	1	0
New Farm Clinic	0	0	0	0
Princess Alexandra	13	10	64	13
Redcliffe Caboolture	6	5	24	3
RBWH	8	7	52	6
Royal Children's	0	0	0	0
Sunshine Coast	7	5	32	1
The Park	1	0	34	5
The Park - High Security	9	2	50	39
The Prince Charles	10	7	49	13
Toowong Private	0	0	0	0
Toowoomba	9	6	61	10
Townsville	10	5	57	9
West Moreton	11	2	53	7
Wide Bay	4	2	13	0
Total	**134**	**75**	**693**	**133**

* See Appendix 4 for full AMHS title

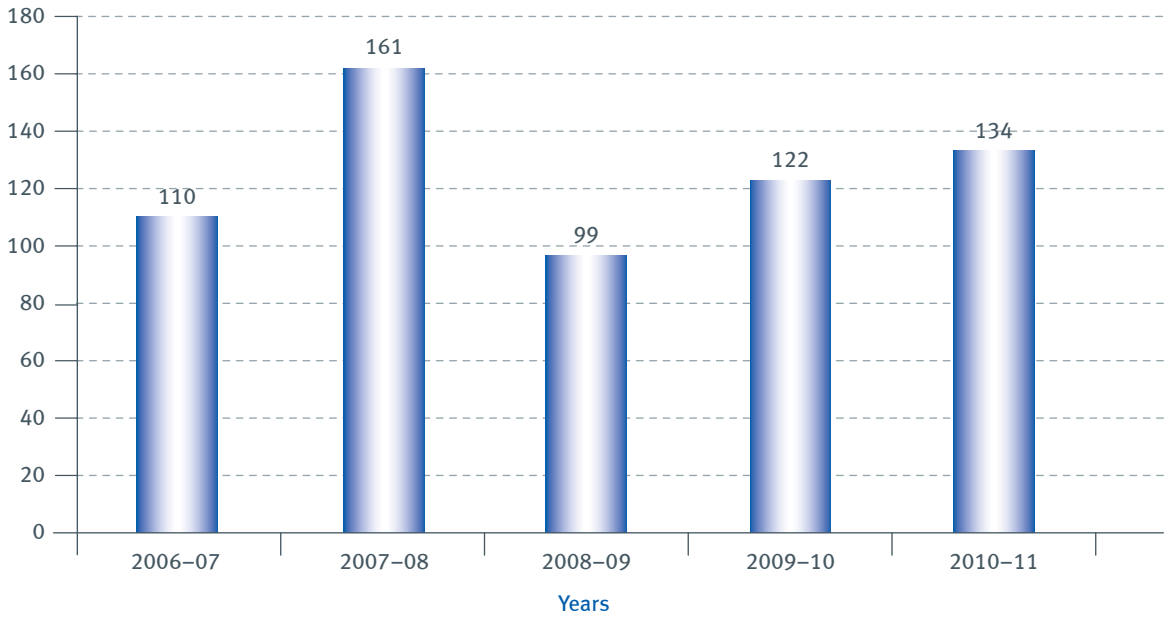
** Patients represented in this column are also in Column Four, 'total number of patients with forensic orders as at 30 June 2011'.

Figure 7 Total number of forensic orders made by authorised mental health service 2010–11



Graph 6 represents the total number of forensic orders made over the five-year reporting period from 2006–07 to 2010–11.

Graph 6 Forensic orders made over a five-year reporting period



The increased activity with respect to forensic orders made in 2007–08 is attributed to a higher number of Court sittings in this reporting period which resulted in the clearing of a backlog of cases and issuing a higher number of forensic orders following recommendations made in the Butler Report.

Overview of involuntary status

Figure 8 and Table 10 provide a summary of patients with involuntary status as at 30 June 2011. The percentage breakdown of involuntary status remains largely unchanged from previous years.

However, there has been an overall increase of six percent in the number of involuntary patients as at the end of the reporting period from 2009-10 to 2010-11. This increase is consistent across all streams, with the exception of forensic patients.

Figure 8 Breakdown of involuntary status as at 30 June 2011

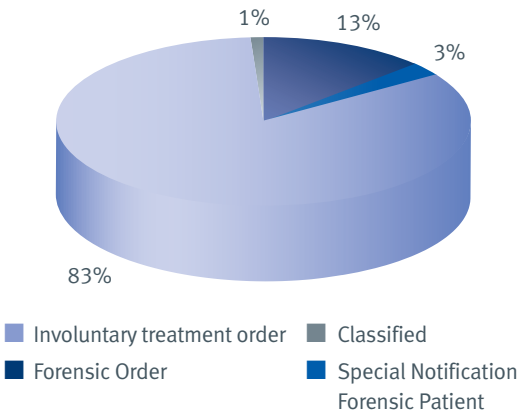


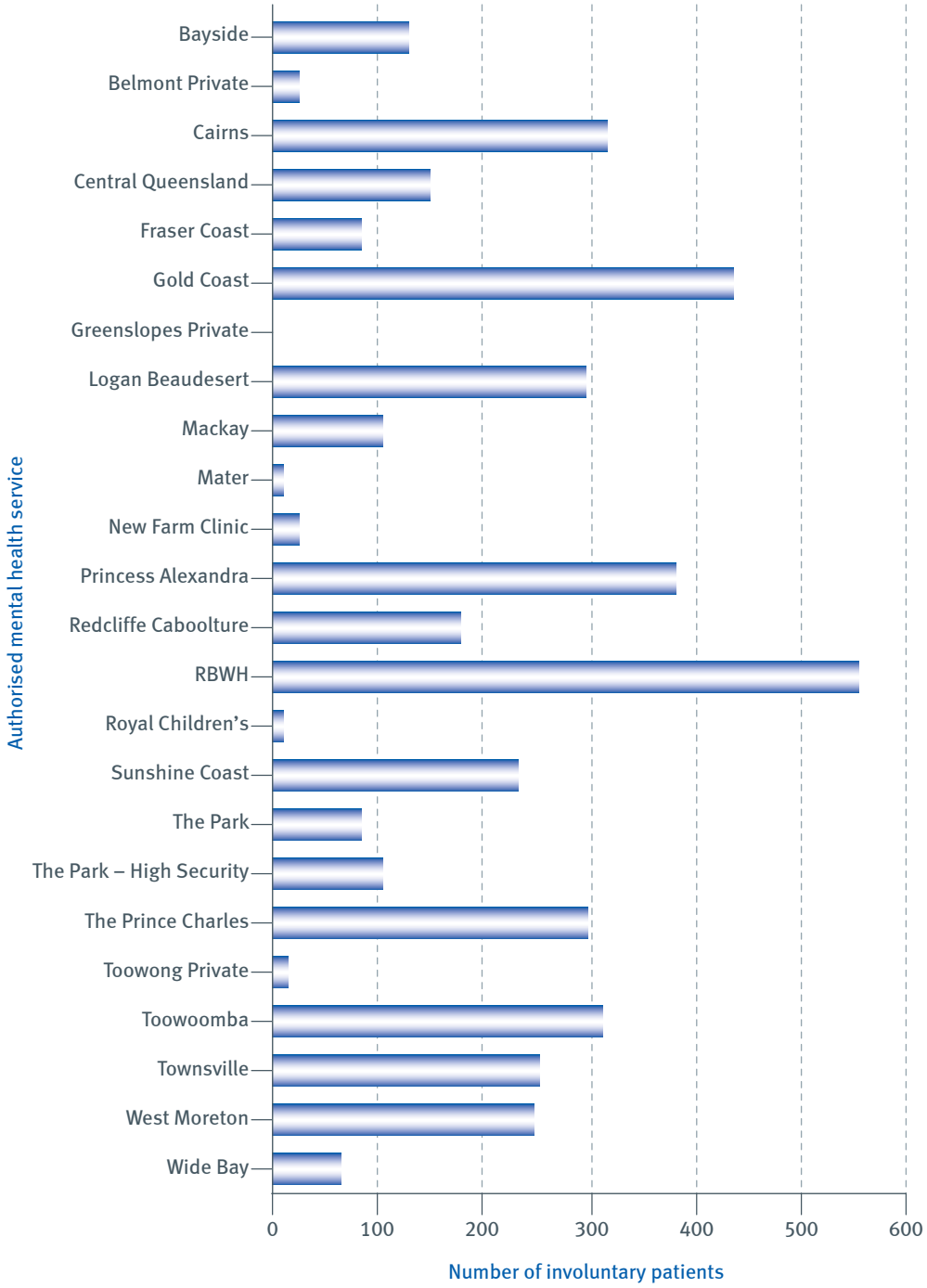
Table 10 Number of involuntary patients as at 30 June 2011

Authorised mental health service*	Involuntary treatment orders	Classified patients	Forensic Orders – not including special notification forensic patient	Forensic Orders – special notification forensic patient only	Total
Bayside	102	1	17	4	124
Belmont Private	23	0	0	0	23
Cairns	272	2	36	5	315
Central Queensland	120	1	22	1	144
Fraser Coast	68	0	12	0	80
Gold Coast	378	2	46	10	436
Greenslopes Private	1	0	0	0	1
Logan Beaudesert	252	0	37	5	294
Mackay	93	0	8	2	103
Mater	6	0	1	0	7
New Farm Clinic	22	0	0	0	22
Princess Alexandra	312	2	51	13	378
Redcliffe Caboolture	149	1	21	3	174
RBWH	504	0	46	6	556
Royal Children's	8	0	0	0	8
Sunshine Coast	196	2	31	1	230
The Park	44	1	29	5	79
The Park - High Security	34	12	14	39	99
The Prince Charles	248	0	36	13	297
Toowong Private	12	0	0	0	12
Toowoomba	243	4	51	10	308
Townsville	189	2	49	9	249
West Moreton	194	0	46	7	247
Wide Bay	49	0	13	0	62
Total	**3519**	**30**	**566**	**133**	**4248**

* See Appendix 4 for full AMHS title

Figure 9 is a graphical representation of the total number of involuntary patients by AMHS as at 30 June 2011.

Figure 9 Total number of involuntary patients treated by authorised mental health service as at 30 June 2011



Patients charged with an offence

When a person who is subject to an ITO or a forensic order is charged with an offence, their status under the Act changes in accordance with the provisions outlined in Chapter 7, Part 2. These provisions ensure that if a patient under the Act is charged with an offence, due consideration is given to establishing culpability and fitness for trial. To help decide on culpability, the Act provides that a psychiatrist must examine a patient to prepare a report referred to as a Section 238 report. The administrator of the AMHS responsible for the patient's treatment must provide the Section 238 report to the Director within 21 days of the notice – Confirmation of application of Chapter 7, Part 2.

Table 11 identifies actions taken in accordance with Chapter 7, Part 2 of the Act for the 2010–11 reporting period. This table shows that these provisions applied to 838 patients. This figure represents no change from the previous reporting period.

Often a patient will come under these provisions on more than one occasion. This is reflected in the difference between the number of patients under the provisions (838) and the number of occasions in which activity under these provisions commenced (1243) as outlined in Table 11.

Table 11 Actions taken under Chapter 7, Part 2 (patients charged with an offence) 2010–11

Authorised mental health service*	Number of patients where Chapter 7 provisions were commenced	Number of occasions in which activity under the Chapter 7 provisions commenced
Bayside	15	20
Belmont Private	0	0
Cairns	83	114
Central Queensland	44	58
Fraser Coast	14	15
Gold Coast	83	104
Greenslopes Private	0	0
Logan Beaudesert	42	65
Mackay	20	24
Mater	0	0
New Farm Clinic	1	1
Princess Alexandra	84	131
Redcliffe Caboolture	51	79
RBWH	111	225
Royal Children's	0	0
Sunshine Coast	35	44
The Park	7	8
The Park - High Security	20	24
The Prince Charles	45	72
Toowong Private	1	1
Toowoomba	51	70
Townsville	64	88
West Moreton	51	83
Wide Bay	16	17
Total	**838**	**1243**

* See Appendix 4 for full AMHS title

On receiving the Section 238 report, the Director is required to provide the report to the Office of the Director of Public Prosecutions (DPP) or the Court within 14 days. The Director may elect to defer the referral on the grounds that the patient is temporarily unfit for trial and to enable a determination to be made about whether to continue legal proceedings.

Matters which the Director refers to the DPP are:

- offences the Director considers not to be of a serious nature, or
- offences of a serious nature where the psychiatrist reports the person was not of unsound mind at the time of the offence and is fit for trial.

The matters referred to the Court must relate to indictable offences only.

During 2010–11, the Director referred 905 matters, which represents a slight decrease of one per cent from 2009–10 (911). Of these references, 766 referrals were made to the DPP which represents a decrease of four per cent from 2009–10 (798). The remaining 139 matters were referred to the Court which was an increase of 23 per cent from 2009–10 (113).

Table 12 details all referrals made by the Director to the DPP and the Court for the reporting period 2010–11.

There has been a 49 per cent increase in the total number of referrals made by the Director since the 2006–07 reporting period (609 in 2006–07 to 905 in 2010–11).

Table 12 Referrals made by the Director 2010–11

Authorised mental health service*	Number of Chapter 7 referrals to the DPP	Number of Chapter 7 referrals to the Mental Health Court	Total number of referrals made by the Director of Mental Health
Bayside	20	2	22
Belmont Private	0	0	0
Cairns	82	23	105
Central Queensland	29	7	36
Fraser Coast	16	0	16
Gold Coast	57	11	68
Greenslopes Private	0	0	0
Logan Beaudesert	46	8	54
Mackay	16	7	23
Mater	0	0	0
New Farm Clinic	1	0	1
Princess Alexandra	81	16	97
Redcliffe Caboolture	49	7	56
RBWH	96	19	115
Royal Children's	0	0	0
Sunshine Coast	44	3	47
The Park	6	0	6
The Park - High Security	11	11	22
The Prince Charles	45	8	53
Toowong Private	1	0	1
Toowoomba	54	3	57
Townsville	51	5	56
West Moreton	51	6	57
Wide Bay	10	3	13
Total	**766**	**139**	**905**

* See Appendix 4 for full AMHS title

An analysis of the data has shown that there has been a 110 per cent increase in the number of referrals made to the Attorney-General and subsequently the DPP over this five-year period. The greater number of referrals being made to the DPP since the 2008–09 reporting period has been attributed to the implementation of a recommendation from the Butler Report and subsequent amendments to the Act enacted on 28 February 2008, which increased the scope of the decisions that could be made by the DPP.

The Butler Report highlighted long-standing concerns about compliance with the statutory timeframe of 21 days for the administrator of an AMHS to provide a Section 238 report to the Director. The Director cannot make a reference to the DPP or the Court until the Section 238 report is completed to the standard required under the Act. Delays in receiving Section 238 reports increase delays in court processes and consequently can have adverse impact on patients, families and victims.

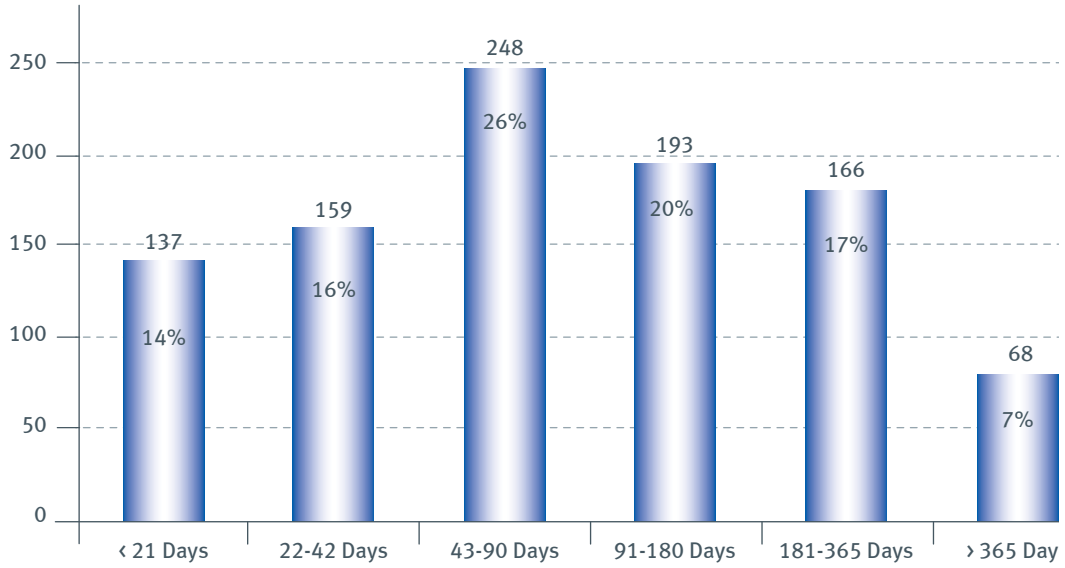
Since the Butler Report, the Director has improved the system for providing monthly reports to administrators of AMHS on overdue Section 238 reports with a requirement that they report back on reasons for the delays.

There are many reasons for delays in providing these reports which include:

- the time required to prepare reports particularly in relation to serious offences and where there is a complex relationship between the patient's mental illness and their offending behaviour
- delays in receiving material from other agencies, particularly in relation to serious offences
- the patient may be too unwell to be interviewed for an extended period of time
- the patient may be AWOP for a lengthy period or may not comply with scheduled appointments.

Figure 10 provides a breakdown of timeframes for the receipt of Section 238 reports in 2010–11 from under the statutory timeframe of 21 days to more than 365 days. This graph demonstrates that 30 per cent of reports are received in the period of up to 42 days from request by the Director, while 56 per cent are received by 90 days from the request. Only a small number of reports (seven per cent) are received more than 365 days after the request. However, they have a significant statistical effect on both the average and median time for receipt of the reports.

Figure 10 Timeframes for receipt of Section 238 reports 2010–11



There are also challenges in compliance with the 14-day timeframe for the Director to refer a matter to the DPP or Court. These can be caused by multiple factors, including the need to obtain further information to ensure that the report meets the statutory requirements.

Table 13 indicates that in the 2010–11 reporting period, there was an average of 17 days for matters to be referred to the DPP, and an average of 19 days for matters to be referred to the Court. These figures represent an increase from 2009–10, in which the average number of days for matters to be referred to the DPP was 14, and there was an average of 12 days for matters to be referred to the Court.

The Director continues to work closely with the Queensland Police Service and the DPP to facilitate and improve processes for obtaining material required to complete Section 238 reports and make references to the DPP or the Court.

Table 13 Reference timeframes for Section 238 reports received by the Director of Mental Health 2010–11

Referenced to	Average length in days	Median in days
Director of Public Prosecutions	17	6
Mental Health Court	19	7
Average	**18**	**6.5**

Case study: Section 238 report

Henry has been charged with common assault and armed robbery after he attempted to rob his local convenience store at knife point. Dr Smith, a consultant psychiatrist, is the current treating doctor for Henry, who suffers from a mental illness and is subject to an involuntary treatment order (ITO). The administrator of the authorised mental health service (AMHS) has become aware that Chapter 7, part 2 of the *Mental Health Act 2000* (the Act) may apply to Henry and notifies the Director of Mental Health (the Director).

As Henry is on an ITO, the Director gives notice to the administrator that a psychiatrist must provide a report under Section 238 of the Act. Dr Smith has been requested to assess whether Henry was of unsound mind at the time of the alleged offences and whether he is fit for trial. In order for the Mental Health Court (the Court) to determine that a person was of unsound mind at the time the alleged offences were committed, there must be evidence that a person was lacking at least one of three capacities when the alleged offences were committed. These capacities refer to the person's ability to:

- understand what they were doing
- control their actions
- know that they ought not do the act, or make the omission.

In order to prepare his report, Dr Smith reviews the police material and Henry's clinical file; and interviews Henry to fully assess his mental health and state of mind at the time of the alleged offences. During his examination of Henry, it becomes clear that Henry had stopped taking his medication during the week of the offences and was suffering from paranoid delusions. Dr Smith assesses that Henry was deprived of two of the three capacities. Dr Smith recommends that the charges be referred to the Court for determination.

The administrator provides the Director with the psychiatrist's report within 21 days. The Director then refers Dr Smith's report to the Court who considers the psychiatrist report and the police material. Henry remains on an ITO and additional measures are taken by his treating team to ensure that he continues taking his medications.

The Section 238 report allows the Court to receive the necessary information about a person's mental state at the time of an offence and to determine whether a forensic order should be made.

Patients absent without permission

Part of a patient's treatment can include the authorisation of leave from their treating AMHS. A patient may have limited community treatment (LCT) approved as part of their treatment plan or be granted a temporary absence for compassionate reasons, for example to attend the funeral of a family member.

If a patient is absent without appropriate approval, the Act contains provisions to authorise their return to the AMHS to resume treatment and care. In this instance, an AD may issue an authority to return. Where requested, police provide assistance to the AMHP in returning the patient.

An AWOP status may result from a number of circumstances, including:

- the patient leaves an inpatient facility of an AMHS without the required authority
- the patient is authorised to be in the community (on LCT or on a community category of an ITO), but is required to return to the inpatient facility because of their mental health needs
- the patient is authorised to be in the community (on LCT), but fails to return to an inpatient facility at the conclusion of the authorised leave.

Table 14 sets out the number of patients who were AWOP and the number of authority to returns issued at each AMHS for the reporting period. In summary, AWOP activity has decreased slightly from the previous reporting period with 3102 authority to returns issued to a total of 1692 patients, compared to 3200 authority to returns issued to a total of 1704 patients in 2009-10. The average length of time an authority to return was in force was approximately 7.38 days in the reporting period which is a decrease of 4.62 days over the previous two years.

During the 2009–10 reporting period the office of the Director implemented several changes regarding the management of patients who were AWOP under the Act. These changes were recommended following a review of policy and administrative processes relating to the management of patients who are AWOP. Some of the key changes that resulted from this review included amendments to the Act related forms and the re-printing of the AWOP flipchart in 2010-11.

Table 14 Authority to return activity 2010–11

Authorised mental health service*	Patients	Number of authorities to return issued	Average length of time authority to return in force (days)
Bayside	41	73	4
Belmont Private	10	10	3
Cairns	129	242	6
Central Queensland	58	85	4
Fraser Coast	34	59	9
Gold Coast	159	305	6
Greenslopes Private	0	0	0
Logan Beaudesert	134	226	4
Mackay	59	94	1
Mater	3	3	0
New Farm Clinic	8	13	0
Princess Alexandra	199	517	6
Redcliffe Caboolture	106	151	5
RBWH	260	471	12
Royal Children's	2	2	4
Sunshine Coast	71	111	14
The Park	19	43	1
The Park - High Security	0	0	0
The Prince Charles	124	222	6
Toowong Private	7	8	7
Toowoomba	79	125	10
Townsville	101	182	7
West Moreton	66	123	5
Wide Bay	23	37	16
Total	**1692**	**3102**	**7.38**

* See Appendix 4 for full AMHS title

The AWOP flipchart is intended to provide an easy access step-by-step process for clinicians to follow if a patient is AWOP under the Act. The revised flipchart has been distributed to AMHS across the State. An electronic copy of the amended forms and AWOP flipchart is available on the Queensland Health Electronic Publishing Service (QHEPS).

Seclusion and mechanical restraint

Reducing and, where possible, eliminating the use of seclusion and restraint is one of the four priority areas of the National Safety Priorities in Mental Health: a national plan for reducing harm. To support this priority, seclusion and mechanical restraint activity is monitored by the office of the Director and reported annually.

At present, there is no capacity to electronically register episodes of mechanical restraint, however, it is proposed that in 2011–12 that there will be a statutory obligation imposed upon AMHSs to notify the Director of any episodes of mechanical restraint.

Table 15 sets out the data for 2010-11 from two clinical indicators relating to the use of seclusion. A comparison cannot be made with seclusion data from previous reporting periods, as a new methodology to analyse data relying on information drawn exclusively from CIMHA has been used. This revised methodology will continue to be used in future reports.

Table 15 State-wide clinical indicators for 2010–11

Indicator	2010–11
Seclusion events per 1,000 accrued patient days (acute)	14.0
Proportion of acute inpatient service episodes with at least one seclusion	7.3%
Seclusion events per 1,000 accrued patient days (non-acute)	8.2
Proportion of non-acute inpatient service episodes with at least one seclusion	9.6%

Notes:

- The data source utilised to construct these indicators is different from previous reports and as such there will be variation to data previously reported.
- Compared to previous reports, data has been sourced for both acute and non-acute mental health inpatient units, and now includes data for inpatient units for older persons (aged over 65 years), as well as inpatient units for adults (aged between 18 and 65 years).
- Compared to previous reports, all data is now sourced from CIMHA (the Consumer Integrated Mental Health Application). Data used to measure accrued patient days is broadly comparable to other sources.
- 2010-11 data is indicative.

Use of electroconvulsive therapy

Electroconvulsive therapy (ECT) is a regulated treatment under the Act and may only be performed in a facility which has been authorised by the Director. The authorised facilities in 2010-11 include all AMHSs and those private facilities as set out in Appendix 6.

Private health facilities have the ability to administer ECT if the Director is satisfied that:

- the services provided at the hospital are part of a mental health program approved by the Chief Health Officer and are incorporated into the relevant licence to operate a private health facility; and
- the service has established policies, procedures and quality activities for the administration of ECT which are consistent with the Act; or
- the hospital has demonstrated its preparedness to institute appropriate procedures that ensure ECT is administered in accordance with the requirements of the Act.

It is an offence to perform ECT other than in accordance with the Act. ECT may be performed on a patient (voluntary or involuntary) at an AMHS only if:

- informed consent has been given by the patient, or
- the Tribunal has given approval for the treatment.

A psychiatrist may make a treatment application (electroconvulsive therapy) to the Tribunal if the psychiatrist is satisfied:

- ECT is the most clinically appropriate treatment for the patient having regard to the patient's clinical condition and treatment history, and
- the patient is incapable of giving informed consent to the treatment.

On making the treatment application, the psychiatrist must also ensure the patient and allied person have been informed. The Tribunal must hear and decide the treatment application within a reasonable time after it is made. If the Tribunal decides to approve the application, its decision must state the number of treatments that may be given and the period in which the treatments may be given.

ECT may be performed on an involuntary patient in emergency circumstances without prior approval of the Tribunal if:

- a psychiatrist has made a treatment application to the Tribunal, and
- the psychiatrist and the medical superintendent at the AMHS where the treatment is to be given have certified in writing in a certificate that it is necessary to perform emergency ECT to:
  - save the patient's life, or
  - prevent the patient suffering from irreparable harm.

The psychiatrist must immediately give the Tribunal the treatment application and a copy of the certificate to perform emergency ECT.

During the course of preparing the report it became evident that there are data quality issues with respect to reporting ECT activity. A project will commence in 2011-12 to reconcile ECT data to ensure accurate reporting.

Information on ECT activity can be found in the Mental Health Review Tribunal Annual Report 2010-11.

Case study: electroconvulsive therapy

James suffers from a serious mental illness. He is currently an inpatient following his admission from prison to the inpatient unit of an authorised mental health service (AMHS) under an involuntary treatment order (ITO). However, his mental state continues to deteriorate.

As his mental state deteriorates James becomes mute and non-responsive and he is unwilling to maintain an adequate dietary intake, including fluids. He is diagnosed with severe depression and has to be managed in the psychiatric intensive care unit of the AMHS. The psychiatrist reviews James' file and notes that he has had serious reactions to some medications in the past, but has responded positively to electroconvulsive therapy (ECT).

As James' condition poses a significant risk to himself, the psychiatrist believes that he requires a course of ECT to stabilise his condition. The psychiatrist assesses that James does not have the capacity to consent to ECT due to the marked deterioration in his mental state.

The psychiatrist makes a treatment application (electroconvulsive therapy) to the Mental Health Review Tribunal (the Tribunal). The Tribunal approves the application, taking into account James' lack of capacity to consent to ECT and the clinical team's decision-making process. The Tribunal approves that a certain number of treatments may be given over a specified period of time.

James receives a course of ECT. After receiving this treatment, his mental state improves to the extent that his treating psychiatrist decides that he no longer requires ECT and that he is well enough to return to the prison with ongoing input from the Prison Mental Health Service.

ECT must only be prescribed in accordance with the relevant provisions of the *Mental Health Act 2000*.

Chapter 5

Monitoring and compliance

Audits and compliance

The *Mental Health Act 2000* (the Act) is the legal safeguard governing care for people with severe mental illnesses and protecting their rights. Under the Act, the Director of Mental Health (the Director) is responsible for monitoring and auditing legislative compliance and has established a formal Act audit process.

The audits of compliance with the Act examine whether patient treatment and care is consistent with the requirements of the Act and associated policies issued by the Director. Statutory compliance monitoring and auditing aims to identify processes that are working well and processes that need to be improved.

A rolling audit process has been established to ensure each authorised mental health service (AMHS) is audited against all relevant provisions of the Act. Ten AMHSs were audited in this reporting year. As at the end of reporting period, all AMHSs, including all private sector services, with the exception of Townsville AMHS, have been audited.

The audits are conducted by the audit team within the office of the Director. The Director and Principal Advisor in Psychiatry participate at key points in the audit process and are committed to identifying issues and improving services. All staff involved in the audits are appointed as approved officers by the Director under the Act. This appointment enables AMHS staff to provide auditors with patient information without breaching confidentiality requirements.

The process of engaging key AMHS staff from AMHSs to be part of the audit team has continued this year. This engagement has brought several benefits including:

- professional development for administrator delegates
- increased sharing of good practices in supporting compliance across services
- increasing the capability of services to self-audit
- improvements in networking and relationship building across services and the office of the Director on compliance matters.

The audit process primarily focuses on system issues (how the service manages and implements processes and policy requirements under the Act) not on individual staff performance. The process involves analysis of:

- information system data drawn from the Consumer Integrated Mental Health Application and the Mental Health Review Tribunal
- local policy documents relating to the Act
- consultation with service staff
- review of clinical and administrator files.

The findings of audit reports are used by the AMHS to form an action plan to address compliance issues. This year refinements to the audit process have given audited services a snap-shot report on key audit findings, as well as the more detailed audit report. This is followed up by visits to AMHSs by auditors one year after the action plan is developed to monitor progress and identify any improvement outcomes.

Audit findings help inform decisions about statewide issues in policy, administration and legislation. Some of the changes instigated through feedback and data collected through the audit processes include:

- clarifying and improving administrative tools
- providing policy clarification on various matters
- proposed legislative amendments to improve interpretation of selected provisions of the Act
- gathering and sharing of good practices in compliance across services
- establishing a working group to examine the use of seclusion and seclusion reduction practices for children and young people.

Clinical audits

Clinical audits are coordinated by the Principal Advisor in Psychiatry in the office of the Director in partnership with designated quality improvement officer positions in health service districts. Clinical audits commenced as a pilot in 2008–09 in conjunction with the statutory compliance audits as part of a systematic and coordinated approach.

In 2009–10, a clinical audit tool was designed to capture measures of compliance with clinical processes, including assessment, admission and discharge, case review and medication and to validate these against benchmarks from consumer and carer surveys, mental health service staff questionnaires and stakeholder surveys. Clinical audits also identify positive clinical practice outcomes and areas for improvement in clinical service delivery.

The clinical audit pilot was continued in 2010–11, with seven AMHSs audited in this period. Significant outcomes of the clinical audit process include:

- funding of a six-month position in the Safe Medication Practice Unit to review, develop and implement a community medication record
- identification of recurrent trends in clinical practice across mental health services that have informed the development of initiatives to address common statewide themes
- improved workforce development and models of service delivery in mental health services.

The clinical audit tool was developed and piloted in 2008-09 and has been refined following evaluations in 2009-10 and 2010-11. Clinical audits aim to establish benchmarks to ensure a consistent auditing framework which best supports quality improvement activities in contemporary mental health service delivery.

Investigations

The Director has statutory powers to commission investigations under the Act into the assessment, treatment and detention of patients in AMHSs.

The decision to conduct an Act investigation rests with the Director. However not all complaints or issues will trigger an investigation. An investigation under the Act is conducted as an impartial and systematic process to examine certain complaints or the occurrence of an incident to determine what occurred. Investigations under the Act aim to identify, avoid, or reduce actual or potential harm in mental health care delivery. Act investigation reports provide recommendations on how the issues will be addressed and can be prevented from recurring. Should the investigation highlight potential breaches of legislation other than the Act, the Director will refer the matter to the appropriate agency.

One investigation under the Act was carried out in the 2010–11 reporting period. This investigation involved assessing the validity of an involuntary treatment order (ITO) made for a patient and examining whether the ‘recovery plan’ developed for the patient met the legislative requirements of a ‘treatment plan’ as defined in Section 124 of the Act.

The investigation found that the involuntary assessment and ITO made for the patient met statutory requirements and the application of the Act in relation to the patient was warranted. The investigators were satisfied that the treating team revoked the ITO when it was considered that the patient no longer met the treatment criteria as detailed in Section 14 of the Act.

The investigators also found that the recovery plan provided to the patient was not a treatment plan as defined in the Act but was an additional plan of care. A treatment plan had been completed which complied with Section 124 of the Act but there was no documentation that this plan was discussed with the patient.

As a result of the investigation, the AMHS involved implemented actions to ensure full compliance with Section 111 of the Act to ensure that the treatment plan is discussed with the patient and that the discussion is clearly documented in the clinical file.

Work was also undertaken during the year to develop an Act Investigation Guideline and resources for investigators. In conjunction with this, the Director continued to fund training places for AMHS staff and staff of the office of the Director on a nationally accredited Certificate IV Government Investigations course. In 2010–11 a further eight Queensland Health staff have been trained as accredited investigators, which expands the number of accredited staff available to conduct Act investigations to 28.

Future developments

The office of the Director will continue to review statutory audit findings and processes to improve statutory compliance. Work has started on examining how the Act audits can better align with the new clinical reform agenda and implementation of the national mental health standards. The office of the Director will continue to develop an overarching Act compliance strategy to improve compliance and coordinate compliance related activities across Queensland Health.

A Mental Health Law and Practice leadership forum will be held in November 2011. The aim is to engage administrators and key clinical leaders in promoting the relationship between the Act and good clinical practice. Trends in legislative reform will be highlighted, as well as good practice in addressing Act compliance issues. This will also be an opportunity for discussion of audit findings and how Act audits can better support improvement in AMHSs, as well as feedback on key audit priorities and engagement processes.

Chapter 6

Building systems for quality

Service system developments

Development of the *Forensic Disability Act 2011*

The report by Brendan Butler AM SC titled Promoting balance in the forensic mental health system – Final Report – Review of the Queensland *Mental Health Act 2000* (the Butler Report) made 106 recommendations for legislative and administrative reform to the forensic mental health system. Recommendation 5.1 of the Butler report was the only recommendation outstanding as at June 2010, concerning a review of provisions of the *Mental Health Act 2000* (the Act) affecting people with an intellectual disability. The recommendation for such a review was also highlighted by the Honourable W.J Carter Q.C in the Carter Report – Challenging Behaviour and Disability - A Targeted Response (the Carter Report). The Carter Report made 24 recommendations for a new model of service delivery and legislation to protect the human rights of people with intellectual disability who exhibit severely challenging behaviours. Notably, Recommendation 22 proposed amending the Mental Health Act to enable the making of a forensic order for a person with an intellectual disability to be detained in a place other than a mental health service.

Implementation of these recommendations was undertaken jointly by the office of the Director of Mental Health (the Director) and the Department of Communities through the development and passage of the *Forensic Disability Act 2011* (Forensic Disability Act) and associated amendments to the Mental Health Act.

These legislative changes primarily enable:

- the establishment and operation of a new forensic disability service at Wacol to be operated by the Department of Communities
- a distinction between the involuntary treatment and care of persons with a mental illness and the care of persons with an intellectual or cognitive disability
- the Mental Health Court (the Court) to place persons with an intellectual or cognitive disability on a specific 'disability' forensic order
- the creation of the position of a Director of Forensic Disability to ensure the protection of rights of forensic disability clients

The establishment of the forensic disability service is a significant step towards improving services for forensic patients with an intellectual or cognitive disability. However, given that the service has limited capacity, authorised mental health services (AMHS) will have an ongoing role in the management and care of these patients.

The Director continues to work with the Department of Communities and the Director of Forensic Disability to develop a service agreement which promotes a collaborative and coordinated response to the needs of people with intellectual or cognitive disabilities on forensic orders.

Queensland Health Forensic Mental Health Strategic Framework

One of the actions taken in Queensland under the Fourth National Mental Health Plan 2009–2014 (NMHP) was the launch of the Queensland Health Forensic Mental Health Strategic Framework (FMHSF) in March 2011. The national and state mental health policy agenda clearly acknowledges that forensic mental health is not the sole responsibility of the mental health treatment sector and that many sectors play important roles in an individual's mental health. In Queensland, these sectors include:

- other areas of state health service delivery
- other Queensland Government agencies, particularly the Queensland Police Service, Department of Communities (Community Mental Health and Youth Justice Services), Department of Community Safety (Queensland Corrective Services) and Department of Justice and Attorney General
- Commonwealth Government agencies that interact with consumers and provide support programs
- the Queensland courts
- non-government organisations that assist in the support and care of people with a mental illness involved with the justice system, particularly during transition from prison to the community.

The FMHSF reflects the significant reforms within Queensland's forensic mental health system and the broader mental health system, since the Queensland Forensic Mental Health Policy: Guiding the Development and Management of Effective Mental Health Services to Mentally Ill Offenders was published by Queensland Health in 2002. This framework articulates the principles that underpin the delivery of forensic mental health services in Queensland and identifies the priorities for continued reform of forensic mental health services under the Queensland Plan for Mental Health 2007–2017 (QPMH).

An implementation plan for this framework will continue to be developed in 2011–12. It is envisaged that this framework will provide the community with information on the provision of mental health services for people involved with the justice system and those at risk of entering or re-entering the justice system.

Supporting Individuals in the System

Information sharing guidelines for mental health clinicians

Following the findings of the Coronial inquest into the death of Andrew David Lather in 2008, it was evident that there was a need for better understanding amongst mental health clinicians regarding confidentiality and disclosure of information about a consumer. The Coronial inquest recommended that Queensland Health develop guidelines defining the issues surrounding confidentiality as they affect consumers and their families and to clarify the circumstances in which it is appropriate for mental health workers to share information about a consumer.

A publication entitled Information Sharing Between Mental Health Workers, Consumers, Carers, Family and Significant Others has been developed by the office of the Director and distributed to all mental health clinicians. This brochure provides an overview of the legislation that enables the sharing of information concerning consumers and how information sharing can be applied in clinical practice.

A key message of the document is the promotion of good clinical practice through identification and engagement of people who are important to the consumer and involved in their care, encouraging information to be shared at every opportunity between clinicians, consumers and those involved in supporting the consumer's recovery.

Patients' rights project

Under the Act, all involuntary patients must be provided with a statement of rights which sets out their rights, including their right to nominate an allied person. All information must be provided in the language or way that the patient is most likely to understand. An allied person is someone chosen by a patient to help them represent their views and wishes about being an involuntary patient to their treating team and the Mental Health Review Tribunal (the Tribunal).

In early 2010, a working group was established to review and make recommendations in relation to the allied persons policy, processes and resources. This working group was comprised of representatives from mental health services, the Tribunal and the office of the Director. The working group recommended the revision of existing resources, including a more comprehensive policy on administration of the allied persons provisions.

A range of materials is being developed which will be translated into 15 languages. In addition resources are being produced specifically for indigenous people and people with low literacy. It is anticipated these resources will be available by December 2011.

At the same time, the Statement of Rights for Involuntary Patients issued by the Director under Section 344 of the Act is being revised and other resources to promote patient rights under the Act are being considered.

Fostering culturally safe service delivery

The establishment of a specialist Aboriginal and Torres Strait Islander hub within the Mental Health Alcohol and Other Drugs Directorate (MHAODD) in early 2010 aims to ensure specialist leadership and oversight is provided in the delivery of mental health services to Aboriginal and Torres Strait Islander peoples in Queensland. A full time director was appointed in early 2011 to develop the hub's strategic directions and consolidate its partnership-building work, while continuing to enable culturally safe support to Aboriginal and Torres Strait Islander workers in their delivery of clinical services. The hub provides cultural advice and guidance in the development of statewide health service directives so that all documents promote and embed the cultural capabilities required to plan, support, improve and deliver services in a culturally respectful and appropriate manner. In 2011-12 the hub will finalise the Queensland Aboriginal and Torres Strait Islander Mental Health Workforce Report to provide high level advice and direction regarding models of service and clinical service provision.

Improving engagement with consumers and carers

The MHAODD is committed to continued engagement of consumers and carers in all aspects of the treatment and care of people with mental illness and in mental health service planning, delivery and evaluation. As part of the journey towards best practice with regards to consumer, carer and family participation in health services, the Consumer, Carer and Family Participation Framework was launched in August 2010. This framework provides AMHSs with a guide about how best to involve consumers, carers and families in the planning and delivery of quality mental health services by adopting a consumer driven, recovery oriented and carer and family inclusive model in the delivery of their services.

At the end of the reporting period the innovative Consumer Companion Program which aims to help current patients overcome their illness, was operating in all acute mental health units, two medium secure facilities and one extended care facility. The program is based on the concepts of shared experience, learning from one another and having support from a companion. These companions help consumers become more positive about their care, treatment and recovery through the provision of one-on-one and structured activities and peer support. A statewide evaluation of this program was undertaken in April 2011 and the final report is due in the next reporting period.

A series of training programs and workshops have also been held throughout the state for consumers and carers in 2010-11, including a three day workshop for the Queensland Health Consumer and Carer Workforce Network in November 2010 and the training of 98 consumers and carers in Mental Health First Aid for Carers.

Improving clinical practices

Reducing seclusion and restraint

The Queensland Health Policy statement on Reducing and Where Possible Eliminating Restraint and Seclusion in Queensland Mental Health Services outlines the key principles to guide planning, implementation and evaluation of strategies to reduce, and where possible eliminate, seclusion and restraint. Currently, all public AMHSs are represented on the Mental Health State-wide Clinical Collaborative on Seclusion Reduction. This collaborative is comprised of mental health clinicians who work together to achieve clinical practice improvements and better outcomes for patient care for the desired outcome of statewide reduction of restraint and seclusion.

Queensland acute adult inpatient services regularly record seclusion events and episodes to inform seclusion clinical indicators. These clinical indicators were reported and discussed at the statewide forum in November 2010. This forum also provided an opportunity for services to review performance on the use of seclusion and showcase initiatives.

Electroconvulsive therapy training

An electroconvulsive therapy (ECT) training committee has been established under the oversight of the Director of Mental Health and is chaired on the Director's behalf by the Principal Advisor in Psychiatry. The training committee oversees the development and review of clinical guidelines and resources related to ECT for consumers and carers.

The training committee provides a training program for psychiatrists on the delivery of ECT, including a session from the consumer perspective. This program was developed in consultation with clinical directors from across the state and national experts, and is accredited by the Director.

The inaugural training program was in April 2009, with two training sessions provided to 52 psychiatrists in 2009–10. All prescribers and clinicians delivering ECT must now complete this training program, or an equivalent program. Throughout 2010–11, training on the delivery of ECT was provided to senior registrars in health service districts.

The ECT Training Committee has also developed a training program for other disciplines involved in the delivery of ECT including the delivery of training for nursing staff.

Enhancing the quality of clinical mental health care – Safe Medication Project

Under the QPMH, commitments were made to develop a clinical mental health care system that promotes standards of best practice and initiatives that support consumer safety.

Safe medication practices and reducing adverse drug events is one of the seven key priorities for action which were identified under the Mental Health Patient Safety Strategic Plan.

The focus upon the development of safe medication practices has led to the initiation of the Mental Health Medication Integration Project in partnership with Medication Services Queensland. The aim of this project is to develop a statewide coordinated approach to reduce adverse medication events. The project has made 14 recommendations which the MHAODD is committed to pursuing under the Medication Management in Mental Health Services Action Plan.

Achievements under this partnership include:

- establishment of the Queensland Psychotropic Medication Advisory Committee under the auspices of the Director to review the quality use of medicines and the safety of medication management, including prescribing, dispensing and administration in Queensland mental health services
- convening two Mental Health Medication Safety workshops in 2010–11 for clinicians (96 participants)
- funding of a six-month project officer position to work with the Safe Medication Practice Unit to June 2011 to develop and implement a community depot medication chart and develop a strategic framework to inform safe medication practice initiatives for 2010–11 which will also assist in the identification of areas for future clinical audits.

Clinical reform initiative - Working Together to Change

The clinical reform initiative, Working Together to Change, was launched in 2010 as part of the ongoing commitment to enhance the quality and consistency of mental health services in Queensland. This key initiative aims to support clinical service delivery in Queensland mental health services through aligning clinical services more effectively with the priorities, principles and policies of the QPMH and affiliated national strategic directions.

To achieve a more efficient and coordinated use of resources, the clinical reform initiative has encouraged greater collaboration between district mental health services and the MHAODD to identify service gaps and needs. The initiative will also engage in evaluation of clinical services to provide opportunities for reform of clinical and corporate structures and processes to improve clinical practices and service delivery in Queensland.

Implementation of the clinical reform initiative is underway in three health service districts. This process involves three concurrent strategies to develop, implement and evaluate targeted change management plans in district mental health services.

Under Strategy One, the MHAODD has developed memoranda of understanding with the three pilot sites of Cairns and Hinterland, Gold Coast and Townsville Health Service Districts to develop localised strategic plans for reform. The plans will take into consideration the identification of opportunities by which service delivery can be improved in line with national and state requirements and localised capabilities and needs. Following a review and evaluation of these pilots, it is proposed that Strategy One will be implemented across the state in all health service districts. It is anticipated that by the end of the 2011–12 reporting year, five districts will have signed memoranda of understanding with Queensland Health to develop these localised strategic plans.

The first priority under Strategy Two is the development and statewide implementation of an acute care team model of service. Implementation of a consistent model for the provision of acute care services throughout the state is essential for equitable access across Queensland to the most appropriate clinical services. This will be achieved by embedding the 'every door is the right door' approach within the core business of all acute mental health services, breaking down service barriers and ensuring people in need are able to be rapidly connected with appropriate, consistent and high quality acute care. A comprehensive communication plan will also be developed to keep mental health service staff and other key stakeholders fully informed throughout the implementation of new models of service as part of Strategy Two.

Eleven statewide models of service have been approved for implementation in district mental health services. By 30 June 2011, the three health districts of Cairns and Hinterland, Gold Coast and Darling Downs were actively engaged in transitioning towards an acute care model of service. Following the completion of a baseline service analysis which takes into account the capabilities, needs and priorities of each of these mental health services, a long term strategic plan will be developed with each health district to align local reforms with relevant state and national directions.

To further the implementation of a rural and remote model of service the MHAODD will also work collaboratively with regional sites to develop district specific plans for an integrated approach to the delivery of mental health services. The aim of this strategy is to provide access to specialist mental health services for consumers that live in rural and remote areas that are equivalent to services available to other Queenslanders.

Work is being undertaken on Strategy Three to develop the Queensland Mental Health Performance Framework in consultation with key stakeholders. This will be a rigorous performance and accountability framework for evaluating the effectiveness of clinical reforms as part of Working Together to Change. As a long term project, the intention of the framework is to assist mental health services to be better equipped to assess their own performance and identify opportunities to improve their service delivery and better meet consumer needs. It is anticipated that this framework will ultimately be incorporated into the core business of each local mental health service to ensure ongoing commitment to continuous engagement in critical analysis and review.

Chapter 7

Future Directions

Looking ahead, there are significant opportunities and challenges for the ongoing statutory work within the Mental Health Alcohol and Other Drugs Directorate in 2011–12. These include progression of strategic reforms at the state and national levels to build a quality mental health system.

There are considerable opportunities for the improvement of the mental health system in Queensland through the continuing development of initiatives under the Queensland Plan for Mental Health 2007–2017 (QPMH). The increased capacity of mental health services with additional mental health staff, inpatient beds and resources will ensure the mental health system works more effectively, produces better results for consumers and contributes to improved mental health outcomes for all Queenslanders.

The mental health system faces ongoing challenges as the state's population growth continues to outstrip the rest of Australia and as we experience natural disasters and suffer economic stress from the global financial crisis.

The natural disaster events in the summer of 2011 placed many Queenslanders under pressures which have in some cases contributed to poorer mental health.

In the coming years we look forward to the continued improvement of mental health services in Queensland.

The Queensland Government has expressed its strong commitment to mental health care reform under the QPMH in the 2011–12 Budget. The Budget allocated substantial resources to mental health care, including funding for the recruitment of 126 additional community mental health staff in the public sector and 30 community mental health positions in the non-government sector.

The Queensland and Australian Governments are also committed to realise the full potential of the National Partnership Agreements on Supporting National Mental Health Reform and the establishment of Early Psychosis Prevention and Intervention Centres.

The increased resources will also assist ongoing reform activities, the development of exceptional information systems, early intervention and prevention programs, improved training for mental health staff, better quality clinical care and a responsive mental health care system that seeks to provide equitable access to all Queenslanders.

It is with great anticipation that we look forward to 2011–12 and the expectation of developing stronger collaboration between the Mental Health Alcohol and Other Drugs Directorate, consumers, carers and other stakeholders to strive for an improved mental health care system in Queensland.

Appendix 1

About us

Our statutory roles and facilities

About the *Mental Health Act 2000*

Queensland Health, through the office of the Director of Mental Health (the Director) administers the *Mental Health Act 2000* (the Act) jointly with the Department of Communities.

The Act contains provisions for initiating involuntary assessment, authorising involuntary treatment, independent review of involuntary treatment and patient rights. It provides processes for the diversion of mentally ill offenders from court or custody and decisions about criminal responsibility, where the person has a mental illness. It also provides for victim information orders and non-contact provisions for family members, victims of crime and other interested persons, as well as provisions addressing community safety.

Under the Act, decision-making processes have been designed to ensure transparency and accountability. The Act has been drafted to reflect contemporary clinical practice, international, national and state policy directions and broad community expectations.

The Director of Mental Health appointment

Appointment

On 22 September 2005, Her Excellency the Governor approved the appointment of Dr Aaron Groves MBBS FRANZCP as the Director of Mental Health under the Act.

Powers and functions

The Act establishes broad monitoring and oversight functions for the Director including:

- ensuring the protection of rights of involuntary patients
- ensuring that involuntary admission, assessment and treatment of persons complies with the Act
- facilitating the proper and efficient administration of the Act
- promoting community awareness and understanding of the administration of the Act
- advising and reporting to the Minister on any matter relating to the administration of the Act.

More specific powers and functions relating to the administration of the Act include:

- declaring authorised mental health services (AMHS) and high security units to provide treatment and care of people with mental illness
- declaring administrators of AMHSs and high security units
- appointing authorised mental health practitioners (AMHP)
- appointing approved officers to conduct investigations under the Act

- developing a Statement of Rights for involuntary patients and their allied persons
- approving forms used under the Act, excluding those required by the Mental Health Court (the Court) or the Mental Health Review Tribunal (the Tribunal).

The Director also has powers and functions in relation to people with mental illness who are, or have been, subject to criminal justice system processes. These include:

- receiving expert psychiatric reports in relation to involuntary patients charged with an offence and referring these matters to the Director of Public Prosecutions (DPP) or the Court for determination
- ordering the transfer of classified patients (patients admitted to a health service from a court or place of custody) and forensic patients (patients found to be of unsound mind or not fit for trial in relation to a criminal offence)
- facilitating return to court or custody for classified patients who no longer need to be detained for treatment of mental illness
- approving limited community treatment (LCT) for classified patients.

Delegation of Director's powers

The Director can delegate certain powers under the Act to an appropriately qualified public service or health service employee. This delegation may include all the Director's powers except those relating to the declaration of AMHSs, high security units and administrators.

During 2010–11, the Director was assisted by a number of psychiatrists who performed the duties as delegate. A list of Delegates granted various powers and functions during the reporting period is set out in Table 16.

Table 16 Director of Mental Health delegates for 2010–11

Delegate	Power delegated	Dates of delegation	Delegated by
Dr Curtis **Gray**	Chapters 2, 3, 4, 5, 6, 7, 8, 12 and s499	13 July 2010 to current	Dr Aaron Groves
Dr David **Crompton**	Chapters 2, 3, 4, 5, 6, 7, 8, 12 and s499	11 February 2009 to current	Dr Aaron Groves
Dr Jacinta **Powell**	Chapters 2, 3, 4, 5, 6, 7, 8, 12 and s499	11 February 2009 to current	Dr Aaron Groves
Dr Jacinta **Powell**	Chapter 5, Pt 2 - specifically ss184 and 185	10 February 2004 to current	Dr Arnold Waugh
Dr William **Kingswell**	Chapters 2, 3, 4, 5, 6, 7, 8, 12 and s499	11 February 2009 to current	Dr Aaron Groves
Associate Professor William Brett **Emmerson**	Chapter 5, Pt 2 - specifically ss184 and 185	11 July 2008 to current	Dr Aaron Groves
Associate Professor William Brett **Emmerson**	Chapters 2, 3, 4, 5, 6, 7, 8, 12 and s499	30 June 2006 to current	Dr Aaron Groves
Associate Professor Jagmohan **Gilhotra**	Chapter 5, Pt 2 - specifically ss184 and 185	03 June 2008 to current	Dr Aaron Groves
Associate Professor Jagmohan **Gilhotra**	Chapters 2, 3, 4, 5, 6, 7, 8, 12 and s499	02 January 2008 to current	Dr Aaron Groves
Dr Terry **Stedman**	Chapter 5, Pt 2 - specifically ss184 and 185	30 June 2008 to current	Dr Aaron Groves
Dr Terry **Stedman**	Chapters 2, 3, 4, 5, 6, 7, 8, 12 and s499	26 May 2006 to current	Dr Aaron Groves
Dr Cassandra **Griffin**	Chapters 2, 3, 4, 5, 6, 7, 8, 12 and s499	14 February 2004 to current	Dr Arnold Waugh

The Director can also delegate limited functions to specified senior clinical positions. These functions relate to approving a patient's temporary absence to receive medical care as specified under the Act or to appear before a court, tribunal or other body.

Table 17 sets out a list of positions which have been delegated limited functions as at 30 June 2011.

Table 17 Director of Mental Health delegates (limited functions) for 2010–11

Delegate	Power delegated	In relation to patients at	Date of delegation	Delegated by
Psychiatrist on call, The Park – Centre for Mental Health	184, 185, 186(2)(a) and 186(2)(b)	The Park – Centre for Mental Health AMHS and the Park High Security Program: Central and Southern Zones	11 February 2009 to current	Dr Aaron Groves
Clinical Director	184, 185, 186(2)(a) and 186(2)(b)	The Park – Centre for Mental Health AMHS and the Park High Security Program: Central and Southern Zones	29 November 2005 to current	Dr Aaron Groves
Director of Clinical Services, The Park – Centre for Mental Health	184, 185, 186(2)(a) and 186(2)(b)	The Park – Centre for Mental Health AMHS and the Park High Security Program: Central and Southern Zones	11 February 2009 to current	Dr Aaron Groves

Authorised Mental Health Services

AMHSs are health services authorised under the Act to provide involuntary examination, assessment and treatment to persons with mental illness. They include both public and private sector health services (Appendix 3).

In authorising AMHSs, the Director takes account of the professional expertise required in the assessment and treatment of people with a mental illness, as well as the need to ensure appropriate access to services across the state. In most instances, AMHSs comprise inpatient and community components. Inpatient facilities are generally based in metropolitan and regional centres, while community components are established in rural and remote locations as well as major centres. In addition, Section 15 of the Act provides that all public hospitals are AMHSs for the purpose of providing involuntary examination and assessment.

Authorised mental health services administering electroconvulsive therapy

A small number of private sector health services have been established as AMHSs for the specific purpose of administering electroconvulsive therapy (ECT) to patients who have given informed consent (Appendix 6). This ensures that private sector patients continue to have appropriate access to this treatment. The private sector facilities established for this purpose are licensed under the *Private Health Facilities Act 1999* and have demonstrated that their practices comply with legislative requirements.

High security units

High security units are AMHSs that provide the highest level of security and containment. The Act applies special requirements to these units to protect the rights of patients and the interests of the wider community, including those related to admission and discharge of patients and security of the facility.

As of 30 June 2011, one AMHS, The Park High Security Program, had been declared as a high security unit (Appendix 5).

Administrators of authorised mental health services and high security units

The Act provides that the Director may, by gazette notice, declare a person or the holder of a stated office to be the administrator of an AMHS or high security unit.

The administrator of an AMHS, including a high security unit, is responsible for a range of administrative responsibilities relating to involuntary patients under the Act. The position plays a critical role in coordinating and overseeing the operation of the Act at the service delivery level.

A list of AMHS administrators as at 30 June 2011 is set out at Appendix 2.

Powers and functions of the administrator include:

- giving notice to patients and other parties (for example, an allied person or the Tribunal) of various matters relating to the patient's involuntary status or changes to their involuntary status
- ensuring that patients receive treatment in accordance with their treatment plan, including regular assessment by an authorised psychiatrist
- choosing an allied person for patients who do not have capacity to choose their own allied person
- ensuring the Statement of Rights is prominently displayed in AMHSs or high security units and provided to involuntary patients and their allied persons
- giving notice of various matters to the Director in relation to an involuntary patient charged with an offence
- refusing a visitor's access to a patient if the administrator is satisfied that such a visit would adversely affect the patient's treatment
- giving agreement to the admission of a person who is in custody or before a court
- assuming responsibility for the legal custody of classified patients (patients admitted from court or custody) and forensic patients (found temporarily unfit for trial)
- appointing authorised doctors (AD) for an AMHS or high security unit
- maintaining records and registers and providing information on involuntary patients to the Director.

Authorised doctors

Under the Act, certain decisions relating to involuntary patients must be made by an AD.

ADs are appointed by the administrator of an AMHS. In appointing an AD, the administrator must believe that the doctor has the experience and expertise needed to undertake this specialist role. Most ADs are psychiatrists or psychiatric registrars.

Table 18 sets out the number of ADs, including authorised psychiatrists, appointed to each AMHS.

The functions performed by an AD require a good understanding of the provisions of the Act. The Director's policy for appointment, renewal and cessation as an authorised doctor was developed to assist services with streamlining their procedures in relation to appointing ADs. The policy outlines the importance of standardised appointment processes and sets out the skill set and training required to undertake statutory responsibilities under the Act.

The functions and powers of the AD include:

- assessing a patient to determine whether the involuntary treatment criteria apply and, if so, making an involuntary treatment order (ITO)
- determining whether a patient subject to an ITO is to receive treatment in an inpatient facility or in the community
- ensuring a treatment plan is prepared for an involuntary patient
- requiring a patient to be taken to an AMHS when the patient is receiving treatment in the community and has not complied with the requirements of the ITO
- authorising LCT for an involuntary patient receiving treatment in an inpatient facility
- documenting the requirement to return of a patient who is absent without permission
- revoking a patient's ITO, if satisfied that the treatment criteria no longer apply.

The Act also requires that an AD who is a psychiatrist (an authorised psychiatrist) undertakes certain functions. For example, ITOs must be made or confirmed by an authorised psychiatrist and all involuntary patients are required to be examined by an authorised psychiatrist at regular intervals as specified in the patient's treatment plan.

Table 18 Number of authorised doctors (including authorised psychiatrists) appointed to each authorised mental health service as at 30 June 2011

Authorised mental health service*	Authorised psychiatrist	Other authorised doctor	Total
Bayside	15	31	46
Belmont Private	33	4	37
Cairns	19	17	36
Central Queensland	10	16	26
Fraser Coast	5	9	14
Gold Coast	38	49	87
Greenslopes Private	6	0	6
Logan Beaudesert	24	20	44
Mackay	5	8	13
Mater	13	19	32
New Farm Clinic	44	12	56
Princess Alexandra	36	36	72
Redcliffe Caboolture	16	40	56
RBWH	40	64	104
Royal Children's	9	10	19
Sunshine Coast	18	21	39
The Park	30	13	43
The Park - High Security	30	13	43
The Prince Charles	33	42	75
Toowong Private	41	2	43
Toowoomba	33	35	68
Townsville	21	14	35
West Moreton	14	13	27
Wide Bay	3	7	10
Total	**536**	**495**	**1,031**

Note: Doctors may be appointed as an AD at more than one AMHS

* See Appendix 4 for full AMHS title

Authorised mental health practitioners

AMHPs play an important role in initiating involuntary assessment. An AMHP may, if satisfied that the assessment criteria apply to a person, make a recommendation for assessment. This document, together with a separate document - request for assessment - authorises the taking of the person to an AMHS for assessment.

AMHPs are appointed by the Director. Nominations are made by the administrator of the relevant AMHS. The Director's policy for appointment, renewal, transfer and cessation as an authorised mental health practitioner was developed for use within Queensland AMHSs to regulate procedures across Queensland. The policy requires AMHPs to possess the necessary competence to fulfil their statutory responsibilities and outlines the minimum requirements for appointment as an AMHP, including:

- being a health practitioner, as defined under the Act
- being a health service employee of an AMHS or another officer or employee of Queensland Health
- having the requisite knowledge of the Act and ability to communicate this knowledge to others. Demonstration of knowledge includes completion of the following online training system modules:
  - LMO-2018 – Classified Patients and the MHA2000
  - LMO-2019 – The Forensic Provisions of the MHA2000
  - LMO-2027 – Involuntary Assessment and Treatment Provisions of the MHA2000
  - LMO-2029 – The Return Provisions of the MHA2000
- a minimum of two years experience working in mental health service provision, including training and expertise required to assess persons believed to have a mental illness
- participating in regular clinical supervision
- an awareness of potential conflicts of interest and the importance of not exercising powers in circumstances where such conflicts exist (for example, a practitioner who, under an administrator delegation, agrees to the assessment of a person as a classified patient should not complete the recommendation for assessment for that person).

The policy also states AMHPs may, subject to administrator approval, operate across different services. In addition, the policy provides for annual renewal of appointments.

The AMHP renewal process is intended to promote practitioners' maintenance of up-to-date knowledge of legislative changes and associated policies and procedures.

Table 19 sets out the number of AMHPs at each AMHS as at 30 June 2011.

Table 19 Number of authorised mental health practitioners at each authorised mental health service as at 30 June 2011

Authorised mental health service*	Total authorised mental health practitioners
Bayside	52
Belmont Private	30
Cairns	91
Central Queensland	47
Fraser Coast	25
Gold Coast	94
Greenslopes Private	7
Logan Beaudesert	85
Mackay	27
Mater	25
New Farm Clinic	20
Princess Alexandra	83
Redcliffe Caboolture	77
RBWH	118
Royal Children's	29
Sunshine Coast	108
The Park	16
The Park - High Security	1
The Prince Charles	86
Toowong Private	13
Toowoomba	65
Townsville	82
West Moreton	61
Wide Bay	39
Total	**1,281**

* See Appendix 4 for full AMHS title

Statewide information and liaison service

Mental Health Act Liaison Officers (MHALO) in the office of the Director provide information on the Act and patient rights. The service provided by MHALOs is used by consumers, carers, service providers, non-government and government organisations and members of the public. MHALOs are available during standard business hours on free call 1800 989 451 and via email on the *Mental Health Act 2000* website, **www.health.qld.gov.au/mha2000.**

Appendix 2

Administrators of authorised mental health services

as at 30 June 2011

Authorised mental health service	Title
Bayside	Executive Director, Mental Health
Belmont Private	Director, Belmont Private Hospital
Cairns Network	Executive Director of Mental Health
Central Queensland	Service Manager
Fraser Coast	Executive Director Wide Bay Fraser Coast
Gold Coast Network	Director of Psychiatry
Greenslopes Private	Director of Psychiatry
Logan-Beaudesert	Executive Director, Mental Health
Mackay	Service Manager
Mater Health Services Child and Youth	Director of Mater Health Services, Child and Youth Mental Health Services
New Farm Clinic	Director of Clinical Services
Princess Alexandra Hospital	Executive Director Mental Health
Redcliffe Caboolture	Clinical Director
Royal Brisbane and Women's Hospital	Executive Director, Royal Brisbane and Women's Hospital mental Health Service
Royal Children's Hospital Authorised Mental Health Service	Executive Director
Sunshine Coast	Executive Director, Mental Health Service
The Park – Centre for Mental Health	Executive Director of Mental Health Services
The Park High Security Program	Executive Director of Mental Health Services
The Prince Charles Hospital	Clinical Director, Metro North Mental Health Service
Toowong Private	Chief Executive Officer
Toowoomba	Executive Director of Mental Health Services
Townsville	Director of Mental Health Services
West Moreton	Executive Director of Mental Health Services
Wide Bay	Executive Director Wide Bay Fraser Coast

Appendix 3

Schedule of authorised mental health services

as at 30 June 2011

Mental Health Act 2000 Schedule of authorised mental health services

Authorised mental health service	Component facilities	Address
Cairns and Hinterland Health Service District, Cape York Health Service District and Torres Strait-Northern Peninsula Health Service District		
Cairns Network Authorised Mental Health Service	• Cairns Base Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	The Esplanade Cairns QLD 4870
	• Smithfield Mental Health Service (North Team)	Smithfield Community Health Centre 16 Danbulan Street, Smithfield Cairns QLD 4870
	• Acute Care Mental Health Service	165 Sheridan Street Cairns QLD 4870
	• Child and Youth Mental Health Service	130 McLeod Street Cairns QLD 4870
	• Evolve Team	1A Water Street Cairns QLD 4870
	• Forensic Mental Health Team	1A Water Street Cairns QLD 4870
	• Far North Queensland Intensive Rehabilitation and Recovery Support Team – FIRRST	165 Sheridan Street North Cairns QLD 4878
	• Homeless Health Outreach Team	125 Sheridan Street Cairns QLD 4870
	• Edmonton Mental Health Service (South Team)	Edmonton Mental Health Service (South Team) 10–12 Robert Road Edmonton QLD 4869
	• Innisfail Mental Health Service – Innisfail	Innisfail Hospital Innisfail QLD 4860

Authorised mental health service	Component facilities	Address
Cairns and Hinterland Health Service District, Cape York Health Service District and Torres Straight–Northern Peninsula Health Service District *(continued)*		
	• Innisfail District Community Mental Health Service – Tully	Tully Community Health Centre Tully QLD 4854
	• Tablelands District Mental Health Service – Atherton	Atherton Health Centre Louise Street Atherton QLD 4883
	• Tablelands District Mental Health Service – Mareeba	Lloyd Street Mareeba QLD 4880
	• Cape York Health Service District Mental Health Service	Corner of Northern and Central Avenue Weipa QLD 4874
	• Cooktown Multi Purpose Health Service	Cooktown Multi Purpose Health Service Hope Street Cooktown QLD 4871
	• Torres Strait / Northern Peninsula Area Community Mental Health Service	Thursday Island Community Health Centre Thursday Island QLD 4875
	• Torres Strait / Northern Peninsula Area Community Mental Health Service	Bamaga Health Centre Bamaga QLD 4876
Central Queensland Health Service District		
Central Queensland Network Authorised Mental Health Service	• Rockhampton Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Canning Street Rockhampton QLD 4700
	• Community Mental Health Service	Quarry Street Rockhampton QLD 4700
	• Child and Youth Mental Health Service	Quarry Street Rockhampton QLD 4700
	• Psychogeriatric beds within Eventide Home	North and Campbell Street Rockhampton QLD 4700
	• Capricorn Coast Community Mental Health Service	8 Hoskyn Drive Yeppoon QLD 4703
	• Gladstone Community Adult Mental Health Service	Kent Street (Gladstone Hospital Campus) Gladstone QLD 4680
	• Gladstone Child and Youth Mental Health Service	Kent Street (Gladstone Hospital Campus) Gladstone QLD 4680
	• Gladstone Hospital Emergency Department	Kent Street Gladstone QLD 4680
	• Biloela Community Mental Health Service	Outpatients Department Biloela Hospital 2 Hospital Road Biloela QLD 4715
	• Central Highlands Mental Health Service – Emerald	Community Health Service, on the hospital campus, Hospital Road Emerald QLD 4720

Authorised mental health service	Component facilities	Address
Children's Health Service District		
Mater Health Services Child and Youth Authorised Mental Health Service	• Mater Children's Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Raymond Terrace South Brisbane QLD 4101
	• Mater Child and Youth Mental Health Service	Raymond Terrace South Brisbane QLD 4101
	• Greenslopes Clinic – Mater Child and Youth Mental Health Service	34 Curd Street Greenslopes QLD 4120
	• Inala Clinic – Mater Child and Youth Mental Health Service	7 Kittyhawk Avenue Inala QLD 4077
	• Yeronga Clinic – Mater Child and Youth Mental Health Service	51 Park Road Yeronga QLD 4104
	• Brisbane South Evolve – Mater Child & Youth Mental Health Service	Ground Floor, Block C, Garden Square 643 Kessels Road Upper Mt Gravatt QLD 4122
Royal Children's Hospital Authorised Mental Health Service	• Royal Children's Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Bramston Terrace Herston QLD 4029
	• The Royal Children's Hospital and Health Service District Child and Youth Mental Health Service	Corner Rogers and Waters Streets Spring Hill QLD 4000
	• Evolve Therapeutic Services	289 Wardell Street Enoggera QLD 4051
	• Nundah Child and Youth Mental Health Clinic	Nundah Community Health Centre 10 Nellie Street Nundah QLD 4012
	• Pine Rivers Child and Youth Mental Health Clinic	Pine Rivers Community Health Centre 568 Gympie Road Strathpine QLD 4500
	• North West Child and Youth Mental Health Clinic	North West Community Health Centre 49 Corrigan Street Keperra QLD 4054
	• Future Families	31–33 Robinson Road Nundah QLD 4012
Darling Downs-West Moreton Health Service District and South West Health Service District		
The Park – Centre for Mental Health Authorised Mental Health Service	• The Park – Centre for Mental Health in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	The Park – Centre for Mental Health Treatment, Education & Research corner Ellerton Drive and Wolston Park Road Wacol QLD 4076
The Park – High Security Program Authorised Mental Health Service	• The Park – High Security Program	The Park – Centre for Mental Health Treatment, Education & Research corner Ellerton Drive and Wolston Park Road Wacol QLD 4076

Authorised mental health service	Component facilities	Address
Toowoomba and Darling Downs Network Authorised Mental Health Service	• Toowoomba Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Pechey Street Toowoomba QLD 4350
	• Baillie Henderson Hospital in-patient and specialist health units (excluding the intellectual disability beds, the grounds of the hospital and non-treatment facilities on the hospital campus)	Hogg Street Toowoomba QLD 4350
	• Adult Community Mental Health Service	Fountain House, Toowoomba Hospital Pechey Street Toowoomba QLD 4350
	• Child and Youth Mental Health Service	Pechey Street Toowoomba QLD 4350
	• Older Persons Mental Health Service	Armstrong Clinic, Toowoomba Hospital Pechey Street Toowoomba QLD 4350
	• Dalby Mental Health Service	Dalby Hospital Hospital Road Dalby QLD 4405
	• Gatton Community Mental Health Service	97–103 William Street Gatton QLD 4343
	• Stanthorpe Community Mental Health Service	The Boulders Stanthorpe Hospital McGregor Terrace Stanthorpe QLD 4380
	• Southern Downs Community Mental Health Service	McCarthy House 56 Locke Street Warwick QLD 4370
	• Inglewood Community Mental Health Service	Inglewood Hospital, Cunningham Highway Inglewood QLD 4387
	• Chinchilla Mental Health Service	Cnr Heeney and Hypatia Street Chinchilla QLD 4413
	• Roma Community Mental Health Service	Arthur Street Roma QLD 4455
	• Charleville Community Mental Health Service	2 Eyre Street Charleville QLD 4470
West Moreton South Burnett Authorised Mental Health Service	• Ipswich Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Chelmsford Street Ipswich QLD 4305
	• West Moreton Integrated Mental Health Service	Bell Street Ipswich QLD 4305
	• South Burnett Health Service District Community Mental Health Service	166 Youngman Street Kingaroy QLD 4610

Authorised mental health service	Component facilities	Address
Gold Coast Health Service District		
Gold Coast Authorised Mental Health Service	• Gold Coast Hospital, Southport Campus in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Nerang Street Southport QLD 4215
	• Gold Coast Hospital, Robina Campus in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	2 Bayberry Lane Robina QLD 4226
	• Burleigh Child and Youth Mental Health Service	18 Park Avenue Burleigh Heads QLD 4220
	• Palm Beach Community Clinic	9 Fifth Avenue Palm Beach QLD 4221
	• Ashmore Community Mental Health Service	Suite 10, Ashmore Commercial Centre 207 Currumburra Road Ashmore QLD 4214
	• Southport Child and Youth Mental Health Service	60 High Street Southport QLD 4215
	• Gold Coast Early Psychosis Service	191 West Burleigh Road West Burleigh QLD 4220
Mackay Health Service District		
Mackay Authorised Mental Health Service	• Mackay Base Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Bridge Road Mackay QLD 4740
	• Mackay Integrated Adult Mental Health Service	12–14 Nelson Street Mackay QLD 4870
	• Mackay Child and Youth Mental Health Service	12–14 Nelson Street Mackay QLD 4870
	• Whitsunday Community Health Centre	12 Altmann Avenue Cannonvale QLD 4802
	• Moranbah District Mental Health Service	Moranbah Community Health Centre 142 Mills Avenue Moranbah QLD 4744
	• Bowen Community Mental Health Service	Gregory Street Bowen QLD 4805
	• Whitsunday Mental Health Service	26–32 Taylor Street Proserpine QLD 4800

Authorised mental health service	Component facilities	Address
Metro North Health Service District		
Redcliffe Caboolture Authorised Mental Health Service	• Caboolture Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	9 McKean Street Caboolture QLD 4510
	• Redcliffe Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Anzac Avenue Redcliffe QLD 4020
	• Caboolture Adult Mental Health Service	6/69 King Street Caboolture QLD 4051
	• Redcliffe Adult Mental Health Service	181 Anzac Avenue Kippa Ring QLD 4020
	• Redcliffe Caboolture Child and Youth Mental Health Service	181 Anzac Avenue Kippa Ring QLD 4020
	• Redcliffe Caboolture Child and Youth Mental Health Service	80 King Street Caboolture QLD 4051
	• Redcliffe Caboolture Acute Care Team	5/69 King Street Caboolture QLD 4051
	• Cooinda House Psychogeriatric Unit	Recreation Street Redcliffe QLD 4020
Royal Brisbane and Women's Hospital Authorised Mental Health Service	• Royal Brisbane and Women's Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Herston Road Herston QLD 4029
	• Inner North Brisbane Mental Health Service	162 Alfred Street Fortitude Valley QLD 4006
The Prince Charles Hospital Authorised Mental Health Service	• The Prince Charles Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Rode Road Chermside QLD 4032
	• Aspley Community Mental Health Service	Cnr Zillmere and Brickfield Road Aspley QLD 4034
	• Nundah Community Mental Health Service	Corner Nellie Street and Melton Road Nundah QLD 4012
	• Pine Rivers Community Mental Health Service	568 Gympie Road Strathpine QLD 4500
	• Chermside Community Mental Health Service	The Prince Charles Hospital Rode Road Chermside QLD 4032
	• The Prince Charles Hospital Acquired Brain Injury/Mental Health Unit	Eventide Beaconsfield Terrace Brighton QLD 4017
	• 16 Psychogeriatric beds within Flinders House Eventide Nursing Home	Eventide Beaconsfield Terrace Brighton QLD 4017

Authorised mental health service	Component facilities	Address
Metro South Health Service District		
Bayside Authorised Mental Health Service	• Redland Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Weppin Street Cleveland QLD 4163
	• Daintree Psychogeriatric Inpatient Unit	New Lindum Road Wynnum West QLD 4178
	• Wynnum Continuing Care	New Lindum Road Wynnum West QLD 4178
	• Redlands Continuing Care	Weppin Street Cleveland QLD 4163
	• Bayside Child and Youth Mental Health Service	Weppin Street Cleveland QLD 4163
	• Acquired Brain Injury Unit Extended Care	New Lindum Road Wynnum West QLD 4178
Logan Beaudesert Authorised Mental Health Service	• Logan Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Corner Armstrong and Loganlea Roads Meadowbrook QLD 4131
	• Beenleigh Adult Mental Health Service	10-18 Mount Warren Boulevard Mt Warren Park QLD 4207
	• Beenleigh Child and Youth Mental Health Service	10-18 Mount Warren Boulevard Mt Warren Park QLD 4207
	• Logan Central Adult Mental Health Service	Corner Wembley and Ewing Roads Logan Central QLD 4114
	• Child and Youth Mental Health Service	91 Wembley Road Logan Central QLD 4114
	• Child and Youth Mental Health Service	39a Wembley Road Logan Central QLD 4114
	• Child and Youth Mental Health Service	39b Wembley Road Logan Central QLD 4114
	• Acute Care Team	91 Wembley Road Logan QLD 4114
	• Evolve Therapeutic Support Service	Unit 12/3–19 University Drive Meadowbrook QLD 4131
	• Older Persons Mental Health	2 Mooney Street Logan QLD 4114
	• Alternatives to Hospitalisation Program	91 Wembley Road Logan QLD 4114
	• Beaudesert Hospital – Community Mental Health Service	Beaudesert Hospital Tina Street Beaudesert QLD 4285
	• Mobile Intensive Treatment Team	91 Wembley Road Logan QLD 4114
	• Browns Plains Adult Community Mental Health Service	Cnr Middle Road and Wineglass Drive Hillcrest QLD 4118

Authorised mental health service	Component facilities	Address
Metro South Health Service District		
Princess Alexandra Hospital Authorised Mental Health Service	• Princess Alexandra Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Ipswich Road Woolloongabba QLD 4102
	• Burke Street Community Mental Health Service	2 Burke Street Woolloongabba QLD 4102
	• Inala Adult Mental Health Service	64 Wirraway Parade Inala QLD 4077
	• Mount Gravatt Adult Mental Health Service	519 Kessels Road Macgregor QLD 4109
	• Mater Misercordiae Hospital (Adult and Mothers) in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Raymond Terrace South Brisbane QLD 4101
	• Queen Elizabeth II Jubilee Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Kessels Road Coopers Plains QLD 4108
Sunshine Coast-Wide Bay Health Service District		
Fraser Coast Authorised Mental Health Service	• Hervey Bay Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Corner Nissan and Urraween Roads Hervey Bay QLD 4655
	• Maryborough Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	185 Walker Street Maryborough QLD 4650
	• Fraser Coast Integrated Mental Health Service, Village Community Mental Health Service	34 Torquay Road Pialba QLD 4655
	• Fraser Coast Integrated Mental Health Service, Bauer Wiles Community Health Centre	167 Neptune Street Maryborough QLD 4650
Sunshine Coast Network Authorised Mental Health Service	• Nambour Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Hospital Road Nambour QLD 4560
	• Glenbrook Residential Aged Care Unit	4 Jack Street Nambour QLD 4560
	• Gympie Mental Health Service	20 Alfred Street Gympie QLD 4570
	• Community Mental Health Service	Ground Floor, Centenary Square Nambour QLD 4560
	• Community Mental Health Service	100 Sixth Avenue Maroochydore QLD 4558

Authorised mental health service	Component facilities	Address
Sunshine Coast Network Authorised Mental Health Service *(continued)*	• Child and Youth Mental Health Service	15 Beach Road Maroochydore QLD 4558
	• Mobile Outreach Team	2 Lady Musgrave Drive Mountain Creek QLD 4557
	• Evolve Therapeutic Support Team	108 Brisbane Road Mooloolaba QLD 4557
Sunshine Coast-Wide Bay Health Service District		
Wide Bay Authorised Mental Health Service	• Bundaberg Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	Bourbong Street Bundaberg QLD 4670
	• Bundaberg Adult Community Mental Health Service	Bourbong Street Bundaberg QLD 4670
	• Bundaberg Child and Youth Mental Health Service including Evolve Therapeutic Services	Bourbong Street Bundaberg QLD 4670
	• Wide Bay Rural Mental Health Team based at :	
	– Gayndah Hospital	69 Warton Street Gayndah QLD 4625
	– Monto Hospital	Flinders Street Monto QLD 4630
	– Childers Hospital	44 Broadhurst Street Childers QLD 4660
	– Gin Gin Hospital	5 King Street Gin Gin QLD 4671
Townsville Health Service District and Mount Isa Health Service District		
Townsville Network Authorised Mental Health Service	• Townsville Hospital in-patient and specialist health units (excluding the grounds of the hospital and non-treatment facilities on the hospital campus)	100 Angus Smith Drive, Douglas Townsville QLD 4814
	• Ayr Community Mental Health Service	Ayr Hospital 2 Chippendale Street Ayr QLD 4807
	• Kirwan Rehabilitation Unit and Acquired Brain Injury Unit	Thuringowa Drive Kirwan QLD 4817
	• Palm Island Community Mental Health Service	Joyce Palmer Hospital Palm Island QLD 4816
	• Ingham Community Mental Health Service	Ingham Community Health McIlwraith Street Ingham QLD 4850
	• Charters Towers Community Mental Health Service	Gill Street Charters Towers QLD 4820
	• Charters Towers Rehabilitation and Transitional Unit	Gladstone Road Charters Towers QLD 4820
	• Pandanas Special Care Unit	Eventide Nursing Home Charters Towers QLD 4820

Authorised mental health service	Component facilities	Address
Townsville Network Authorised Mental Health Service *(continued)*	• Townsville Community Mental Health Service	138 Thuringowa Drive Kirwan QLD 4817
	• Townsville Homeless Health Outreach Team	142–201 Walker Street Townsville QLD 4810
	• Parklands Residential Aged Care Facility – Pandora Unit	138 Thuringowa Drive Kirwan QLD 4817
	• Townsville Community Mental Health Service	33 Gregory Street North Ward QLD 4810
	• Mount Isa Integrated Mental Health Service	26–28 Camooweal Street Mt Isa QLD 4825
Private Sector Services		
Belmont Private Hospital Authorised Mental Health Service	• Belmont Private Hospital in-patient and specialist mental health units, and grounds as approved by the Director of Mental Health and published on: **http://www.health.qld.gov.au/mha2000/amhs/documents/amhs_schedule.pdf**	1220 Creek Road Carina QLD 4152
Greenslopes Private Hospital Authorised Mental Health Service	• Greenslopes Private Hospital in-patient and specialist health units, and grounds as approved by the Director of Mental Health and published on: **http://www.health.qld.gov.au/mha2000/amhs/documents/amhs_schedule.pdf**	Newdegate Street Greenslopes QLD 4120
New Farm Clinic Authorised Mental Health Service	• New Farm Clinic in-patient and specialist health units, and grounds as approved by the Director of Mental Health and published on: **http://www.health.qld.gov.au/mha2000/amhs/documents/amhs_schedule.pdf**	22 Sargent Street New Farm QLD 4005
Toowong Private Hospital Authorised Mental Health Service	• Toowong Private Hospital in-patient and specialist health units, and grounds as approved by the Director of Mental Health and published on: **http://www.health.qld.gov.au/mha2000/amhs/documents/amhs_schedule.pdf**	496 Milton Road Toowong QLD 4066

Appendix 4

Authorised mental health service abbreviations

Authorised Mental Health Service (Abbreviated)	Authorised Mental Health Service (full title)
Bayside	Bayside Authorised Mental Health Service
Belmont Private	Belmont Private Hospital Authorised Mental Health Service
Cairns	Cairns Network Authorised Mental Health Service
Central Queensland	Central Queensland Area Network Authorised Mental Health Service
Fraser Coast	Fraser Coast Authorised Mental Health Service
Gold Coast	Gold Coast Network Authorised Mental Health Service
Greenslopes Private	Greenslopes Private Hospital Authorised Mental Health Service
Logan-Beaudesert	Logan-Beaudesert Authorised Mental Health Service
Mackay	Mackay Network Authorised Mental Health Service
Mater	Mater Health Services Child and Youth Authorised Mental Health Service
New Farm Clinic	New Farm Clinic Authorised Mental Health Service
The Prince Charles	The Prince Charles Hospital Authorised Mental Health Service
Redcliffe Caboolture	Redcliffe Caboolture Authorised Mental Health Service
RBWH	Royal Brisbane and Women's Hospital Authorised Mental Health Service
Royal Children's	Royal Children's Hospital Authorised Mental Health Service
Sunshine Coast	Sunshine Coast and Cooloola Authorised Mental Health Service
The Park	The Park – Centre for Mental Health Authorised Mental Health Service
The Park – High Security	The Park High Security Program Authorised Mental Health Service
Princess Alexandra Hospital	Princess Alexandra Hospital Authorised Mental Health Service
Toowong Private	Toowong Private Hospital Authorised Mental Health Service
Toowoomba	Toowoomba and Darling Downs Network Authorised Mental Health Service
Townsville	Townsville Network Authorised Mental Health Service
West Moreton	West Moreton South Burnett Authorised Mental Health Service
Wide Bay	Wide Bay Authorised Mental Health Service

Appendix 5

High security units

as at 30 June 2011

Authorised mental health service:

The Park High Security Program
Authorised Mental Health Service

Administrator:

Executive Director of Mental Health Services

Address:

The Park – Centre for Mental Health Treatment, Education and Research

Cnr Ellerton Drive and Wolston Park Road,
Wacol QLD 4076

Appendix 6

Facilities established as authorised mental health services

specifically for the purpose of administering electroconvulsive therapy, as at 30 June 2011

Sunshine Coast Private Hospital Authorised Mental Health Service

Address:

Sunshine Coast Private Hospital
Syd Lingard Drive, Buderim QLD 4556

Pine Rivers Private Hospital Authorised Mental Health Service

Address:

Pine Rivers Private Hospital
Dixon Street, Strathpine QLD 4500

St Andrew's Hospital Toowoomba Authorised Mental Health Service

Address:

St Andrew's Hospital
280-288 North Street, Toowoomba QLD 4350

The Palm Beach Currumbin Clinic Authorised Mental Health Service

Address:

The Palm Beach Currumbin Clinic
37 Bilinga Street, Currumbin QLD 4213

Appendix 7

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Abbreviations and acronyms

Acronym	Full title
AD	authorised doctor
AMHP	authorised mental health practitioner
AMHS	authorised mental health service
AP	authorised psychiatrist
AWOP	absent without permission
Butler Report	Promoting balance in the forensic mental health system – Final Report – Review of the Queensland Mental Health Act 2000
CIMHA	Consumer Integrated Mental Health Application
COAG	Council of Australian Governments
CPIO	classified patient information order
CSS	Child Safety Services
DPP	Director of Public Prosecutions
ECT	electroconvulsive therapy
EEO	emergency examination order
FMHSF	Forensic Mental Health Strategic Framework
FPIO	forensic patient information order
ITO	involuntary treatment order
JEO	justices examination order
JP	Justice of the Peace
LCT	limited community treatment
MHALO	Mental Health Act liaison officer
MoU	Memorandum of Understanding
NDS	National Drug Strategy
NSMHS	National Standards for Mental Health Services
PMHS	Prison Mental Health Service
QHEPS	Queensland Health Electronic Publishing Service
QHVSS	Queensland Health Victim Support Service
QPMH	Queensland Plan for Mental Health 2007–2017
SNFP	special notification forensic patient
The Act	*Mental Health Act 2000*
The Court	Mental Health Court
The Director	Director of Mental Health
The Tribunal	Mental Health Review Tribunal

Appendix 11

Reference list

Document	Web address
Fourth National Mental Health Plan	health.qld.gov.au/mentalhealth/pub/nat_pub.asp
Queensland Plan for Mental Health 2007–2017	health.qld.gov.au/mentalhealth/abt_us/qpfmh/default.asp
Promoting balance in the forensic mental health system – Final Report – Review of the Queensland Mental Health Act 2000	health.qld.gov.au/mentalhealth/docs/Promoting_balance.pdf
National standards for mental health services 2011	health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-servst10
Queensland Health Forensic Mental Health Strategic Framework	health.qld.gov.au/mentalhealth/docs/for_fw.pdf
Mental Health Plan Statement of Rights and Responsibilities	health.gov.au/internet/main/publishing.nsf/content/mental-pubs-m-rights
Council of Australian Governments (COAG) National Action Plan on Mental Health (2006–2011)	coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/nap_mental_health.pdf
The National Drug Strategy 2010–2015	nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/DB4076D49F13309FCA257854007BAF30/$File/nds2015.pdf

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Your feedback is welcome

We welcome your feedback on this annual report. We have included a feedback form on page 89 for you to complete and return to us.

Obtaining copies of the report

This report is available both on our website and in limited hardcopy.

To obtain a hard copy contact the Statutory Administration and Policy Unit in the Mental Health Alcohol and Other Drugs Directorate.

Phone: 1800 989 451

Email: **mha2000@health.qld.gov.au**

Post: Statutory Administration and Policy Unit,
Mental Health Alcohol and Other Drugs Directorate
Queensland Health
GPO Box 2368
Fortitude Valley BC QLD 4006

How you can contact us

Phone: 07 3328 9506

Email: mhmarketing@health.qld.gov.au

www.health.qld.gov.au/mentalhealth

Feedback form

Please fill out this form and return it via:

Fax: 07 3328 9619
Email: mha2000@health.qld.gov.au

Post: Statutory Administration and Policy Unit,
Mental Health Alcohol and Other Drugs
Directorate, Queensland Health,
GPO Box 2368, Fortitude Valley BC QLD 4006

1. **Overall how effectively do you think our annual report communicates our activities?**

   - ☐ Very effectively
   - ☐ Effectively
   - ☐ Average
   - ☐ Poorly
   - ☐ Very poorly

2. **Please rate the following elements of the annual report according to the rating scale below:**

   1 = Very poor, **2** = Poor, **3** = Average, **4** = Good, **5** = Excellent

   - ☐ Information/content
   - ☐ Layout of information
   - ☐ Ease of finding information
   - ☐ Readability
   - ☐ Ease of comprehension

3. **Which version of the annual report did you find most useful?** *(If more than one, please indicate.)*

   - ☐ Printed version
   - ☐ PDF on website
   - ☐ HTML on website
   - ☐ Electronic word version

4. **For what purpose did you read or refer to the annual report?**

   - ☐ Background information on public mental health services in Queensland
   - ☐ Information on our performance in 2010–11
   - ☐ Other

5. **Do you have any comments you would like to make about the annual report?**

   _____

   _____

   _____

   _____

6. **In your opinion, how could our next annual report be improved?**

   _____

   _____

   _____

   _____

7. **Please indicate the group that best describes you.**

   - ☐ Consumer or carer
   - ☐ Non-government organisation
   - ☐ Private sector
   - ☐ Private individual
   - ☐ Professional association
   - ☐ Queensland Health staff member
   - ☐ Queensland Government employee
   - ☐ Other government employee
   - ☐ Other (please specify)

Please note: Personal details will not be added to a mailing list or stored, nor will Queensland Health disclose these details to third parties without your consent or unless it is required by law.

Toward Q2
Tomorrow's Queensland

Queensland Government

www.health.qld.gov.au/mentalhealth